

# The Right Hospital and the Right size?

## Flaws in the privately-funded £335m project to build the Midland Metropolitan Hospital

### Introduction

This report is a critique of plans for the proposed new 669-bed Midland Metropolitan Hospital for Sandwell and West Birmingham Hospitals NHS Trust.

There are concerns on a number of levels about the viability of this £340m project, which is to be one of the first hospitals funded under a variant of the controversial Private Finance Initiative, known now as PF2.

As with many other PFI schemes, it is planned to have fewer acute beds than the current Trust provision: this is a gamble given the local levels of ill health and a rising population.

It's clear that the actual cost of the MMH project over the lifetime of the 30-year contract with Carillion is underestimated in the Final Business Case. It does not set out the full implications of inflation indexation on at least part of the project.

Nor does it identify the cost of interest payments on the £97.2m of public money from the Infrastructure Projects Authority, which is key to reducing the level of private sector borrowing and thus containing the level of the annual payments (Unitary Payments) over the 30-year contract.

It's clear from the still limited information in the FBC that the borrowing of £216m from private sector banks, with the raising of an additional £28m in equity funding, will still result in a hospital that is considerably more expensive than one financed through government borrowing at today's historically low interest rates.

The optimistic presentation of the affordability of the project hinges on assumed year by year increases in caseload and income to the Trust, despite a tightening financial squeeze on the NHS and reduced numbers of acute beds to handle any increased caseload.

At the same time the expectation of efficiency savings is highly dependent upon a near halving of the non-clinical workforce, but also cuts in the pay bill for junior doctors and clinical staff other than nurses, raising concerns that the workforce will be adequate to deal with increased intensity of work.

The increases also assume a drastic reduction in average length of stay of acute patients, which in turn implies a greater reliance on the intermediate beds – but also on care OUTSIDE hospitals, community health care and social care. However there is no clear financial support for expanded community services, and social care has been subjected to repeated cuts in

resources and faces its own funding gap in the next few years, questioning the viability of the plans outline in the Final Business Case.

The claims of increased efficiencies from single site working ignore the continued requirement within the project to retain outpatient clinics, specialist services and “intermediate” beds at three other sites scattered within the Trust catchment area. This means the Trust must also retain the related backlog maintenance and potential upgrade costs for these buildings, for which no funding is identified.

The level of consultation and engagement of local people prior to embarking on this costly and risky project was minimal – a consultation exercise almost 10 years ago. Since then there has been little evidence that the concerns most raised by local people – over the viability of replacing hospital beds with community care, and the travel problems arising from the location of the hospital at the southern end of the catchment – have been taken seriously or in any way addressed.

The clinical viability of the project seems to hang to a large degree on wishful thinking and policies which have yet to demonstrate evidence of success. The financial viability is likely to be tested in the tough times of continued austerity and frozen real terms NHS funding: the extra costs of PF2 rather than public funding could yet make the difference on affordability.

And above all the question emerges from the various unresolved problems of this project: is the Midland Metropolitan Hospital the right proposal for Sandwell and the right size to serve local communities as proposed for the next 30 years?

## EXECUTIVE SUMMARY

**1.** The new hospital will have 135 fewer acute beds than the current Trust provision – a reduction of almost 17%. This is a gamble in an area with a rapidly rising population, and above average levels of ill-health.

**2.** NHS budgets have been frozen in real terms since 2010, while local authority funding for social care has been repeatedly cut: both areas of public spending face severe pressures to 2020.

The SWBHT previous surplus is no more. There are doubts if the local commissioners and providers have adequate resources.

**3.** The plan for the new hospital promotes it as a new specialist hospital, and a centralisation of services for increased efficiency.

But while the theory of this may make sense, in practice the plan involves use of more intermediate beds, some miles from the MMH site.

**4.** The small scale of the new hospital also requires the retention of clinic, outpatient services, Treatment Centre and Urgent Care Centre at City Hospital and Sandwell, all rebranded as “community facilities. Redevelopment and backlog maintenance will require additional investment, but no source of funding is identified.

Intermediate beds would also be at Sandwell, City & Rowley Regis – leaving services far from centralised.

**5.** 78% of the proposed cost-cutting “efficiencies” centre on savings on pay, with a near-halving of numbers of non-clinical staff. This will have an economic impact in Sandwell and Birmingham.

**6.** Whether or not some of the new technology will deliver the promised improvements in efficiency is open to doubt. The use of automated guided vehicles to substitute for porters raises questions over nursing and other professional staff taking on additional tasks.

The new hospital will not have its own mortuary: cadavers will need to be transported to Sandwell.

**7.** The key to the financing of the new hospital as a PF2 (variant of the Private Finance Initiative) is the addition of £97.2m of public sector capital. The Unitary Payment on the PF2 investment also covers only the cost of the building and the “Hard Facilities Management” support service contract, which the contractor Carillion has estimated to be worth £140m over 30 years.

Other support services (“Soft FM”) are excluded from the contract.

**8.** Even with the public sector money reducing the amount of private capital involved, the funding of the new hospital under PF2 only appears to be cheaper than public funding if a theoretical £105 million worth of “risk” is added to the public sector costs over the 30 years.

This validity of this concept of “risk” – which is an essential assumption in the calculation of the comparative cost of every PFI scheme – has been challenged for over 15 years by academics and by the National Audit Office.

The “Public Sector Comparator” – a costing of an equivalent theoretical project, to be funded through public money – is designed to be unconvincing and more expensive than the PF2 project. For almost all new hospital building PFI/PF2 remains “the only game in town”.

**9.** The FBC makes clear that elements (38%) of the Unitary Payment would be index-linked, rising 2.5% a year or by RPI, over the 30-year contract. This means payments will increase from £20.5m in year one to £28.7m by year 30. If the whole payment were indexed the annual charge would more than double over 30 years.

The public sector investment would be in the form of Public Dividend Capital, which does not need to be repaid, but incurs a 3.5% annual interest charge – £3.4m per year. This means the actual cost begins at £23.9m annually and rises to £30.4m, with a total cost of £810m

By contrast if the government borrowed the money at current rates of interest, the Trust could repay at £10.4m per year for the loan and £3.4m for PDC, at a total cost of just £415m.

It is standard practice in PFI to discount the value of future payments at 3.5% per year to calculate the “Net Present Value” of a project: the total Unitary Payment and PDC interest would on this basis add up to an NPV of £782m – more than double the £366m claimed in the FBC (p140)

**10.** The 30-year contract is with a specific form of company, a Special Purpose Vehicle through which the money is borrowed, and through which payments are passed on to shareholders.

£216m of the capital is borrowed from banks: another £28m is equity capital invested in the SPV, of which the government (Infrastructure Projects Authority) has invested 10% (bringing the public investment to £100m), Carillion, the preferred provider 50% and another investment company Richardsons Capital the remaining 40%.

The project is made to seem affordable by assuming an extra £10m a year in clinical income to the Trust in 2019/20 and onwards, although this is questionable given financial pressures and reduction in available beds.

**11.** The funding through PF2 delivers profits to the private investors at a time of frozen NHS funding.

One response proposed by Drop the NHS Debt is to nationalise the SPV, although on its own this would leave the loans and the PDC costs.

**12.** The project will leave the Trust with 160 fewer acute beds, but does allow “expansion space” for another 96 beds if required.

The FBC assumes a dramatic and substantial reduction in average length of stay – equivalent to around 100 beds: but the actual length of stay has increased since 2009. The Trust is also hampered by sustained high levels of delayed transfers of care – patients who do not need to be in hospital, but for whom there are no alternative services.

**13.** Clearly based on the reduced lengths of stay, the Trust is projecting significant increases in income every year from 2019 – but a drastic 19% overall reduction in staff, with a reduction planned of 16% in the junior doctor pay bill, “other clinical staff” pay bills are expected to drop by 27% and non-clinical staff by 60%.

**14.** The FBC lays claim to having been endorsed by a public consultation on reconfiguration of hospital services back in 2006-7, another age completely in the context of the NHS and its financial situation.

However the FBC makes only the most passing reference to issues raised as significant public concerns in that consultation, especially the issue of the location of the new hospital in relation to the Sandwell catchment, and the accessibility of the proposed services by public transport, especially after 6pm.

These gaps in the Trust’s planning may yet have an impact on the effectiveness and efficiency of the resulting services, which depend so heavily on reducing average lengths of stay.

**15.** The assumed caseload of the hospital depends upon the development of services outside hospital, notably social care. It appears that very optimistic assumptions have been made.

**16.** However adult social care has been subject to drastic cuts in funding for local government every year since 2010, with further cutbacks to come.

**17.** In England as a result of the cuts, 400,000 fewer people are now receiving social care than in 2005. Birmingham City Council acknowledges “higher levels of unmet need”.

**18.** The Better Care Fund, money top-sliced from CCG budgets, is already committed: the FBC hopes that it may deliver system changes to release more NHS resources from emergency services to invest in out of hospital care.

This assumption is based on outdated guidelines, which have now been revised in the light of a failure to deliver the planned reduction in use of A&E services in most BCF areas.

Sandwell and West Birmingham are not the only areas to be facing these problems: but it’s clear that the situation is not as favourable as expected and some of the cherished models of out of hospital care do not deliver the expected results.

**19.** According to SWBCCG, much of the hospital workload diverted from hospitals by the BCF is in fact expected to be offloaded onto already overworked GPs and primary care services: but it's not clear whether GPs have the will or the resources to do this.

The 2-year local plan envisages the BCF resources being deployed to facilitate a "downward trajectory" of acute beds. It remains to be seen whether or not this is possible.

**20.** SWBHT is pressing ahead with plans to speed the discharge of patients: however there has not yet been any evaluation of initiatives designed to facilitate this, such as "seven-day services for social care", or experimental "place based" networks of primary care.

Neither the costs nor the clinical viability of these schemes has been proved, or the appropriateness of scaling them up to operate across the CCG.

**21.** Sandwell's health & social care need to be planned with an eye to the specific needs of a 65+ population that will make up almost a quarter of the population (23%) by 2030, and a very substantial (56%) increase in numbers of residents aged over 85.

A 70% increase is expected of Sandwell residents entitled to support under the Fair Access to Care Services (FACS) criteria: they currently receive services costing £9.3 million per year, and this could rise to almost £16 million.

**22.** Sandwell council states that it needs to trim £23m (28%) from its £83m budgets for care and support services, with bigger cutbacks to be carried through by 2017.

It's not likely this can be done without impacting the quality and quantity of care and services available. On a best case scenario, and if all of the savings plans agreed so far were implemented, Sandwell council faces a deficit of up to £25.3m by 2020.

**It's not clear why councillors are not willing to be more open about the impossible position they are being put into by relentless central government cutbacks.**

**23.** The plans for the new hospital in Smethwick appear to be based on ill-placed optimism with a determined effort to close eyes against the looming pressures and problems in health and social care funding. For the sake of people in Sandwell and West Birmingham we have to hope that they are right: but there is little evidence that the plans are for the Right Hospital – or the right size.

**John Lister  
March 2016**

## 1. Will the new hospital be big enough?

1.1 The proposed new 670-bed Midland Metropolitan Hospital in Smethwick, to serve a population of 553,000 in Sandwell and West Birmingham, will result in a significant reconfiguration of services in Sandwell and City hospitals. This means a reduction in numbers of 135 acute beds (with an increasing reliance on trolleys in place of proper beds, and a proposed increase of 106 in the numbers of “intermediate beds” which would not be in the new hospital, but in the old sites) (FBC pp107-109).

Type of bed	Bed numbers	Bed numbers
	2014-15	2019-20
Critical care Levels 2 & 3	30	30
Children	51	50
Neonatal	29 funded cots (37 spaces)	36
Maternity	44	60*
Adult Acute Assessment	103 medical (82 beds plus 21 trolleys), 21 Surgical	117 (94 medical & 23 surgical)
Medical Acute Beds	318	224
Surgical Acute Beds	208	152
<b>Sub total</b>	<b>804</b>	<b>669</b>
<b>Change by 2019-20</b>		<b>-135</b>
<b>Intermediate care</b>	42	148
<b>SWBH Total</b>	<b>846</b>	<b>817</b>

\*Includes 10 'transitional care beds'

Source FBC pp 106-109

1.2 This is a drastic reduction in front line capacity at a time when the total population served by the local Sandwell and West Birmingham Clinical Commissioning Group (CCG) has been growing, and is expected to increase by 6% over the next 20 years. The new hospital's catchment has above average levels of health problems, suggesting more acute capacity will be required rather than less.

1.3 The plan is a major gamble, based on the shaky assumption that the growing caseload of increasingly elderly patients requiring hospital admission can be held down and reduced by diverting patients to alternative services “in the community”. The evidence for this is to say the least sketchy and insubstantial.

1.4 The £344m project, which has been signed off with the details only retrospectively published in the Final Business Case, is to be funded through a new variant of the controversial Private Finance Initiative (known as PF2), which means that the eventual cost to the Trust will be much higher than the initial capital investment.

1.5 An additional problem is that even if alternative services outside of hospital can be shown to work, they need to be set up, staffed, managed and funded. There are no spare funds to facilitate this, and no proposals for this in the PF2 Business Plans.

## **2. Frozen budgets**

2.1 The NHS in England has already endured five years of virtually frozen real terms budgets, while the main local authority, the Metropolitan Borough of Sandwell has suffered five years of outright government-imposed spending cuts.

2.2. For both NHS and council services there are five more years of cash squeeze yet to come. Yet there is no discussion of this gloomy financial background in the Business Case, and no attempt to estimate the impact of cuts in social care budgets and services.

2.3 Services are already under strain, and the December Trust Board papers for Sandwell and West Birmingham show that its finances – which the Business Plan boasted were basking in comfortable surplus – are now substantially off track for its 2015-16 targets.

2.4 There is no sign that the local NHS or local councils (Sandwell and Birmingham) have either the resources or the political commitment to deliver any appropriate level of increase in social care and community services outside hospital to support older people.

## **3. One new centre – or three centres?**

3.1 The new hospital scheme also claims it will make savings through the centralisation of acute hospital services on a single site, in place of the current split between the Trust's two sites, City Hospital on Dudley Road, and Sandwell General in West Bromwich, four miles away.

3.2 It's clear that in an ideal world a new single site acute hospital could allow some rationalisation of rotas for consultant, medical and other professional staff within such a relatively small area.

3.3 On closer examination it's clear that the "centralisation" is far from complete: the two existing hospital sites will continue to deliver a considerable volume of outpatient and other services. Problems of adequate medical and nurse staffing will if anything be made more complex with the addition of a new hospital, to create a **3-site** service.

**"Once Midland Met opens we will provide intermediate care beds in the following locations:**

- **Rowley Regis Hospital – 38 beds**
- **STC – 45 beds**
- **Sheldon Block - 45 beds**
- **Leasowes – 20 beds.<sup>1</sup>**

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<sup>1</sup> Appendix 5b Clinical Service Model for 2020, p29 (Appendices Vol 1).



## 4. Old buildings retained

4.1 Escaping from a substantial backlog maintenance bill – which, if moderate and low level problems are included adds up to £96 million – is cited as one of the main attractions of the new build single site hospital.

4.2 But the ageing Sandwell and City sites will not be completely disposed of. Instead the plan is to leave outpatient and other services on the City and Sandwell sites, which will be rebranded as “community” facilities. This means that the capital charges payable to the DH on the value of the sites will continue, alongside the additional costs of the PF2 contract – and a share of the backlog maintenance.

4.3 The PF2 plan does not identify any source of funding for redevelopment or new buildings on these sites, even though the City Hospital in particular requires a very substantial amount of maintenance.

4.4 Sandwell, City and Rowley Regis will continue to provide between them 150 “intermediate” beds, in theory to enable more rapid discharge of patients from a limited number of front-line beds in the new hospital, although length of stay in the “intermediate beds” is expected to average 17 days. But this geographical spread creates logistical problems of transporting patients between sites 4 and 7 miles away from the new hospital – and possibly further again from their homes and families.

## 5. “Efficiencies” that may not materialise

5.1 There are also grounds for concern that the planned halving in numbers of non-clinical staff could result in a problem maintaining standards of hygiene and patient care across all three sites.

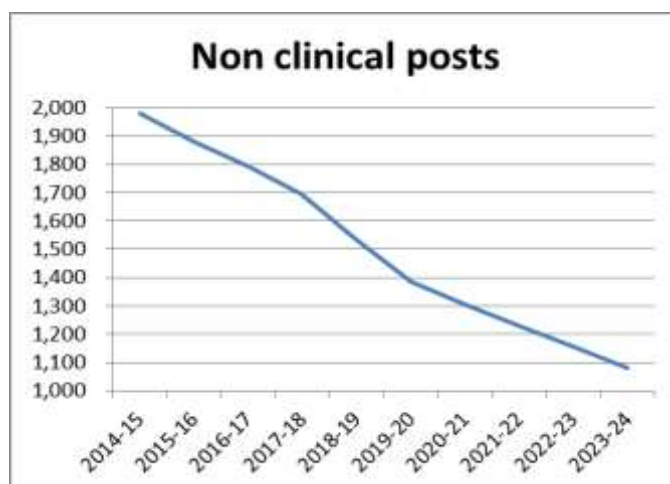


Figure 1: from FBC page 44

No less than 78% of all of the planned “cost efficiencies” in the Business Case are expected to come from savings on pay, by downsizing the workforce, and the rapid downhill trend in staff numbers can be gauged from a graph of the projected staff numbers outlined in the FBC:

5.2 While a reduction in staff on the level required might be achieved without redundancies through ‘natural wastage’ (given the Trust’s relatively high rate of turnover) the reduced staff numbers and bed capacity still represent a serious loss of jobs in the area, with all the economic implications for the communities in the vicinity of the new hospital – and, from the point of view of this analysis, raise serious questions over the ability to deliver adequate services to a growing and ageing population.

## 6. High hopes for technology

6.1 While the Trust argues that some of these jobs are being lost simply as part of the financial squeeze rather than as a result of the PFI – raising further questions about the potential impact on patient care of changes that are motivated primarily by financial concerns – it’s clear that some of the changes are linked to the new hospital.

Some of the much-vaunted “efficiencies” for example appear to depend upon the effective implementation of a new and as yet still incomplete Electronic Patient Record system (the Holy Grail sought by IT experts for at least the past 15 years, which requires considerable investment<sup>2</sup>) and other IT systems, while others depend upon a system of automated guided vehicles to replace porters which initially cost more in capital investment, and have yet to be put in place, let alone proven reliable<sup>3</sup>.

Nonetheless the electronic system – even if it does eventually work – still needs input of accurate information, to be gathered from patients. The automated trolleys – even if they work – need to be loaded up and unloaded, with goods in each case hopefully in the right place.

6.2 Of course support staff are not to be employed to do this work, it will fall to clinical staff – mainly nurses – to do it, over and above, or instead of their main clinical work. Given the high levels of nursing vacancies requiring costly use of agency staff, whether this is seen as “efficient” or not is a matter for some debate. Interestingly spending on agency staff seems to be expected to remain almost constant under the projections in the FBC.

6.3 Meanwhile a new, inbuilt *inefficiency* arising from the PF2 scheme is the (unexplained) plan for the Trust’s main mortuary to be located not on the new £285m acute hospital site, but remain at Sandwell, with just a “body store” to be provided in the MMH – requiring regular van journeys to transfer the deceased, unless a robot has been devised for this task (FBC p119).

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<sup>2</sup> See FBC pp 40,57,156,212 and passim

<sup>3</sup> The FBC argues optimistically that one benefit of the AGVs if they work is that their “Availability 24 hours a day, seven days per week” and that if they do in fact work as promised, and the goods they required are properly stored in the right place by the reduced numbers of human portering staff, they would therefore generate savings in staff costs and avoid wasted time searching for needed supplies (FBC p 193: see also p 159-160).

## 7. Hidden handouts that make PF2 seem cheaper

7.1 The FBC makes clear that the PF2 scheme relies financially on a handout of £97.2 million of public sector capital towards the total cost of the new hospital, which reduces the level of private sector borrowing, and as a result the repayments, since there is no requirement to repay the core investment. (FBC p220).

In addition the financial projections include a “tapering” fund, another hidden subsidy, again of public money to ease the first years of the Unitary Charge (p230).

7.2 As a slimmed-down project compared with many of the more extravagant PFI deals signed in the West Midlands since 1997 (not least Dudley Hospitals, where a £137m hospital is set to cost £2.2 billion in escalating unitary charge payments over the PFI contract), the MMH contract includes no support services (“Soft FM” – p159) – only the provision of the new hospital building itself and the maintenance of the building (so-called “Hard Facilities Management”) over the lifetime of the 30-year contract (p159).

7.3 Other so-called Soft FM non-clinical support services (cleaning, catering, portering, security) which provide an additional profit-stream for PFI consortia in most early PFI schemes are specifically excluded, although the Trust may in a separate process decide to put these out to tender.

So the “Unitary Payment” (the annual fee payable to the PFI “partner” for the use of the hospital and the linked services) covers relatively little. Outside of the pages of the FBC, Carillion has estimated to its shareholders that the value of the Hard FM contract, which runs for the duration of the PF2 agreement, will be £140m over 30 years<sup>4</sup>.

7.4 Since Carillion is a hard-headed private corporation with long experience of PFI schemes, we can assume with some confidence that this builds in some guaranteed profit to make it worth their while. It’s not clear how much hard bargaining was focused on seeking a reduction in this very substantial cost in proportion to the whole scheme.

## 8. Who carries the risk?

8.1 The justification for using private sector money to build the new hospital hinges on the £97.2m public sector handout, along with the assumption that the private sector would take over responsibility for any “risk” in the project – **and that this “transfer of risk” can be valued at £105m** (FBC p142).

The National Audit Office in 2012 pointed to the limited amount of risk involved in PFI schemes, especially in the NHS, where the government is underwriting costs. The NAO states:

“Equity investors’ returns are expected to be high relative to the senior debt lenders because they take on greater risk. There has not, however, been a recent conclusive

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<sup>4</sup> <http://www.project-resource.co.uk/blog/article/carillion-finally-reach-agreement-on-430m-midlands-hospital>

overall evaluation of whether equity returns are justified by the amount of risk equity investors bear<sup>5</sup>.”

Professor Allyson Pollock goes further in addressing the specific way in which the assumed cash value of “risk” is used both to distort comparisons and make publicly-funded options appear more expensive, and to inflate the interest rates payable:

“The UK parliament has repeatedly questioned the lack of evidence in support of risk transfer and value for money claims. In July 2010, a National Audit Office paper to a House of Lords committee described value for money as “subjective judgements of risk, which can easily be adjusted to show private finance as cheaper.” The chairman of the Public Accounts Committee described PFI as “probably the most secure projects to which the banks could lend.”<sup>6</sup>

Back in 2001 as the use of PFI as the way to fund new hospital projects was first becoming established, Julie Froud and Jean Shaoul investigated the way in which the figures were manipulated and came to the conclusion that the cash pricing of “risk transfer” was the key to the argument for PFI financing:

“The process of risk transfer is ...central to PFI, not least because, as the Health Minister recognised, a privately financed option is unlikely to represent value before risk transfer. Quite how much risk should be transferred is a matter of some ambiguity. The policy has shifted from an early recommendation of ‘maximum’ to a seemingly more scientific but essentially vague ‘optimal’.”<sup>7</sup>

**So the Midland Metropolitan Hospital is similar in this respect to almost every other PFI project. Only on this questionable assumption of transferred risk can the Trust make a hypothetical “Public Sector Comparator” – which would otherwise be seen as cheaper – appear to come out more expensive than the PF2 scheme.**

Of course all of these figures are purely hypothetical, as is the very nature of the “Public Sector Comparator”, which is a notional publicly-funded plan used as a comparison with the PFI cost. But of course this theoretical plan is never intended to do anything other than fail in comparison with the actual PF1/PF2 project.

8.2 The questionable use of such subjective methods to make PFI projects seem better value for money has been challenged repeatedly over the years by critics of the system, who point out that much of the “risk” is largely imaginary. This is because in any scheme, even one that

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<sup>5</sup> National Audit Office (2012) Equity investment in privately financed projects (page 15), Report by the Comptroller and Auditor General HC 1792 Session 2010–2012, 10 February 2012, The Stationery Office, London

<sup>6</sup> Pollock AM, Price D. (2013) *PFI and the National Health Service in England*, [http://www.allysonpollock.com/?page\\_id=1737](http://www.allysonpollock.com/?page_id=1737)

<sup>7</sup> Froud J & Shaoul J (2001) Appraising and evaluating PFI for NHS hospitals, *Financial Accountability & Management*, 17(3), August 2001, 0267-4424 available (£): <http://onlinelibrary.wiley.com/doi/10.1111/1468-0408.00130/epdf>

were publicly-funded, the most risky phase – the construction of the new building on time and within budget– would be contracted out to construction companies, with penalty clauses for late completion and faulty work<sup>8,9,10</sup>. These would in fact transfer the risk to the private sector anyway.

Others have questioned the need to transfer risk at all for a contract with such a long life-span.

8.3 The MMH PF2 Business Plans argue that a (mythical and deliberately unconvincing) “Public Sector Comparator” would leave the Trust holding risk equivalent to £112.4 million, compared with trust risks of just £20.3m under the PF2 plan – conveniently reversing the initial costing elements, to make the Public Sector Scheme appear £84.6m more expensive than PF2.

We should not be surprised that this is the finding, since the design of the PSC was always intended to deliver this unfavourable comparison – otherwise the case could not be proven for PF2, and in the absence of any government funding, the plans for the new hospital would have had to be discarded. The Private Finance Initiative remains the “only game in town” for trusts hoping to secure new hospitals<sup>11</sup>.

## 9. More financial manipulation

9.1 The Final Business case (p224) makes clear that 38% of the Unitary Payment would be indexed annually, with an increase of at least 2.5% each year, or RPI, to allow for inflation. It does not explain that this means that payments which are expected to begin in year one at £20.5m will rise over the 30 years to £28.7m: if the whole of the UP were indexed at 2.5% it would rise from £20.5m to £42m by year 30 – with a total cost of £900m.



<sup>8</sup> Hellowell, M and Vecchi, V. (2012), 'What return for Risk? The Price of Equity Capital in Public-Private Partnerships'. In Greve, C and Hodge, G (eds), *Rethinking Public-Private Partnerships: Strategies for Turbulent Times*, Abingdon, Oxon; New York, NY: Routledge, ch. 3

<sup>9</sup> [https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwj59eL\\_x5vLAhUEAZoKHUQkB90QFggcMAA&url=http%3A%2F%2Fricardoraphael.com%2Fwp-content%2Fuploads%2F2015%2F08%2FCosts-of-PFI--Drop-the-NHS-Debt.pdf&usq=AFQjCNEbdXTsC5slvQ9AFQO1MT\\_YVWyVnA&cad=rja](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwj59eL_x5vLAhUEAZoKHUQkB90QFggcMAA&url=http%3A%2F%2Fricardoraphael.com%2Fwp-content%2Fuploads%2F2015%2F08%2FCosts-of-PFI--Drop-the-NHS-Debt.pdf&usq=AFQjCNEbdXTsC5slvQ9AFQO1MT_YVWyVnA&cad=rja)

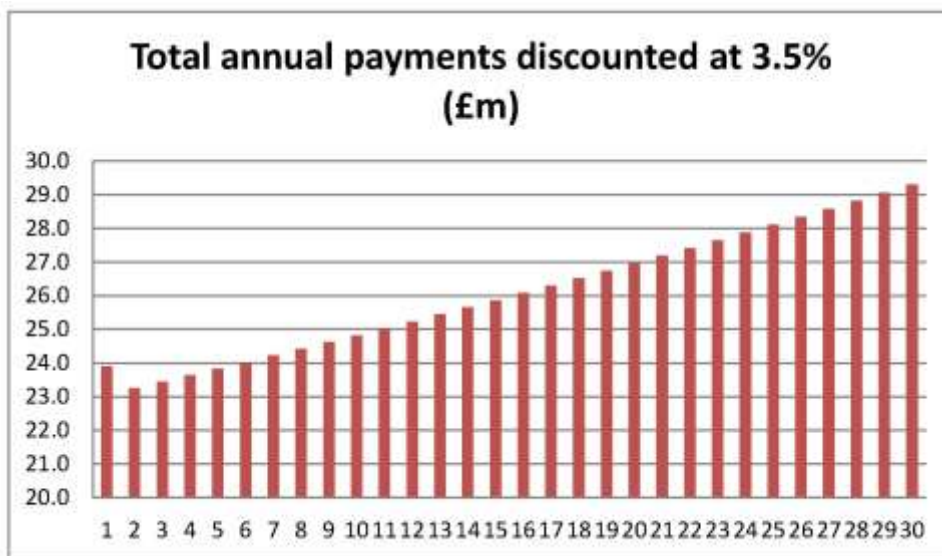
<sup>10</sup> <http://www.theguardian.com/commentisfree/2009/apr/07/olympics-2012-m25-pfi>

<sup>11</sup> Nicholas Timmins: “Warning of 'spurious' figures on value of PFI”, *Financial Times*, 05.06.2002

It also appears from the FBC that the Public Dividend Capital would be an investment, and as such not be repaid, but would be subject to additional interest payments of 3.5% (at least £3.4m/year, to continue indefinitely)(FBC p 224). This would mean that actual costs to the trust are set to increase from £23.9m in year one to £30.4m over the 30 years – **a total outlay of £810m on the new hospital project.**

Since we know from Carillion that £140m of this total payment would be in payment for Hard FM services, this would leave the **cumulative cost of the building itself at £670m** –almost double the cost of the new hospital.

In fact even if the combined UP and PDC interest are discounted at 3.5% the real total cost, taking into account indexation seems likely to be **£782m** – far higher than a publicly -funded option.



**9.2 By contrast, in 2015 and 2016, governments have been able to borrow for investment at less than 1% interest<sup>12</sup>.** Even repaying the government the **full total capital cost** at an exorbitant 2% per year, a publicly funded scheme would cost less than £15m a year, and a **total of less than £450m** over 30 years.

If the £97.2m was to be left unpaid, as is proposed with the PF2 contract, public sector borrowing could allow the Trust to repay the remaining £235m over 30 years at just over **£10.4m per year, for a total cost of £313m**, in addition to the 3.5% interest on the Public Dividend Capital – **a total of £415m.**

***So the cost is clearly higher under PF2.***

**9.3** In the Business Cases the cash cost of the project is minimised by the practice of discounting the present value of Unitary Payments each year using the 3.5% rate assumed for calculating NPV in other PFI schemes (p128).

<sup>12</sup> <http://www.ft.com/cms/s/0/90ca12c0-d0b0-11e5-831d-09f7778e7377.html#axzz41Ud09Two>

If this is done, of course the “net present value” of the £19.6m Unitary Payments over the life of the contract (with no indexation, and no account taken of the PDC interest charges) can be made to seem much smaller, at £366m (p140) rather than the £588m total if we just calculate 30 years at £19.6m.

**But the cost of the PF2 project is still HIGHER than public funding options (9.2 above) in these times of extremely low interest rates.**

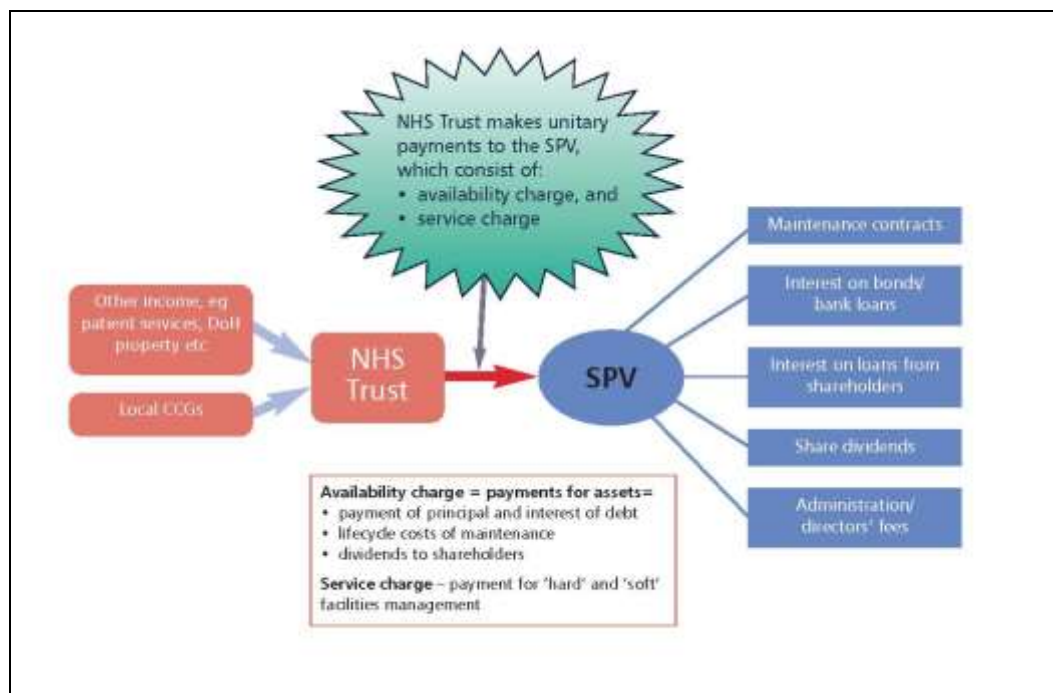
In fact the payments start not at £19.6m but at **£20.5m** (FBC p37), and the total Unitary Payment and PDC interest would even on the basis of 3.5% discounting, **add up to an NPV of £782m** over 30 years – more than double the £366m claimed in the FBC.

**The FBC seriously understates the actual cost of the project**, and it appears that the Trust is misleading itself, with potentially serious consequences.

**And with NHS funding frozen, diverting any additional scarce NHS revenue funding into private coffers makes no sense at all except to the bankers who will profit from it.**

## 10. Where does the money go?

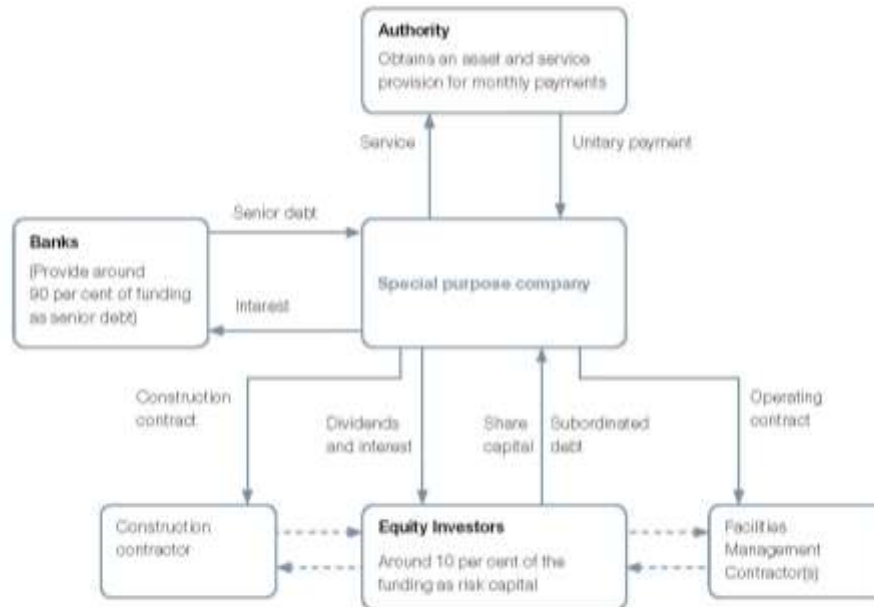
10.1 The 30-year contract for the new hospital is one between the Sandwell and West Birmingham Hospitals Trust and a special form of company, known as the Special Purpose Vehicle (SPV) – The Hospital Company – through which the consortium of companies and financing bodies is held together.



**Figure 2 The workings of the SPV - from Nationalise the Special Purpose Vehicles, People vs Barts PFI, December 2015 <https://peoplesbartspfi.wordpress.com/2015/12/10/413/>**

10.2 The Final Business Case sums up the way this works. Under a normal PFI the capital investment would be financed largely by the preferred provider, most of it through loans. A small proportion of the total will be raised as equity, paying dividends to those with a share.

A typical project company financing structure



**NOTES**

- 1 Banks, or bondholders, provide the senior debt on a project finance basis.
- 2 Broken arrows represent the likelihood that the contractors will also be investors.

Source: National Audit Office

In the £341.8m MMH PF2 scheme, the public sector (Infrastructure UK, now the Infrastructure and Projects Authority, IPA) puts up a share of the capital – more than a quarter of the total (£97.2m).

The remainder (£244.6m) was to be raised through “senior debt funding” of £216.5m, plus an ‘Equity Bridge Loan’ of £28m.

Again distinctive to PF2 is that part of this £28m Equity funding was also subject to competition. The IPA has also taken a share (10%) with the same returns as the selected equity funder (FBC p199).

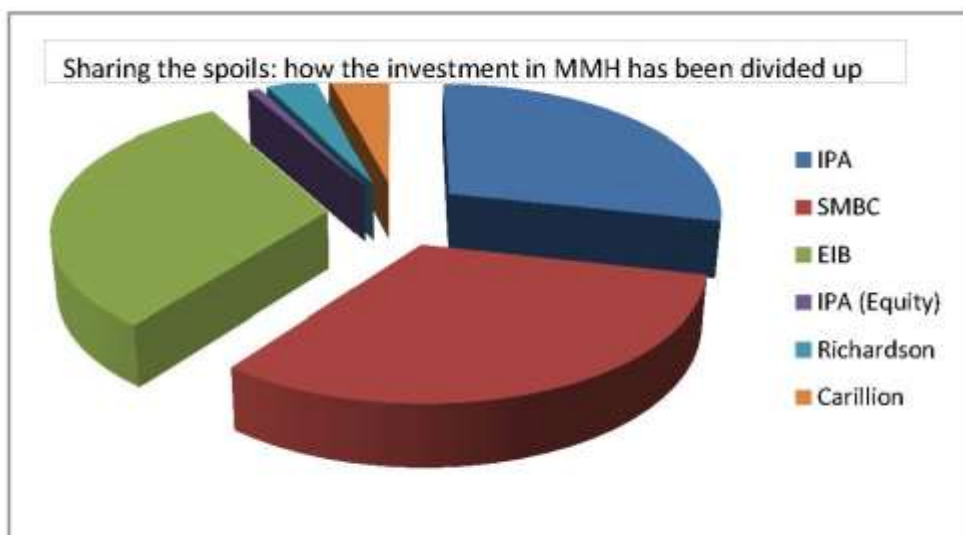
50% of the equity was to be taken by the preferred provider Carillion (in the event the figure was £16m), and 40% by Richardsons Capital, the third party company that came out best in the competition.

Of the £216m of “senior” debt, £109m is to be funded by banks Credit Agricole, KfW and Sumitomo Mitsui Banking Corporation (SMBC)<sup>13</sup>, with the remaining £107m from the European Investment Bank EIB, from the European Fund for Strategic Investments<sup>14</sup>.

<sup>13</sup> FBC p204

<sup>14</sup> <http://www.operis.com/news/midland-metropolitan-hospital-pf2-reaches-financial-close/>





The interest rates payable on these loans have not been divulged, although the forecast amount of interest payable by the Trust increases by over £10m a year from 2019, which should be the first full year of the new hospital (FBC p224, table 93).

If the interest payments were to continue at £10m-plus higher than pre-PF2 for the 30 years of the contract, this would obviously amount to £300m: even discounted over the years at 3.5%, this would still be the equivalent of £187m in net present value.

So the annual Unitary payments, covering availability of the new hospital and Hard FM services, which start at £20.5m (FBC p224) will cover interest and repay principal over 30 years, but also pay interest to each of the banks and to Carillion, Richardson and the IPA on the equity, while the public sector stake (Public Dividend capital) will be subject to a 3.5% (£3.4m) annual 'dividend' or interest charge.

**10.3 The sums only balance at all because the Trust is also assumed to gain an additional £10m of clinical income in 2019/20, and further increase clinical income thereafter (FBC p224) – although this is not explained in the context of the reducing number of beds, the focus on reducing numbers of admissions, and frozen NHS budgets falling in real terms.**

## 11. A long term problem for the Trust

11.1 As we have seen (above) the profits for the banks from this investment come at the expense of the NHS and public purse, and increase the cost of delivering the new hospital at a time when real terms NHS funding is little more than frozen in real terms.

PF2 is little different in this sense from the PFI schemes it has replaced.

In response, Drop the NHS Debt, together with People vs Barts PFI have published a proposal to address the potential long term costs and leeching of NHS resources into private sector coffers by nationalising the Special Purpose Vehicles, shares in which are already in any case the centre

of a lively trade in the equity markets,<sup>15</sup> often scooped up by offshore banks and investment houses which pay little if any tax on the profits they collect.

11.2 The proposal for nationalising SPVs does not yet address the specifics of PF2, and on its own would leave the Trust holding the loans and the PDC costs. However it seems to be a relatively low-cost way of undoing some of the long term damage and costs that would otherwise impact on health services in Sandwell and West Birmingham, as well as traditional PFIs elsewhere in the NHS.

## **12. Will the new hospital be viable financially?**

**12.1 The plans would leave the Trust with substantially reduced medical and surgical bed numbers in the new hospital. Conspicuously the plans include provision of “expansion space” for up to 96 extra beds if projections go wrong (FBC p 112).**

The FBC assumes – but does not explain or give evidence for expecting – a rapid, dramatic and substantial reduction in average length of stay – equivalent to a reduction of around 100 acute beds(pp 118, 133, 213):

“The planned reduction in length of stay reduces the forecast bed requirements within the acute hospital and this is reflected within the cost projections over the next few years as length of stay and improved models of care impact on bed provision. **A net reduction of circa c100 beds is modelled to occur by 2019-2020 with circa 160 fewer acute beds and circa 60 more intermediate care beds compared with today’s model of care.**” (p213)

However it’s not clear in the FBC whether this is to be achieved simply by switching patients to “intermediate” beds elsewhere in the Trust.

**Meanwhile, *against the blithe optimism*, according to HSCIC figures the Trust’s actual ALOS is not falling, but has gone UP since 2009 from 3.8 days to 4.**

12.2 The Trust’s December Board meeting notes the problem of the current “sustained high delayed Transfers of Care” patients in acute beds. It proposes this should be partly tackled (or at least relocated) by establishing a “joint Health and social care ward” at the City Hospital site in 2016.

The FBC also assumes reductions in numbers needing in-patient treatment: this appears to hinge on assumptions of rapid results from “public health” interventions, an illusion shared by most NHS plans including Simon Stevens *Five Year Forward View*.

But in Sandwell and West Birmingham there have been increases in caseload since 2009 among under-14s (up 15%) and over 75s (up 13%). There’s not much chance public health measures will have much short term impact on these groups, whose health is already impaired.

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<sup>15</sup> <https://peoplesbartspfi.wordpress.com/2015/12/10/413/>

### **13. More patients, more income – fewer staff?**

13.1 The Trust's projections assume numbers of admissions to rise again from 2016/17, with levels of income from admitted patient care also rising after a slight dip 2017 to 2019, with consistent increases thereafter (FBC p218).

**According to the FBC the projected levels of NHS clinical income are expected to grow by upwards of 2.5% per year from 2018, while pay costs are expected reduce by £53m (18.5%) in the ten years to 2023/4.**

**Numbers of staff are to be reduced by 19% overall, from 6,962 in 2014/15 to just 5,674 in 2023/4.** (FBC p 222)

Spending on **junior doctors** is expected to fall by 16%, the pay bill for **acute nursing staff** is expected to fall by 7%, **other clinical staff pay (including HCAs** who play a key role in patient care) is expected to **plummet by 27%**, and non-clinical staff pay is expected to more than halve, with a massive 60% reduction over 10 years (£57m down to £22m).

Community nursing is the only pay bill expected to rise, by 55%, from £18m to £28m.

13.2 All of the contradictory or inconsistent approaches raise serious questions over the longer term financial and clinical viability of the new hospital and the trust itself. The mix of insufficient revenue and staff in a hospital with potentially rising caseload and inflexible and steadily rising overhead costs in the PFI payments is a formula for financial and organisational chaos.

### **14. Is the hospital in the right place?**

14.1 The public consultation on the outline proposals for the new hospital project was carried out no less than nine years ago, in another time completely as far as NHS finances and the general pressures on services are concerned. That was mid-way through the rising budgets of the 2000s: we are now half way through the frozen budgets that will dominate from 2010-2020.

14.2 There is only the most token reference to the consultation and the issues raised in the FBC, but the analysis of the Right Care Right Here consultation back in 2007, published as Appendix 3c to the Outline Business Case, showed a considerable level of public unease over the proposed changes.

14.3 Asked whether there were any parts of the proposals that people were concerned about, the highest number (453 responses) centred on concerns over the Community Care proposals, and doubts over whether they could deliver sufficient support to reduce need for hospital beds and enable the system to reduce the numbers of beds as planned.

14.4 There were another 348 responses which were grouped by the analysis under “Management” but which also centred on doubts whether there would be sufficient hospital provision, and whether it would be accessible.

14.5 Transport, travel and access issues were also high on the list of concerns, with 358 responses, and many of these raised the issue of the location of the hospital away from the geographical centre of Sandwell, and much closer to Birmingham, and the City Hospital. Conversely those from the West Birmingham side have spoken out since against moves to centralise emergency surgery at Sandwell in the period prior to the new hospital. Underlying these are concerns over the congestion of traffic, the costs, frustrations and delays of inadequate public health links, especially after 6pm and before 8am, and the specific concerns of parents and carers fearing the need to transport children or frail older patients to and from more remote hospital services.

Significantly issues of access and transport were not among the 15 issues on which they were asked to express their level of concern:

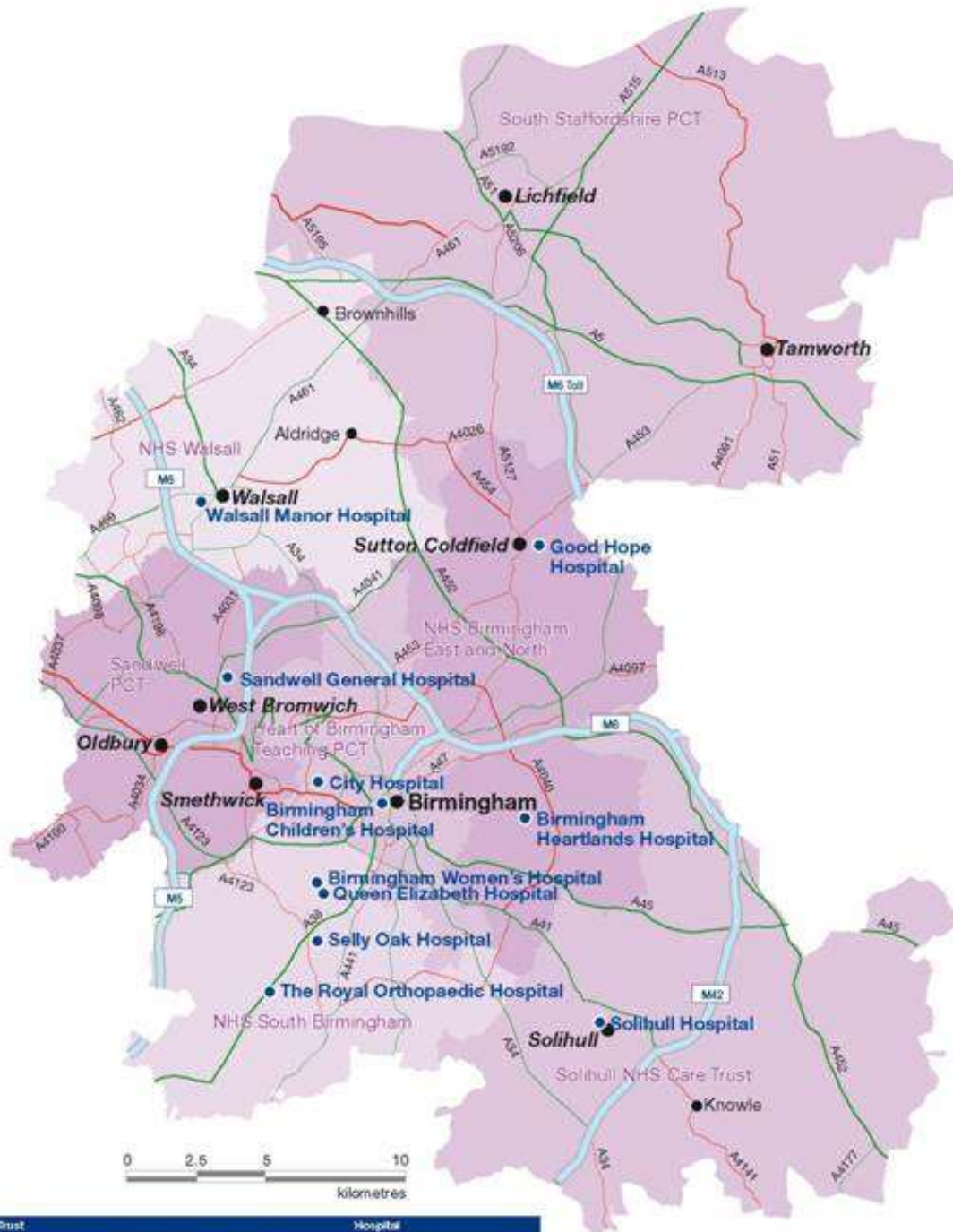
“Respondents were asked to rate a range of 15 services and aspects of services according to their perceived level of importance, and these were attributed a figure: not important (1), slightly important (2), important (3), and very important (4).”

(FBC Appendices Vol 5: Appendix 21a p62).

It seems from this that the consultation was designed by those who did not want to know the public’s views on access issues.

14.6 Responses to the concerns raised over accessibility of the new hospital have been consistently vague, evasive and inadequate. It’s clear that few senior NHS managers and fewer of those brought in to research issues for the Trust in preparing the FBC make regular journeys by public transport, or have any comprehension of the problems faced by single parents on low incomes with more than one child having to transport one of their children to hospital with others in tow.

Less surprisingly, therefore, given the obvious low level of Trust interest in seeking consultation responses on the issue and low awareness of community concerns among trust management, transport links for patients and visitors are barely discussed in the FBC itself, with references largely restricted to page 276.



Trust	Hospital
Birmingham Children's Hospital NHS Foundation Trust	Birmingham Children's Hospital
Birmingham Women's NHS Foundation Trust	Birmingham Women's Hospital
Heart of England NHS Foundation Trust	Good Hope Hospital Solihull Hospital
Royal Orthopaedic Hospital NHS Foundation Trust	The Royal Orthopaedic Hospital
Sandwell and West Birmingham Hospitals NHS Trust	City Hospital Sandwell General Hospital
University Hospital Birmingham NHS Foundation Trust	Queen Elizabeth Hospital
Walsall Hospital NHS Trust	Selly Oak Hospital Walsall Manor Hospital



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Strikingly, the FBC lacks any map showing the new hospital's precise Smethwick location in the catchment area, any explanation of why this location (which clearly favours West Birmingham residents rather than those further into Sandwell) was chosen, or any discussion of accessibility issues.

14.7 As a result, the problems have not been addressed, and the equality impact of the chosen location for the new main hospital (and the resultant deployment of “intermediate beds” across the Trust’s geographical area, with potentially more complex journeys for family visitors) remain largely unexplored.

These gaps in the Trust’s planning may yet have an impact on the effectiveness and efficiency of the resulting services, which depend so heavily on reducing average lengths of stay.

## **15. Will social care take the extra load from NHS?**

15.1 The highly optimistic assumption of how many fewer beds can safely be provided once the new Midland Metropolitan Hospital is in place hinges fundamentally on the ability to develop new services outside hospital – in community health care and social care. There are real and growing doubts over the viability of such assumptions.

15.2 Back in 2012, Sandwell & West Birmingham Hospitals Trust and the CCG felt able to sign up for “The Birmingham & Solihull Partnership Compact” which outlined aspirations of social care taking over from hospitals, promising a “new landscape of health and social care in Birmingham and Solihull ... characterised by:

- Social care and health monies being used more for prevention than being limited to crisis support. ... We will seek the near elimination of delayed discharges.
- “fewer emergency admissions, shorter lengths of stay”
- “The size of the community/primary care sector will increase....<sup>16</sup>”

Of course there have been ritual nods in support of such notions of diverting care away from hospitals – but these gestures have not been sufficient to generate the required changes on the ground.

## **16. Social care under pressure**

16.1 In fact, as the population rises in Sandwell and West Birmingham, and with it the proportion of over-65s and more dependent older age groups, the resources for any alternative services are being dangerously cut back.

Gross spending on adult social care in England was just £17.3 billion in 2013/14 – of which £2.7 billion (almost 16%) was raised from means-tested fees and charges on service users, mainly on older people with assets and savings: 52% of adult social care goes on older people, but the remaining 48%, younger adults, people with mental health problems and learning difficulties, seldom have much in the way of means to test.

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<sup>16</sup> NHS Birmingham & Solihull (2012) The Birmingham & Solihull Partnership Compact, available [http://www.solihull.gov.uk/Portals/0/StrategiesPlansPolicies/SocialCare/Frail\\_Elderly\\_Programme\\_Plan.pdf](http://www.solihull.gov.uk/Portals/0/StrategiesPlansPolicies/SocialCare/Frail_Elderly_Programme_Plan.pdf)

16.2 In addition another £10 billion is forked out privately for care each year, much of this by older people who have been left to cover their own costs with no social care service support. Many of these have needs which fall just below the increasingly high threshold for eligibility to social care – the very people for who appropriate preventive care might make the difference between them needing hospital care and being able to support themselves.

## 17. Austerity cuts bite

17.1 Official figures show that as the cuts have impacted on social care, reducing budgets in England by around £4.6 billion in the last five years (a cut of around 31% in real terms) some **400,000 fewer** people are now receiving publicly funded support than in 2005, while it's expected that there will be a **50% INCREASE** in the numbers of people living with multiple long-term conditions in the 10 years 2008 to 2018.

To make matters worse, private sector providers of social care and nursing home provision are being forced into crisis, and more than half of them facing financial problems as a result of the prolonged freeze on prices paid for care by councils: some providers are pulling out of the care “market”.

All this, according to Birmingham City Council's summary of findings from the Association of Directors of Adult Social Services – from which the above data has been taken -- means “**higher levels of unmet need**”, much of which is displaced “most likely to unpaid carers **and the NHS**” [emphasis added JL]<sup>17</sup>.

17.2 Birmingham City Council, which has lost 9.34% of its spending power since 2012, has been hit by the sixth heaviest cutback among local authorities, impacting on the West Birmingham catchment of the Trust. Further cuts which are set to take place up to 2020 will have an increased impact on adult social care “because the potential for more savings in other areas of [local government] expenditure is ever-reducing”<sup>18</sup>.

Only a reducing share – currently 18% – of Birmingham City Council's care provision is directly provided, so the remaining 82%, delivered by private and non-profit providers, is under severe pressure, with another 40% reduction in resources yet to come<sup>19</sup>.

And to cap it all the government has imposed a **£200m cutback in Public Health budgets**, impacting on precisely the preventative services that are supposed to relieve the longer term burden on hospital and the NHS.

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<sup>17</sup> Alan Lotinga (2015) *Funding of Adult Social Care – Care and Dementia Show – Service Director Health and Wellbeing Birmingham City Council*, Birmingham 3/11/15.

<sup>18</sup> Cordis Bright Consulting (2015) *Cordis Briefing*, July 2015.

<sup>19</sup> Steve Wise (Birmingham City Council) (2014) *The Transformation and enterprise of social care*, paper at CIPFA Annual Regional Seminar Reforming the Public Sector October 2014.

## 18. The Better Care Fund to the rescue?

18.1 Great store has been placed on the resources that can be drawn from the Better Care Fund, most of which is in fact an NHS fund, composed of resources top sliced from NHS (CCG) budgets.

A 2015 Update to Better Care Fund plans for Sandwell and Birmingham argues both that the plan itself “supports the delivery of ... for Sandwell and West Birmingham the Midland Metropolitan Hospital Business Case,” and refers to “enhancing existing health and social care integration”<sup>20</sup>.

But it goes on in the very next paragraph to admit that “the BCF is not ‘new’ money; the fund is currently committed against existing service provision.”

Nonetheless it goes on to argue that “The 2 year plans outline the expectation that the BCF work programme **will deliver system changes** which will **enable the release of resources currently spent on unplanned care** in order **to invest in out of hospital care** and protect social care provision under threat from funding cuts.”

However this is based on the 2015-16 guidelines for the BCF, which held back £1 billion nationally to reward those areas where emergency admissions were reduced by 3.5% in the year. Subsequent guidance, apparently as a result of the near-universal failure to achieve such reductions, has been revised.

While this may mean that more money is technically available, it also means that hopes of recycling resources from front line emergency services into out of hospital care are definitely unrealistic at present.

18.2 However the "provider commentary" in January 2015 from the Sandwell and West Birmingham NHS trust is less than a ringing endorsement. It notes that:

"Non-elective demand is running significantly ahead of plan in 14-15. **We foresee little prospect of the above reduction [893 non-elective admissions] in 2015-16. However we recognise that the BCF plan aims to do that....** We note the age profile of City admissions and think that further work is needed to ensure that projects to change admissions target accurately at the admitted population. ...

The trust [has] considered these proposals carefully. **As drafted they are at variance with forward plans**, but we accept the commitment of RCRH partners to reconcile

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<sup>20</sup> Local Government Association & NHS England (2015) Better Care Fund planning template – Part 1, January 2015: page 36-37.



aspirations and to ensure that the income plan envisaged to support acute reconfiguration through Midland Met is delivered.<sup>21</sup>"

18.3 Sandwell's trust is not alone in doubting the achievability of the planned reductions in emergency admissions: the Heart of England NHS Foundation Trust chief executive points out: "In considering the implications of these plans, we have taken account of the current growth trend in emergency admissions. As our current forecasts indicate an annual growth in emergency admissions of over 5% the Birmingham Cross City CCG **we do not expect a reduction in the level of resources required as a result of these plans, to deliver services.**"<sup>22</sup>

Birmingham University Hospital Foundation Trust chief executive takes the same view too: "Whilst we agree with the target 3.5% reduction related to BCF schemes and we are working closely with the CCG to realise this, **the likely outturn for trust activity in 14-15 will be higher than plan....**"<sup>23</sup>

Nor does the BUHFT response seem to accept the idea of releasing resources for primary care and community services outside hospital. Instead: "The trust welcomes the opportunity to reduce the level of emergency admissions into hospital as this will **free up capacity for tertiary care.**"

## 19. Will GPs accept – and cope with – the extra work?

18.1 Not only is there no evidence that these savings can actually be made, but it's clear that according to the CCG, much of the hospital workload is in fact expected to be offloaded onto already overworked GPs and primary care services:

"GPs will play a central role as both commissioners of services, providers of primary health services and care co-ordination of the most vulnerable patients."<sup>24</sup>

Whether GPs in Sandwell and West Birmingham are willing and able to take on this potentially heavy additional caseload on top of their existing commitments is open to serious doubt, especially given the problems already evident across the country in recruiting and retaining doctors to work as GPs. We note that in Birmingham the Local Medical Committee, responding to these proposals and the "direction of travel", expressed concerns about general practice capacity across Birmingham<sup>25</sup>.

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<sup>21</sup> Local Government Association & NHS England (2015) Better Care Fund planning template – Part 1, January 2015: Annex 2- Provider Commentary, pages 73-74.

<sup>22</sup> Local Government Association & NHS England (2015) Better Care Fund planning template – Part 1, January 2015: Annex 2- Provider Commentary, page 75

<sup>23</sup> Local Government Association & NHS England (2015) Better Care Fund planning template – Part 1, January 2015: Annex 2- Provider Commentary, page 76

<sup>24</sup> Sandwell and West Birmingham CCG *Operational Plan 2014-16*, p 24

<sup>25</sup> Local Government Association & NHS England (2015) Better Care Fund planning template – Part 1, January 2015: page 39

19.2 Not only is the Better Care Fund supposed to generate savings in reduced use of emergency services, it's also supposed to facilitate a dramatic **reduction in lengths of stay in hospital beds** – on which the optimistic assumptions on bed provision in the new hospital are based:

"the 2 year plan clearly draws the role of the BCF in delivering an efficient urgent care system, effective intermediate care and enablement home-care services to ensure rehabilitation and enablement: **the reduction of lengths of stay and the elimination of delayed transfers of care.**"<sup>26</sup>

Indeed the BCF document also explicitly states that:

"during the next two years and during the transition to the new Midland Metropolitan Hospital, **the bulk of the Better Care Fund will have been deployed in support of a continued downward trajectory of acute beds** and an upward trajectory of primary care, community and voluntary services."

**While the downward trajectory is clear in the plans for the new hospital, the promised boom in primary, community and voluntary services is less apparent, and not itemised in any concrete or convincing plan. Nowhere is there any discussion of the rising numbers of older and vulnerable people in the catchment of the hospital, or the pressures their needs potentially put on acute, primary and community-based services.**

## 20. No evaluation of projects

20.1 The Sandwell and West Birmingham hospitals trust is pressing ahead with plans which they hope will speed the discharge of patients: however in Birmingham there has not yet been any evaluation of initiatives designed to facilitate this, such as "seven-day services for social care, rapid home visiting services, acute on-site mental health psychiatric liaison services" and extended primary care services. **All of these have a cost, which is not discussed in the BCF document, and it's not clear whether these are sustainable or cost-effective over a longer period.**

The same is true of the 10 experimental "place based" networks of primary care set up by five CCGs including Sandwell and Birmingham. Again the cost is not discussed of managerial support for each network consisting of "a clinical lead, senior commissioning manager, commissioning manager, quality officer, medicines management officer and finance officer"<sup>27</sup>.

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<sup>26</sup> Sandwell Health & Wellbeing Board, 2-year BCF plan, published in response to FoI request: available [https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&cad=rja&uact=8&ved=0ahUKewjOmYP0iMPLAhWCZA8KHffBDjcQFggzMAQ&url=http%3A%2F%2Fwww.sandwell.gov.uk%2Fdownload%2Fdownloads%2Fid%2F22752%2Fnovember\\_2014\\_-\\_health\\_and\\_wellbeing\\_boards\\_better\\_care\\_fund\\_plan&usg=AFQjCNHNdtTKsERF900CDd-2xc1qjj8djQ](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&cad=rja&uact=8&ved=0ahUKewjOmYP0iMPLAhWCZA8KHffBDjcQFggzMAQ&url=http%3A%2F%2Fwww.sandwell.gov.uk%2Fdownload%2Fdownloads%2Fid%2F22752%2Fnovember_2014_-_health_and_wellbeing_boards_better_care_fund_plan&usg=AFQjCNHNdtTKsERF900CDd-2xc1qjj8djQ)

<sup>27</sup> Local Government Association & NHS England (2015) Better Care Fund planning template – Part 1, January 2015: page 38

All of these are also likely to require additional secretarial and admin support: such support is necessary to sustain serious expansion of primary care and community services – but we're not told the cost of this project, or the potential cost if rolled out across the whole of Birmingham and Sandwell, or again if this would be affordable in the next five years of tightly constrained funding for the NHS.

20.2 From this background, it's hard to see any reason to accept that there are grounds for the assertion by Birmingham City Council of their "key principle" that "We will always meet your assessed unmet eligible needs" ... "We will provide sufficient funds to ensure that your unmet eligible needs can be purchased"<sup>28</sup>.

In fact the same document goes on a page later to admit that: "It is possible that some of our current service users and their carers **may see a reduction in the amount of money that is available** to them. We need to **reduce some historical levels of service** provided to service users which are greater than the associated levels of assessed need."

For those who have to spend their own life-savings to cover the full cost of their own care, there is no guarantee that the council will be there to support them when the money runs out. It's quite likely they could face a sharp drop in quality of care, or even a disruptive and disturbing move from one care home to another: "when your capital falls below the threshold, [we will] provide you with an assessment **and this may result in a change of provision**. [emphasis added]"

## 21. Sandwell social care

21.1 It's clear that both health services and social care in Sandwell need to be planned with an eye to the needs of a rising total population, but also the specific needs of a 65+ population that will make up almost a quarter of the population (23%) by 2030, and a very substantial (56%) increase in numbers of residents aged over 85<sup>29</sup>. Since almost one in five of the over 85s are currently supported by council funded care, this could mean almost 700 more people in Sandwell entitled to support under the Fair Access to Care Services (FACS) criteria – a likely 70% increase on the 1008 who currently receive services costing £9.3 million per year: a 70% increase would push this up to almost £16 million.

Three quarters of these eligible adults are already in residential care at an annual cost of £29 million: a 70% increase would take that to £49 million.

**So the potential for increased demand for these services and for healthcare as the older population of Sandwell increases is obvious: less obvious are the possibilities for reducing this demand or making savings from this level of spending as pressures increase.**

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<sup>28</sup> Birmingham City Council (2014) *Social Care for Adults in Birmingham – A Fair Deal in Times of Austerity*, page 2

<sup>29</sup> Sandwell MBC (2014) Care and Support Market Position Statement, page 6 ff.

21.2 Social care in Sandwell is not so much one service as a patchwork of 350 “independent sector providers” in and outside the borough. Given the financial pressures on these providers there is no guarantee at all that as Sandwell claims “This ensures that people are able to choose the provider and services that are most appropriate for their needs”. The best that can be hoped for is that the limited amount of choice open to those who are not obliged to pay for their own care means that service users may be able to choose the least inappropriate, or least worst option.

In fact the Market Position Statement makes clear that Sandwell wants to find ways to minimise spending on “residential care, nursing care and supported living arrangements [which] currently account between them for just under two thirds of the money spent by the council, despite supporting only one third of clients”<sup>30</sup>.

## **22. Requirement for cuts**

**22.1 While the demographics threaten to increase pressures and costs, the council states that it not only cannot cover these rising costs, but it needs to find ways to trim £23 million from its £83 million budgets for care and support services (28%). Indeed the same report (page 17) quotes an even higher figure of £29.3 million for cutbacks to be carried through by 2017.**

It's hard to see how this will be done without impacting the quality and quantity of care and services available. And this in turn again questions the assumptions on the reduced numbers of beds to be available from the NHS once the new hospital opens.

22.2 Sandwell argues (page 10) that they aim to "reduce the demand the long-term care and support through services that prevent, delay and reduce needs..." But the evidence to show this is possible is vanishingly small. No examples are quoted of areas that have proved the effectiveness of "assistive technologies" to reduce the level of hospital admissions among the very frail elderly.

The council's own information shows that the optimistic assumptions so far have been seriously wrong. The PowerPoint slides outlining "Sandwell Community Offer" outline the aim "to prevent or delay the need for people to access more acute health and social care services," with the effect of "reduced hospital admissions" and "reduced admissions to residential care". But the slide headlined "what has been achieved?" notes that: "non-elective commission set up" and "residential admissions are up overall..."<sup>31</sup>

22.3 A meeting of Sandwell Council on January 12 2016 heard (Agenda Item 7) that even with the addition of the discretionary Adult Social Care precept to council tax payments, and if all of the savings plans agreed so far were implemented, the council faces a growing annual deficit adding up to £25.3m by 2020 (1.24).

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<sup>30</sup> Sandwell MBC (2014) Care and Support Market Position Statement, page 10

<sup>31</sup> Sandwell & W Birmingham CCG & Sandwell Council (2015) Sandwell Community Offer <http://goo.gl/iKvugW>

**It's not clear why councillors – especially those involved with social services – are not willing to be more open about the impossible position they are being put into by relentless central government cutbacks.**

### **23. Hoping for the best**

23.1 Overall the plans for the new hospital in Smethwick appear to be based on ill-placed optimism with a determined effort to close eyes against the looming pressures and problems in health and social care funding.

There seems to be an assumption that a drastically reduced workforce with fewer beds and a far from streamlined availability of resources will somehow manage through sheer dedication to deal with the increased numbers of patients as the population rises, and that the incantations of preventive and public health campaigns can magically reduce dependence on hospital care.

23.2 For the sake of people in Sandwell and West Birmingham we have to hope that they are right: but there is little evidence that the plans are for the Right Hospital – or the right size.

**John Lister.  
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