A PFI REPORT FOR UNISON

DEBTS, DEFICITS AND SERVICE REDUCTIONS

Wakefield Health Authority's legacy to primary care trusts

UNISON

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Debts, deficits and service reductions:

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TABLES

ABBREVIATIONS

DoH	Department of Health
FBC	Full Business Case
OBC	Outline Business Case
PFI	Private Finance Initiative
PSC	Public sector comparator
SOC	Strategic Outline Case (in text, refers to the 2nd Strategic Outline Case)
SOC2	2nd Strategic Outline Case
WHA	Wakefield Health Authority

Executive summary

National scene

Financial deficits caused by underfunding have driven the reconfiguration of NHS services and downsizing of NHS hospitals across the UK. Lack of capital for investment is evident in the NHS's dilapidated, poorly maintained buildings and hospitals.

But underfunding has also resulted in cuts in services and NHS care. Major reductions in NHS services for elderly and vulnerable people, rehabilitation and community care have been accompanied by a shift in responsibility from the NHS to individuals and local authorities and by the privatisation of some services such as long term care, dentistry and optical services. Compared with long-term care and community services, acute services have been relatively protected from underfunding. However, as long term care and community services in the NHS have been pared away, acute hospitals have become the main focus of cost management strategies.

In 1992 the introduction of capital charges in the NHS compounded the problems of underfunding, making new claims on revenue budgets for patient care. For the first time the NHS has had to pay the Treasury for its use or consumption of capital, ie, land and assets. This payment is known as a capital charge, and has three elements, depreciation, interest, and public dividends. Under the capital charging policy, NHS bodies are obliged to operate in such a way as to generate annual surpluses equivalent to 6% of their existing capital assets – buildings, land, and equipment. These charges amount to an average of 8% of the annual income of NHS trusts.

NHS trusts unable to cover the costs of both patient care and the new capital charges have seen their deficits spiral. This in turn has led to cost-cutting measures masquerading as service reconfiguration and modernisation plans.

The Health and Social Care Act, 2001, is a central part of the modernisation agenda. The Act will create new care trusts offering both free NHS and chargeable local authority care. Where hospital trusts seek to overcome underfunding by transferring patients to community or intermediate care settings, they are effectively transferring their deficits to care trusts, which will come under increasing pressure to redefine some NHS care as means-tested and chargeable social care.

The Wakefield strategy

Wakefield Health Authority (WHA) has been in deficit since its inception. By 2000, NHS services in the area had accumulated a debt of £16 million. The debt, caused by underfunded patient care across all sectors, has been the main driver of hospital reconfiguration.

In 1997, WHA was advised by management consultants that it could no longer afford two district general hospitals. The management consultants, Newchurch & Co, concluded that the only solution to chronic lack of funding was to treat fewer patients and reduce services by providing fewer hospital beds. To achieve this they recommended investing in one new hospital to replace the two existing old ones at Pinderfields and Pontefract. In the same year WHA and the Northern and Yorkshire NHS Executive agreed on a three year programme for getting out of deficit. In 1998 WHA published *Grasping the nettle*, a hospital reconfiguration and cost-cutting plan that culminated in the first Strategic Outline Case (SOC), the prelude to a Private Finance Initative (PFI). The first SOC was rejected, but the plans were revisited in 2000 in a second SOC (SOC2), the subject of this report.[1]

THE PROPOSALS

The plan covers all NHS services in the area, not just the hospital sector, as well as local authority services. It proposes reducing the number of acute hospitals from three to two and centralising acute services on the Pinderfields site in Wakefield where a new hospital is to be built.

1. In the text, SOC refers to the 2nd Strategic Outline Case, unless otherwise stated.

In the course of centralisation, by 2006-07 acute inpatient beds across the hospital trust will be reduced by 24%. Pontefract Hospital will lose all acute inpatient beds and will be downgraded to become predominantly an outpatient and daycase centre.

A new type of facility known as 'intermediate care' will replace the acute inpatient beds but the SOC does not say what these facilities are or how they will be funded and staffed, or whether they will be managed by the NHS or by local authorities.

Other bed closures in neighbouring facilities are also proposed but they have not been quantified.

THE FINANCIAL PLAN

The SOC sets out a capital spending requirement of £176 million (£210 million inflation adjusted) of which £164 million relates to the Pinderfields and Pontefract Acute Hospitals NHS Trust (hereafter Pinderfields and Pontefract Trust). Approximately £160 million of it will be financed through the PFI.

The capital requirement statement excludes the £19.7 million investment said to be required for intermediate care and interim provision.

The SOC only provides details of the annual revenue implications of the capital plans for the Pinderfields and Pontefract Trust for a publicly funded scheme. The extra cost to the Pinderfields and Pontefract Trust of the capital investment, compared with the pre-SOC position, is £21.3 million a year, of which £15.8 million is an increased annual cost of capital. The extra annual costs falling on other NHS and local authority services are not described.

If the SOC proposals were publicly financed, the cost of capital to the Pinderfields and Pontefract Trust would rise from 4.2% to 13.3% of the trust's current income. PFI involves considerable additional costs that would not be incurred using public finance, but these are not examined in the SOC, although it is proposing to seek between £157 and £163 million private finance in Pinderfields, Pontefract, and Dewsbury hospitals.

The £21.3 million increase in the Pinderfields and Pontefract Trust's annual costs will be partly met by reductions in other parts of the trust's budget and partly by increased income from the health authority.

The plan proposes to cut existing capital costs by £2.3 million by getting rid of land and buildings, and it proposes savings in staff costs totalling £6.3 million.

The plan also involves shunting patients to other parts of the NHS, to the local authority sector where health care is chargeable, and to neighbouring health authorities. The SOC does not examine the income implications of such movements in caseload.

If all the estimated savings are achieved the trust will still require an additional £6.6 million a year from the health authority, which at the time of going to press amounts to 92% of the authority's expected annual growth in income for all purposes.

THE SERVICE PLAN

The SOC turns on a reduction in total acute bed capacity of 24% when the new hospital sites open in 2006-07.

The SOC relates only to current and projected bed provision in three hospitals. It does not provide an overview of current NHS and local authority provision across the district as a whole and notably absent is a comprehensive account of long stay, intermediate care, and acute NHS beds and NHS day care. Local authority provision is also omitted, and in particular the number of funded residential and nursing care places and day care and home care services. Thus of 328 new intermediate care beds, 128 may be in non-NHS funded settings.

When planning for future beds, it is usual to consider what the future trends in caseload and use will be. However, although the strategy turns on major reductions in acute beds and on the diversion of caseload to other parts of the NHS including primary care and intermediate care settings, and to social services, no estimates are provided in the SOC of the volumes and caseload. There is no evidence of either needs-based planning or the 'whole system approach' to care recommended by the National Beds Inquiry.

The assumption that acute bed capacity can be substantially reduced is not supported by national or local trend data. However, the downsizing of NHS general and acute care provision in WHA's area assumes that caseload can be transferred to primary

and community care settings without detriment to the provision of emergency and elective care in acute specialties. Moreover, the national evidence shows that efficiency savings and gains in decreasing length of stay and increasing turnover and day case surgery have already been exhausted.

There is no evidence to show that Pinderfields, Pontefract and Dewsbury hospitals have insufficient critical mass to be viable in the longer term. Pontefract Infirmary and Pinderfields Hospital have over 400 acute beds each. In 1997-98 one in seven acute hospitals in England (15%) fell into the same category.

The deficits that have plagued the Wakefield area for more than seven years are the result of a lack of funding for patient care. The new strategy will aggravate this problem and have a major adverse impact on the elderly, the sick, and those with chronic illnesses.

QUESTIONS TO ASK ABOUT THE FINANCIAL PLANS

1. Has the authority correctly estimated the total capital costs of either a new public build or the PFI scheme, the annual NHS revenue that will be necessary to repay private lenders and shareholders under the scheme, the revenue implications of ensuring comprehensive patient care and the financial viability of the trust?

2. How are the intermediate care investment plans to be funded? The strategy appears to rely in part on local authority managed beds while the affordability of SOC proposals is only estimated with respect to the NHS. Thus we do not know the proposed scale of the local authority contribution to intermediate care, or the financial viability of the proposals for the system as a whole.

3. Given the higher cost of capital and the plans to divert growth money from other sectors, how will caseload displaced into intermediate care settings be funded? The authority has yet to identify revenue streams and sources of funds for the provision of intermediate care, home care, and day care services for the patients displaced from acute beds. A policy of substituting local authority managed beds and day case services for NHS beds and services would amount to the substitution of means-tested, chargeable care for universal health care. Is this part of the funding strategy?

4. Will community services remain viable under the proposals and how will community investment be funded? The proposal to close inpatient capacity at Southmoor and Castleford and Normanton District Hospital raises issues about the future viability of the community trust since the effects will be loss of caseload, services, and hence income.

QUESTIONS TO ASK OF THE SERVICE PLANS

1. Will the proposed reductions in overall levels of bed provision meet the needs of the population given its high levels of deprivation and needs?

2. Will the intermediate care provision support patients displaced from the reduced acute sector? The current problem is alleged to be bed blocking and inappropriate use of beds. But although the health authority intends to replace acute care with intermediate care, the overall provision will still be less than it is currently. Given that there will be fewer beds overall, and that intermediate care beds will not be staffed to such high levels, how will reducing the beds increase efficiency and decrease bed blocking while ensuring that health care needs are met?

3. Will the alternatives to hospital care, that is, home and day care services, be sufficient to support displaced caseload from acute and intermediate care settings as a result of the overall reductions in numbers of beds? The closure of Clayton Daycase Centre and the reconfiguration of community services are based on the policy of bringing services "closer to home". The local authority and NHS have not provided a strategic account of the level of resources, staffing, and inputs into day care and home care services.

Section 1. Introduction

Chapter 1. Background

Summary points

- Lack of funding for patient care and financial deficits led to the drive for the WHA to reconfigure acute hospitals at Pinderfields and Pontefract
- The WHA strategy is to centralise acute services on one new build, single hospital site at Pinderfields and to close acute beds at the Pontefract Hospital and other sites

Area covered by the strategy

Wakefield Health Authority covers the former mining and industrial towns of Wakefield and Pontefract which have a combined population of 317,000 – a population that is expected to decline by 2% from 2000-2010 as a result of outward migration among younger age groups.[2] To the west within the boundaries of Calderdale and Kirklees Health Authority is Dewsbury with a population of 170,000 which is expected to grow by 3% by the year 2010.[3] The total population in the areas affected by the proposed services changes will thus be close to half a million.

Seven of the 31 wards in the area of Wakefield and Kirklees (20%) are in the top decile of socio-economic deprivation in Britain and half of all the wards in Wakefield are in the top decile of health deprivation:

> *Both areas show high rates of death from cancer, coronary heart disease, and stroke… compared to the country as a whole. Other indicators of deprivation and well being are consistently worse than average, reflecting poor housing, high unemployment, high levels of teenage pregnancy and a high percentage of people with a long-term limiting illness.*[4]

The acute hospital services

There are three district general hospitals serving the local populations in the towns of Dewsbury, Pontefract, and Wakefield. Since 1997 Pinderfields and Pontefract Trust, with a combined catchment population of 365,000 residents, has operated the two district general hospitals, Pinderfields General Hospital in Wakefield and Pontefract General Infirmary in Pontefract. Dewsbury Health Care NHS Trust is a 'whole district trust' that runs Dewsbury District Hospital in Dewsbury and provides mental and community health services in North Kirklees for a catchment population of 175,000 residents.

Pinderfields and Pontefract hospitals provide 1,063 beds on two main sites. According to the SOC, Pinderfields' hospital buildings are old and dilapidated,[5] 60% are described as inadequate, and 20% in need of replacement. The backlog in maintenance and repairs is estimated at £30 million. Pontefract Hospital dates from the 19th century, and the engineering infrastructure is described in the SOC as "approaching the end of its useful life." Again, 60% of accommodation is described as inadequate.

Clayton Hospital in Wakefield dates from the 19th century and provides short stay and day case facilities to the acute trust.

Dewsbury Hospital is a modern, 523-bed[6] hospital with no reported backlog in maintenance. In the

2. SOC2, p1.
3. *Ibid*, p2.
4. *Ibid*,para 2.6
5. *Ibid*, para 2.10
6. DoH. *Hospital Activity Statistics 2000-01*. Total available beds.

three years 1999-2001 the hospital trust spent £7 million on capital improvements.

There are also some acute beds in the community trust which comprises Castleford & Normanton District Hospital (CNDH), Clayton Hospital, and Southmoor Hospital, near Pontefract in the north-east of the health authority area. CNDH is a small, modern hospital, managed partly by the acute, and partly by the community trust. It provides nurse-led, long-stay elderly care and out-reach consultant clinics. Southmoor Hospital in Pontefract is a community unit for the elderly and has 25 acute inpatient beds.

Background to the financial situation and the proposals to reconfigure health services

Rising financial deficits are responsible for much of the drive for reconfiguration. In 1995 the government changed the way health authorities were funded and despite Wakefield's relatively high social deprivation scores it lost funding. Unable to cut the volume of services provided, the authority saw its accumulated debt rise to £16 million in 2001.[7,8] WHA does not make clear which sectors were experiencing the greatest problems although in some of its documents it refers to pressures from the demand for tertiary services at Leeds, prescribing pressures and clinical negligence . Despite a substantial increase in revenue funding in 1999-2001, which allowed the authority to repay £7.2 million of accumulated debt, it had by then embarked on radical change.

Over the same period Pinderfields and Pontefract Trust also struggled to balance its books. Only in 1998-99 and 2000-01 did it break even, but it still had an accumulated deficit of £3.4 million from the previous years of underfunded patient activity.[9] In 2001 the trust was again reporting that increased hospital activity was a cause of financial pressure, ie, it was having to provide more care than the purchasers could pay for.[10]

Wakefield Health Authority's response to the deficit

THE FIRST PUBLIC CONSULTATION ABOUT DEFICITS – *MEETING THE CHALLENGE*

WHA's first strategy, published in March 1995, did not propose major service changes to its acute hospitals. But by 1997, faced with a worsening financial situation and under pressure from the Northern and Yorkshire NHS Executive to balance the books within three years, the authority commissioned a firm of management consultants, Newchurch & Co, to draw up options for service reductions. Newchurch concluded that the only solution to chronic lack of funding was to treat fewer patients and reduce services by providing fewer hospital beds. To achieve this they recommended investing in one new hospital to replace the existing hospitals at Pinderfields and Pontefract.

The management consultants[11] proposed centralising acute hospital services on one site.[12] This would allow the release of land and estate for sale and reduce the services provided and the number of patients to be treated. They estimated that these measures would reduced the trust's costs by between 8% and 14%.

In 1997, WHA published *Meeting the challenge*, a consultation document based on the Newchurch proposals. It too called for radical change:

> *As has been well broadcast, we face a significant recurring financial deficit. Reducing costs and increasing efficiency may provide some short term relief, but this approach has been applied over a number of years without removing the*

7. SOC, 5.2.
8. This took place under a scheme managed by the regional office of the NHSE (interview with Norman Roberts, Finance Director, WHA).
9. *Ibid*. How much of the increased funding was of this short-term nature is not known.
10. Pinderfields and Pontefract Trust. *Annual Report 2000/01*, p18.
11. Newchurch & Co. *The Challenge for health in Wakefield*, vol. 1, main report, November 1997.
12. The report outlined two centralisation models, options A and B. Both options centralised complex elective and all emergency surgery on one site with the other site downgraded to provide care of the elderly and a minor injuries unit. The options differed only on the question of whether the downgraded site should also include maternity and gynaecology services. Newchurch. *op cit* vol. 1, main report, November 1997, p.46.

*problem and does not tackle the underlying issues. **The only approach which is likely to be successful is to look for more radical and long term changes which will reduce the costs structure.***[13]

THE SECOND PUBLIC CONSULTATION ABOUT DEFICITS – *GRASPING THE NETTLE*

By 1998 the preferred strategy for dealing with the deficits was to downgrade acute services at Pontefract General Infirmary and build a new hospital at Pinderfields along the lines of the Newchurch proposals. Public consultation was mounted under the slogan, *Grasping the nettle*.[14] But there was not just one nettle, there were several. The health authority had already admitted that remodelling on the scale required would mean major new investment, reductions in services and increased inequalities in access to health care. A single acute hospital site "could only be achieved at major capital cost and would inevitably reduce access for some district residents to hospital services."[15]

Moreover under the Labour Government's modernisation programme the only realistic source of investment funds for a new hospital had become the PFI. As a result, plans for resolving the deficit problem became absorbed into the PFI planning process, which began with a Strategic Outline Case.

THE FIRST STRATEGIC OUTLINE CASE (1998)

A Strategic Outline Case is the document the government relies on when assigning priority to competing NHS capital investment proposals.[16] It is produced collaboratively by the hospital trust seeking new investment, the local health authorities, and the NHS Executive Regional Office for the area, and contains financial and health care planning data. A SOC should show the strategic context for the proposed investment, the health service need it will meet, and the "affordability ceiling" for the scheme, ie, the annual amount that the local health service can afford to pay for the new capital.

The SOC is only the first stage in the planning process. The data contained are only estimates and these are drawn up prior to discussion with private partners. After the strategy is approved, plans are refined in a series of business cases. An Outline Business Case (OBC) sets out and evaluates the various options possible under the strategy in order to provide a basis for negotiations with the private sector. A Full Business Case (FBC) presents the results of these negotiations in the form of a detailed plan for managing the project. Cost and planning data first published in the SOC are liable to change substantially during the business case cycle.

The first Strategic Outline Case (SOC1) proposal for centralisation and acute sector downsizing was rejected by the Department of Health in 1998 because the plans were insufficiently developed.[17] However, the Minister of State backed the principle of centralisation, writing:

There is a strong health service need for redevelopment. The sites of Pinderfields and Pontefract both have poor quality capital stock which impacts on patient care, and the integration between clinical departments is unsatisfactory. Both sites currently serve populations of less than 200,000 which is not sufficient to sustain acute provision. [18]

In effect the minister concurred with Newchurch that there was a need to centralise acute services and undertake a new build. So in 2000 the health authority produced a second Strategic Outline Case (SOC2), the subject of this report.

13. WHA. *Meeting the challenge for health services in Wakefield. Consultation document*, December 1997, p.6. Emphasis added.
14. WHA. *Meeting the challenge for health services in the Wakefield District. Grasping the nettle. Consultation document*, October 1999.
15. WHA. *Meeting the challenge for health services in Wakefield. Consultation document*, p.12.
16. Two SOCs were prepared. The first was rejected by the DoH. The second is the subject of the present report. See notes 1 and 3.
17. SOC2, para 2.62.
18. *Ibid*, para 1.2.

Chapter 2. The second Strategic Outline Case – the service proposals

Summary points

- The second strategic outline case proposes centralising acute services on the Pinderfields hospital site
- This will require a new hospital to be built which the SOC proposes will be financed using private finance
- Pontefract, Southmoor, and Castleford hospitals will lose all acute inpatient beds and Pontefract Infirmary will be downgraded to become predominantly an outpatient and daycase centre
- The number of acute inpatient beds in the acute trust is to be reduced by around 24% between 2001 and 2007
- Acute care is to be re-provided in intermediate care settings but the location, source of funding and staffing of all these services and beds is not detailed

How the SOC proposals fall in line with the minister's letter

I. ACUTE HOSPITALS

The second SOC responded to the minister's requirement for centralisation of acute hospitals, stating:

> *None of the three acute hospitals are of sufficient critical mass to ensure long-term clinical viability in isolation … reconfiguration of acute services in Wakefield, coupled with managed clinical networking with Dewsbury, will not only provide the platform for developing existing services, but provide the opportunity for local provision of new services which requires a minimum population of 500,000.*[19]

The SOC proposes building a new single acute PFI hospital (an 'acute specialist centre') on the Pinderfields Hospital site to replace Pinderfields and Pontefract acute hospitals.

The new Pinderfields Hospital will retain consultant-led Accident and Emergency services and a comprehensive range of District General Hospital specialties, including paediatrics, critical care, maternity, and all other existing specialties. It will also provide a diagnostic and treatment centre, or ambulatory care centre, for the local population of Wakefield.[20]

Pontefract Infirmary will cease to be a District General Hospital and be downgraded to a centre offering outpatient and day-case care with, additionally, "a 24-hour medically-staffed A&E service, intensive rehabilitation and step-down, and a midwife-led delivery unit."[21] No plans are described for Dewsbury Hospital, although it is included in the integrated care model.

The proposals envisage a 24% reduction in total acute bed numbers from 2000/01 to 2006/07 across the three sites and alternative provision in intermediate care beds and alternative settings.[22]

II. NON-ACUTE CARE

The Wakefield SOC is presented as an 'integrated care' model, ie, it covers both acute hospital, general practice and community-based services. Because the hospital reconfiguration requires extensive changes in non-acute or sub-acute care, the SOC proposes capital development in primary care facilities and new intermediate care capacity in North Kirklees, Wakefield, and Pontefract.[23]

'Intermediate care' is not defined in the SOC but is central to the strategy. The plan involves creating 148 new intermediate care beds in the medium term (ie,

19. *Ibid*, para 3.19
20. *Ibid*, p.21.
21. *Ibid*, p.21.
22. The SOC does define 'current' capacity. We assume current means year of SOC publication, 2000-01.
23. SOC2, p.23.

by 2003/04), with a total of 328 intermediate care beds in the long-term (by 2006/07).[24,25] However, the SOC does not make clear where the new intermediate care capacity will be provided, how it will be staffed and funded, or whether it will be in the NHS or in the chargeable private and local government sectors (see Part 3 – the service plans).

Since April 2002 primary care trusts (PCTs) have been responsible with the acute trust, the strategic health authority, and the local authority for planning and providing intermediate care. There are two PCTs in the WHA area.[26] Wakefield West PCT covers Wakefield city centre and surrounding towns, including Ossett and Horbury, and has a budget of over £100 million. Eastern Wakefield PCT covers Pontefract, Castleford and Normanton, Featherstone, Knottingley, South Elmsall, South Kirkby, Hemsworth, Sharlston, part of Crofton and Ackworth. It has a budget of about £130 million.

The interim configuration

The SOC proposes an interim configuration of services because "long-term reconfiguration of services, which is dependent on major capital development, will take several years to deliver."[27] In the short term this will require an increase in acute bed capacity to "take into account the need to increase capacity and reduce levels of bed occupancy, in line with the projections of the National Beds Inquiry and waiting time targets."[28] The source of funding, and the nature and location of interim beds, are not clear.

In conclusion the second SOC, while not being worked through, does fall in line with the DoH requirements for a centralised, new build and major service reduction.

In the next chapter we consider the financial implications of the SOC proposals for the annual budgets of the health authority and the NHS trusts.

24. 'Intermediate care' is not defined in the SOC but is presumably intended to denote certain elements of non-acute health care. It is a vital component of the strategy to reduce acute sector activity because it is proposed as a substitute for acute care. It is probable that intermediate beds are different from NHS general and acute beds because the latter are destined to fall by 24%. This raises the possibility that intermediate beds will not be in the NHS but in the chargeable private and local government sectors. There is a need to clarify the nature, ownership, and staffing of intermediate beds.
25. SOC2, para 5.2
26. WHA Strategic framework for intermediate care. Draft May 2001. Executive summary.
27. *Ibid*, para 4.21.
28. *Ibid*, para 4.23.

Section 2. The financial analysis

Chapter 3. The proposals for capital investment

Summary points

- The plan proposes a new building programme and some refurbishment at a cost of £176 million (£210 million inflation adjusted), of which £164.1 million relates to the Pinderfields and Pontefract Trust
- Sales of existing assets and sites will be used to partly fund the scheme
- The capital requirement statement does not include the envisaged interim investment of £4.7 million, nor the £15 million intermediate care investment in WHA area
- Private finance is to be the source of between £157 and £163 million of the new investment

The SOC sets out an estimated cost of capital investment of £176 million (£210 million inflation adjusted).[29] The new hospital at Pinderfields will require a total capital spend of £164.1 million, Pontefract Hospital will require £17 million, and intermediate care in North Kirklees will require £12 million.[30] (Table 1)

Of the £176 million capital requirement, between £157 and £163 million is to be sought from private finance.[31]

Table 1. Summary of capital requirements according to SOC proposals

Scheme	*Public capital £m*	*PFI capital (inflation adjusted) £m**	*Total capital for approval £m*	*Total capital (inflation adjusted) £m*
Pinderfields	*7.8*	*139.4 (165.9)*	*147.1*	*175.6*
Pontefract	*2.2*	*14.6 (17.4)*	*17.0*	*20.3*
Total Wakefield	*10.0*	*154.1 (183.4)*	*164.1*	*195.9*
North Kirklees primary and intermediate				
– Option 1	*8.2*	*3.6 (4.3)*		*n/a*
– Option 2	*3.1*	*9.3 (11.1)*		*n/a*
Total North Kirklees	*3.1-8.2*	*3.6-9.3 (4.3-11.1)*	*n/a*	*n/a*
Total capital requirements	*13.1-18.2*	*157.7-163.4 (187.7-194.5)*	*175.9-176.5***	*209.4-210.1***

Source: SOC Table 19, p. 24, and appendix E.

** Inflation-adjusted ('outturn') figures have not been supplied for all costs. Inflation adjusted costs for PFI capital have been estimated using the same inflation uplift the SOC has applied to "total capital for approval".*

*** The SOC does not state a capital approval total for Kirklees. These figures are estimates.*

n/a – not available

29. Financial data in the SOC is presented with and without adjustment for inflation, that is, at 2000/1 and 2006/7 prices. Inflation adjusted figures are the sums that will actually be borrowed but it is only possible to show the revenue impact of this borrowing before inflation adjustment. 2001 prices are used throughout this report unless otherwise stated.
30. Total capital requirement refers to the capital for which approval is being sought in the SOC. Approval is not being sought for other expenditure not classified as a capital requirement but mentioned in the SOC. Capital for approval is not adjusted for inflation.

How accurate are the estimates of total capital requirements?

The SOC financial tables exclude £19.7 million of the envisaged extra capital costs, including £4.7 million interim reconfiguration costs, and £15 million[32] intermediate care costs in the WHA area.[33,34] The omission of the intermediate care expenditure in the Wakefield area is not explained. The authority simply notes that "it will be met by a separate publicly-funded scheme, to be undertaken during 2007-08, with a maximum cost of £15 million."[35]

Although land sales will release cash, thereby reducing the amount of capital that has to be borrowed, some receipts from land sales are to be set aside for major items of equipment purchase because the costs of equipping the new hospital are not included in the PFI proposal but are expected to be met from this source. The SOC provides insufficient data on land sales to determine whether enough cash will be released to cover the capital cost of new equipment,[36] although the trust assumes that public funds will be available in any event.

It should be noted however that SOC provides only estimates of capital costs and in reality major cost escalations occur throughout the planning process. The first 14 PFI hospitals experienced an average of 72% cost escalation between the OBC and the FBC.[37,38,39,40,41]

31. SOC2, appendix E. The balance of approximately £15 million is largely attributable to equipment costs which are to be publicly funded and public capital at North Kirklees.
32. *Ibid*, para 5.2. The figure of £15 million is a guess because the independent evaluation of this element of total capital cost is not scheduled until 2004/5.
33. *Ibid*.
34. *Ibid*.
35. *Ibid*. The figure of £15 million is a guess because the independent evaluation of this element of total capital cost is not scheduled until 2004-05.
36. SOC 2, paragraph 5.8: "Capital receipts from the sale of the trusts's land are assumed to be made available to the trust in the form of advanced brokerage and applied to the financing of major items of equipment."
37. Gaffney D, Pollock AM, Price D, Shaoul J. NHS capital expenditure and the private finance initiative – expansion or contraction? *British Medical Journal* 1999;319:48-51.
38. Gaffney D, Pollock A.M., Price D, Shaoul J. PFI in the NHS - is there an economic case? *British Medical Journal* 319:116-9, 1999.
39. Pollock AM, Dunnigan M, Gaffney D, Price D, Shaoul J. Planning the 'new' NHS: downsizing for the 21st century. *British Medical Journal* 1999;319:179-184.
40. Gaffney D, Pollock AM. Price D, Shaoul J. The politics of the private finance initiative and the new NHS. *British Medical Journal*, 1999; 319:249-53.
41. Gaffney D, Pollock AM. Can the NHS afford the Private Finance Initiative? London: *British Medical Association* 1997.

Chapter 4. The annual revenue implications of new capital investment for the Pinderfields and Pontefract Trust

Summary points

- Since 1991 all new NHS investment has been subject to a capital charge which has to be paid out of the operating budget of each NHS trust
- The value of the asset base at Pinderfields and Pontefract Trust will increase almost fourfold, from £55 million in 2001 to an estimated £198 million
- The annual revenue impact has only been calculated for part of the capital cost
- On this basis the trust will have to find an extra £21.3 million annually from its operating budget, of which £15.8 million relates to servicing the cost of the new investment
- The payments the trust will be making for capital will thus increase from 4.2% to 13.3% of the trust's operating income
- The additional annual cost of servicing debts incurred using private finance is not shown, although PFI involves considerable additional costs compared with using public finance

Since 1991 all capital assets used by the NHS incur a charge on the revenue or operating budget. This is because the capital charging regime introduced as part of the internal market reforms requires that NHS trusts pay a capital charge equivalent to 6% of the value of their capital assets for the use of land and the use and depreciation of buildings, equipment and other physical assets. In order to meet these charges, the average acute trust has to run an annual surplus of income over other expenditure of around 8% of its operating budget.

As Table 2 shows, Pinderfields and Pontefract Trust has a low asset base compared with its income. As a result its capital charges relative to income are low at 4.2% compared to the 8% net average, ie, well below that of most trusts. Nevertheless, in only two of the four years shown in Table 2 was the trust able both to cover its operating costs and to meet its capital charge obligations, and the consequence was an accumulated deficit of £3.4 million in 2001. The trust is underfunded for patient care.

How will new investment affect the payments for capital that trusts must pay?

As part of the approval process the trust must establish as its yardstick the future level of capital charges that it would obtain if the investment were

Table 2. Pinderfields and Pontefract Trust income and expenditure (£m)

	1997/98	1998/99	1999/2000	2000/01
Total revenue	116.7	122.1	139.8	141.4
Operating expenses	114.1	119.3	138.9	138.7
Operating surplus	2.6	2.8	0.9	2.8
Total assets employed	38.1	43.9	58.2	55.5
*Total capital charges**	6.8	6.1	7.1	5.9
(as % of income)	(5.8%)	(5.0%)	(5.1%)	(4.2%)
Retained surplus (deficit)	(1.0)	0.15	(2.4)	0.05
Accumulated deficit since becoming a trust	(1.0)	(1.0)	(3.4)	(3.4)

Sources: Pinderfields and Pontefract Acute Hospitals NHS Trust annual reports 1997-2001,
** Capital charges include depreciation and interest*

financed out of public capital. The yardstick is known as the public sector comparator (PSC). The PSC, which is not adjusted for inflation, is based on the £164.1 million of new investment at Pinderfields and Pontefract acute sites being made available from the public purse. It is thus possible to take the SOC estimate of the future capital charge implications of the investment plans and compare it with the situation in 2001 to show what this new investment will mean.

Table 3. The value of assets and capital charges as a proportion of income (2001) and after new investment, publicly financed Pinderfields and Ponterfract Trust

	Existing (2001)	*After new investment (2006-07)*
Asset base	*£55.5m*	*£198.0m***
Capital charges (% of operating budget)	*£5.9m (4.2%)*	*£18.9m (13.3%)**

Source: SOC2 and Pinderfields and Pontefract Trust annual report.

**Calculation is based on the 2000/01 trust income (£142 m).*

***The asset base after new investment consists of £164.1 million new investment plus an estimated £33.9 million on retained existing estate. The estimate of charges on retained estate has been derived by applying the projected reduction in existing capital charges (£2.3 million or minus 38.9%) to the 2000-01 asset base (£55.5 million). All PSC calculations are in 2000/1 prices.*

Table 3 shows the increase in capital charges that the trust would have to pay on the increased value of its assets resulting from the proposed new hospital investment, if the investment were publicly rather than privately financed. Even after downgrading Pontefract Hospital and selling surplus land and buildings on both sites, the value of the trust's assets will have increased from £55 million to £200 million. This would imply an increase in NHS capital charges from £5.4 million a year to £18.9 million a year – up from 4.2% of the trust's income in 2000 to 13.3% in 2006-07.

The PSC estimate shows a total increase in annual expenditure for the trust of £21.3 million in respect of this increased asset value, of which £15.8 million is due to increases in capital charges and £5.5 million is due to activity growth (table 4).

Table 4. Impact of the SOC proposals on current spending requirements at Pinderfields and Pontefract Trust

Costs of new development	*£m*
Total capital requirement	*164.1**
Increase in annual costs – total	*+21.3*
– revenue costs – capital charges	*+15.8*
– revenue costs – activity growth	*+5.5*

**(assuming Pinderfields site maximum new build)*

**PSC figures are in 2000/1 prices*

No PSC is provided for the interim investment or the investment at North Kirklees; the SOC merely says that "the proposals are assessed by C&KHA and PCG as being affordable".[42]

The SOC does not show the additional annual revenue impact of PFI

The SOC shows the annual revenue implications of exchequer-funded public borrowing for Pinderfields and Pontefract Trust. However, it states that its preferred route for new investment will be private finance which is to be the source of between £157 and £163 million of new investment. In the SOC the annual payments made under PFI are called the 'shadow tariff', but the SOC is not able to provide estimates of the annual PFI shadow tariff for either the Pinderfields and Pontefract Trust or in North Kirklees, since negotiations with the private sector have not begun.

The extra costs of using private finance: the PFI shadow tariff and financing costs

The preferred investment option described in the SOC involves approximately £154 million of private

42. *Ibid*, p.28. 'C&KHA and PCG' means Calderdale and Kirklees Health Authority and Primary Care Group.

finance at Pinderfields and Pontefract Trust. Private finance is not a new source of investment but creates a debt which has to be paid from the revenue/operating budget of hospitals. A critical issue for all NHS bodies is to estimate accurately the annual payments for servicing the debts incurred using private finance. The level of these annual payments (called the shadow tariff in the SOC) is largely dependent on the amount that is borrowed in the first place (the total capital cost or total capital requirement). Thus the revenue impact of PFI is expressed as the PFI shadow tariff.

The SOC does not provide details of the size of the expected PFI shadow tariff in either the Pinderfields and Pontefract Trust or North Kirklees. The project director has since stated that a shadow tariff has been calculated and "is likely to fall within the affordability limits contained in this SOC."[43] He also states that it contains the same savings as have been estimated in the PSC. This means that the PFI shadow tariff is not based on projections of higher workforce cuts than are outlined in the PSC.

However, PFI, which substitutes private borrowing for government borrowing, involves financing costs that do not arise in traditional procurement. Financing costs arise because the annual payments are not made by the trust to the private sector consortium until the new building is ready to use, whereas the consortium which builds and operates the hospital must raise the funds to build it before this. Most of these funds are borrowed.

The interest payments the consortium has to make on these loans during the construction period are 'rolled up' into the annual payments it will start to receive from the hospital trust once the building is operational. This 'rolled up interest', which forms part of the cost of finance under the PFI, is generally added to total capital costs in PFI business cases; that is, it increases the total capital requirement and therefore the PFI annual tariff.

These additional financing costs are significant. Financing costs at Dryburn, Carlisle, and Worcester PFI hospitals were, respectively, £18.2 million, £16.7 million, and £29.9 million, or 25-35% of the total construction costs. At Worcester, financing costs accounted for 50% of the cost inflation that occurred during PFI negotiations, and their emergence contributed directly to the closure of Kidderminster Hospital.[44] These capital costs are unique to PFI: they would not be paid under traditional procurement.

The SOC provides no data on PFI financing costs and because the SOC does not show the PFI shadow tariff it prevents a proper examination of the extra revenue implications of using private finance.

43. Letter from J Mason to D Price, 8 November 2001.
44. Pollock AM, Price D, Dunnigan M. *Deficits before patients: the Worcestershire hospitals reconfiguration*. London, June 2000.

Chapter 5. How will the extra annual costs be met?

Summary points

- The strategy predicts that even using public funding, the new investment will create a new cost pressure within Pinderfields and Pontefract Trust of £21.3 million annually. It aims to meet these increased costs by:
  - reductions in staff budgets of £6.3 million per annum
  - moving patients to other parts of the NHS and to the local authority sector
  - increasing the prices paid by purchasers
  - the diversion by care trusts of much of their new growth moneys to pay the increased prices charged by the new PFI hospital

The trust anticipates that it will need to find £21.3 million in extra income each year to service the debts incurred using public or private finance and increased returns under the new investment programme (Table 5).

Table 5. Projected savings under the SOC, Pinderfields and Pontefract Trust

*Expected savings**	*£m*	*%of projected savings*
Total revenue impact	***+21.3***	
of which		
Reduced NHS capital charges	*2.3*	*16.7*
Savings in staff costs	*6.3*	*45.7*
Savings on estate management	*5.3*	*38.4*
Total projected savings	*13.8*	*100.0*
Shortfall in funds	*7.5*	

*Source: SOC2, fig 20. p.25. *2000/1 prices*

According to the SOC the extra costs of the new investment are to be met in the following ways:

1. Service-related savings in staff and other costs, through performance improvements and integration.
2. Estate-related savings as a result of reduced areas and volumes to be maintained.[45]
3. Reductions in existing capital charges by vacation, disposal, or demolition of assets.

I. SERVICE-RELATED SAVINGS

a. Staff reductions

Service-related savings account for 45% of the total projected savings (£6.3 million out of £13.8 million), as shown in Table 5. The numbers and types of staff affected are not quantified but the areas for reductions include management, ward nursing, ward management, maintenance, sterile supplies, clinical support and operating theatres.[46]

The SOC does not distinguish between clinical and non-clinical staff. Instead it rather vaguely says that in "estimating savings from ward nurse staffing, the cost of providing the new models of care has been calculated by developing a whole time equivalent nursing cost per bed, taking into account the increased dependency and throughput of patients in acute hospital beds."[47]

b. Cost-shunting to other parts of the NHS and to local authorities by reducing and centralising acute bed capacity

The SOC does not provide data on the movement of patients among service sectors and districts. However, the Newchurch report estimated that centralisation of acute services on a single site would increase the number of people seeking treatment out of district and that new 'sub-acute facilities' would act as substitutes for hospital services. The management consultants assumed reductions in hospital caseload of 14-18%: "Through these rationalisations, a third of the existing cost base of [Pontefract Hospital] can be released … Overall, this option sees a 14% reduction in activity actually delivered in the District."[48] The consultants were unable to calculate the flow to the

45. SOC2, para 5.9.
46. *Ibid*, para 5.10.
47. *Ibid*, para 5.11.
48. Newchurch & Co. *The Challenge for health in Wakefield*, vol.1, main report, November 1997, p.46-51. The consultants showed that the outflow of patients increased to 18% if maternity services were to be rationalised in a different way. *Ibid* p.49.

non-acute sector because this depended on "investment in new care facilities, and the scope and role of these facilities needs to be agreed and fully specified."[49]

The reduction in general and acute beds is to be made good by re-provision in intermediate care settings. But the SOC does not make clear how many intermediate care beds will be provided by local councils and how many will be provided by the NHS. One of the options for North Kirklees intermediate care involves converting two "LA [local authority] residential homes."[50] This suggests that the North Kirklees proposal involves the substitution of local authority beds for NHS general and acute beds. The SOC strikes a similar note in references to intermediate care developments in the Pontefract area where "discussions are taking place to review the future local health and social care provision at Southmoor and CNDH [Castleford and Normanton District Hospital]."[51] A WHA document explicitly states: "It will be the responsibility of PCTs [Primary Care Trusts], Housing and Social Care and the HImP [Health Improvement Programme] groups to prioritise and commission intermediate care".[52]

The Newchurch report estimated that the hospital caseload would be reduced as a result of 5,000-6,000 more patients travelling out of the health authority's area for their secondary health care following centralisation of acute facilities at Pinderfields. The cost of paying for the treatment of these patients has not, however, been identified in the SOC.

If centralisation of acute services does indeed lead patients to seek treatment elsewhere patient income will be lost to the new acute trust. However, the plan provides no data on the effect on the viability of the trust of changing patient flows and income.

II. ESTATE SAVINGS

The sale of land and other assets will reduce the annual costs of maintenance, cleaning and heating. There is insufficient evidence available to evaluate projected estate savings of £5.3 million.

Making good the remaining shortfall

Even having made these savings the SOC recognises that the trust will still be faced with an annual £7.5 million affordability gap[53] (Table 6). It anticipates that all of this shortfall will be made good by increasing the prices charged to purchasers for increased activity. If activity growth is insufficient the reference costs will increase, reducing the trust's ability to perform against central targets.[54] In particular, the SOC expects that the health authority will increase its revenue commitment by £6.6 million annually: "Wakefield Health Authority has worked closely with the Trust to confirm projected costs and agreed to fund £6.6 million that will absorb 12.4% of anticipated total growth."[55]

Table 6. How the shortfall in the remaining annual funding for investment in the Pinderfields and Pontefract Trust is to be made good

	£m
Additional annual funding required	*7.5*
Source of additional annual funds:	
Wakefield NHS purchasers	*6.6*
Calderdale & Kirklees NHS purchasers	*0.1*
Other NHS purchasers	*0.8*

Source: SOC2, figure 20, p. 25

Since the SOC was published, however, the project director at the trust has corrected the trust SOC figure for the expected increase in the authority's revenue over the five years 2002-2007, reducing it from a total of £54 million to a total of £36.4 million. The SOC expresses the annual increase in purchaser costs (£6.6m) as a proportion (18%) of this cumulative figure. However, it seems wiser to compare annual increase in purchaser costs with annual increases in purchaser revenue. The cumulative (five year) increase in

49. *Ibid*.
50. SOC2, para 5.28, p.28.
51. *Ibid*, para 19, p.21.
52. WHA *Strategic framework for intermediate care*. Draft May 2001. Executive summary, para 6.1, p.6.
53. *Ibid*, para 5.13.
54. The SOC does not provide caseload details so it is impossible to tell whether activity growth will generate the extra income or whether prices to commissioners will increase.
55. *Ibid*, para, 5.16.

purchaser revenue (£36.4 million) represents average annual growth of £7.2 million. When the new hospital is opened in 2006/7, the £6.6 million the authority has agreed to contribute to the trust's budget to meet the cost of the new hospital will absorb 92% of the new money the authority expected to receive annually from the government, not 18% as stated by the trust.[56]

If WHA has its way, therefore, most of the extra funding the government has set aside for all health service improvement in Wakefield will be diverted into a shrunken acute hospital sector, leaving very few resources to spare for investment in the non-acute sector to which displaced hospital patients will be redirected. This has serious implications for the liabilities of the new primary care trusts.

Investment commitments for social care trusts

The SOC does not state which organisation will fund the capital requirement for social care in North Kirklees (£11-£12 million). It states that "details remain to be finalised about sources of funding".[57]

Conclusion

The management consultants employed by the trust, Newchurch & Co, concluded that the only solution to chronic lack of funding was to treat fewer patients and reduce services by providing fewer hospital beds. To achieve this they recommended investing in one new hospital to replace the two existing hospitals at Pinderfields and Pontefract.

The Newchurch solution will aggravate the financial deficits. The health authority itself has attributed the area's deficit problems not to hospital buildings that are too expensive to run, but to insufficient income for the number of patients needing treatment. Currently capital charges amount to about 4% of the income of the Pinderfields and Pontefract Trust. Under the current system for capital financing any new investment, whether publicly or privately financed, that increases the capital value of the hospital – and hence capital charges – is simply not affordable without a proportionate increase in income. The proposals will cut the funding available for services and care and divert most new growth moneys into the new PFI scheme without ensuring financial viability or stability. This has serious implications for care trusts, and primary and intermediate care services.

QUESTIONS TO ASK ABOUT THE FINANCIAL PLANS

1. Has the authority correctly estimated the total capital costs of either a new public build or the PFI scheme, and the annual NHS revenue that will be necessary to repay private lenders and shareholders under the scheme? Will the project ensure comprehensive patient care and the financial viability of the trust?

2. How are the intermediate care investment plans to be funded? The strategy appears to rely in part on local authority managed beds while the affordability of the SOC proposals is only estimated with respect to the NHS. Thus we do not know the proposed scale of the local authority contribution to intermediate care, or the financial viability of the proposals for the system as a whole.

3. Given the higher cost of capital when the new hospital is occupied and the need to divert growth money from other sectors to pay for it, how will caseload displaced into intermediate care settings be funded? The authority has yet to identify revenue streams and sources of funds for the provision of intermediate care, home care and day care services for the patients displaced from acute beds. A policy of substituting local authority managed beds and day case services for NHS beds and services would amount to the substitution of means-tested, chargeable care for universal health care. Is this part of the funding strategy?

4. Will community services remain viable under the proposals and how will community investment be funded? The proposal to close inpatient capacity at Southmoor and Castleford and Normanton District Hospital raises issues about the future viability of the community trust, since the effects will be loss of caseload, services, and hence income.

56. Letter from J Mason to D Price, 8 November 2001. This seems a fair inference to draw. The promised £6.6 million represents 92% of the projected annual increase (£7.2 million). Furthermore, the additional £6.6 million will have to be paid throughout the life of the PFI contract, usually 30 years.
57. *Ibid*, para 5.24.

Section 3. The service plans

Chapter 6. Missing: the 'whole system' approach to care and needs-based planning

The SOC turns on a reduction in total acute bed capacity of 24% when the new Pinderfields Hospital site opens in 2006/07, and the redirection of patients into intermediate care beds and other primary, domiciliary, or residential care settings. Given the scale of the changes proposed it is essential that the community should be able to judge whether their needs will be met by the new plans.

The National Beds Inquiry noted that "service reconfigurations based on assumptions of major acute bed reductions are unlikely to be safely attainable unless expanded intermediate and community services are put in place". To this end it recommended that health authorities and trusts take a whole system approach to care and review all aspects of service provision across health and social services. However, the SOC relates only to current and projected bed provision in three hospitals. It does not provide an overview of current NHS and local authority provision across the districts as a whole, and notably absent is a comprehensive account of long stay, intermediate care, and acute NHS beds and NHS day care. Local authority provision is also omitted – this includes the number of funded residential and nursing care places and day care and home care services. This is particularly important since a core part of the strategy turns on the proposal to substitute community and intermediate care provision for acute services. In this context we examine in greater detail the authority's plans for the expansion of intermediate care and the planning base which underpins them.

Have all the proposed bed closures been identified?

WHA proposes a reduction in general and acute staffed bed capacity by 2006-07 of 24% in the WHA area and 4.4% in Dewsbury (see Table 7) with a compensatory increase in intermediate care beds.

Table 7. WHA's projections of 'bed' numbers in 2006/07 compared with 2000/01

	Wakefield 2000/01*	*Wakefield* 2006/07*	*North Kirklees 2000/01*	*North Kirklees 2006/07*	*Total 2000/01*	*Total 2006/07*
*General & acute***	*1,047*	*795*	*389*	*372*	*1,436*	*1,167*
Maternity	*62*	*42*	*41*	*31*	*103*	*73*
Day case	*41*	*100*	*20*	*39*	*61*	*139*
Intermediate/Rehab	*–*	*220*	*20*	*128*	*20*	*348*
Total	***1,150***	***1,157***	***470***	***570***	***1,620***	***1,727***

Source: SOC 2, Fig. 9, p.12

**'Wakefield' means 'hospital capacity at Pinderfields General Hospital and Pontefract General Infirmary' and 'North Kirklees' means 'hospital capacity at Dewsbury District Hospital'.*

***The 'general and acute' category is based on form KHO3 and includes rehabilitation and step-down beds.*

While the total number of beds provided appears to increase by 100 beds from 1,620 to 1,727 beds there are four points to note:

1. The table relates only to bed capacity at Pinderfields General Hospital and Pontefract General Infirmary and Dewsbury District Hospital. It is not whole district provision as indicated in the table heading.[58,59]

2. The table excludes the closure of acute in-patient beds at Southmoor Hospital and Castleford and Normanton District Hospital.[60] The Community Trust reports that there are currently around 45 acute beds in these two hospitals.[61]

3. It has not taken a whole systems approach as recommended by the Department of Health. It omits proposed closures of NHS beds other than general and acute beds.

4. Most importantly the table itself does not specify the nature and location of intermediate care beds in the SOC.[62] This is a crucial omission because the SOC indicates that some of the re-provision in Kirklees will be part of a local authority funded scheme to re-provide and refurbish residential care homes. Thus of a total of 348 new intermediate care beds, 128 North Kirklees beds may be in non-NHS funded settings (see chapter 5, section i.b) and subject to user charges.

What local and national evidence is there to support the case for the proposed general and acute bed reductions?

A. LOCAL TRENDS IN ACUTE AND GENERAL BED NUMBERS

On the basis of local trend data there is little evidence to support a 24% reduction in acute beds between 2001 and 2007. As Table 8 shows, bed numbers have remained relatively static in the six year period 1995-2001, indicating that in spite of the deficits and pressure to close services the trust has not been able to do so.

Table 8. Average daily number of general and acute available beds 1995/96-2000/01

	General and acute available beds	
	Pinderfields and Pontefract*	***Dewsbury***
2000-01	*1,000*	*408*
1999-2000	*987*	*406*
1998-99	*1,001*	*393*
1997-98	*1,023*	*389*
1996-97	*1,046*	*398*
1995-96	*1,069*	*401*

**Beds summed for Pinderfields Hospital and Pontefract Hospital for 1995-96 and 1996-97*

Sources: Department of Health, Bed availability and occupancy for England, 1995-96 to 1999-2000. 2000-2001 Department of Health hospital activity website at: http://www.doh.gov.uk/hospitalactivity/index.htm

B. TRENDS IN ACUTE BED PROVISION IN ENGLAND FROM 1993-94 TO 2000-01

Similarly, the assumption that acute bed capacity can be substantially reduced is not supported by national trend data. Acute bed capacity in England has been constant at 108,000 beds over the seven-year period 1993-94 to 2000-01.[63] Between 1999-2000 and 2000-01 the number of acute beds actually increased slightly for the first time in 20 years . Failure to reduce acute bed numbers over this period reflects rising demand, particularly for emergency admissions, and the exhaustion of efficiency improvements, marked by a rapid decline in the rate of fall of length of stay, particularly for surgical admission; ie, the impact of the introduction of day-case surgery was largely over.

The downsizing of NHS general and acute care in the WHA's area assumes that caseload can be transferred to primary and community care settings without detriment to the provision of emergency and elective care in acute specialties. But there is extensive evidence that the assumption in first-wave PFI hospitals that acute bed capacity could be

58. *Ibid*, p.12, notes7&8.
59. Ibid, fig 9, p.12.
60. *Ibid*, para 4.19, p.21. Since going to press the Pinderfields project director has confirmed that figure 9 of the SOC is wrongly labelled and that bed closures at these two hospitals are included in the 24% bed reduction. Letter from J. Mason to A. Pollock, 16 April 2002.
61. Personal communication
62. SOC para 2.55 refers to "flexible options".
63. DoH. *NHS Hospital Activity Statistics, England, Financial year 1990-91 to 2000-01.*

reduced by 30% without impairing service delivery is at odds with national trends.

PFI hospitals in Durham, Carlisle and Calderdale are currently experiencing severe difficulties in accommodating inpatient admissions in general, and elective admissions in particular. The downsizing of acute capacity preceding the construction of PFI hospitals in Worcester and Hereford has resulted in severe shortages of acute beds in both counties.[64]

The most detailed analysis of the results of downsizing acute capacity prior to the opening of a PFI hospital (the Royal Infirmary of Edinburgh) is contained in an analysis of changes in clinical activity in Lothian Health Board hospitals, compared with other Scottish NHS hospitals, between 1990-91 and 2000-01. Substantial reductions in elective admissions compared with other Scottish NHS hospitals were not compensated for by the displacement of caseload to day-case, outpatient, or post-acute ('intermediate' care) settings. There have also been increasing difficulties in accommodating emergency admissions.[65]

Increased efficiency and improved performance?

The SOC model of future capacity requirement (reproduced in Table 9) is based on assumed efficiency improvements in emergency and elective admissions, day case surgery, length of stay, bed occupancy and throughput. However the model provides no information or evidence to support the reduction in services and alternative services which are proposed. Indeed the model is unintelligible from the perspective of needs-based planning.

What is left out of the SOC: needs-based planning

Needs-based planning is the bedrock and foundation of universal health care built on equity. But not only is the SOC short on data on trends in use, it has not attempted to provide any measures of need with respect to trends in caseload by specialty and type of admission, or in unmet need for services in the community. It provides no community needs-based assessments.

I. ADMISSIONS

It would be normal to provide projections of caseload based on past trends in caseload, by specialty and types of admission. In particular when planning new services it is vital to estimate and project the number of patients by specialty, type of care, and admission. Since no caseload data are provided, it is impossible to analyse the basis for the assumptions which lie behind the model's assumption of improved efficiency.[66]

II. PERFORMANCE: LENGTH OF STAY, BED OCCUPANCY, AND THROUGHPUT

The SOC assumes major changes in performance and types of care. But surprisingly it gives no details of trends in length of stay, bed occupancy, or throughput, or of the feasibility and achievability of

Table 9. SOC 2 capacity planning model

Emergency admissions	→	*Converge with national average rates long term*
Elective admissions	→	*Annual % change in line with NBI**
Day cases	→	*Annual % change in line with NBI.* Day case rates increase in DTCs****
Length of stay	→	*Achieve 65th-75th percentile peer group LOS**by 2006/07*
Impact of non-hospital service developments	→	*From point prevalence study. Acute bed days substituted by 1.5 intermediate care days*
Occupancy	→	*82% adults. 65% children. Plus capacity for peaks.*

Source: SOC, Figure 8, p. 12.

**National Beds Inquiry **Length of stay ***DTC=diagnostic treatment centre*

64. Letter from Peter Luff MP to Alan Milburn, Secretary of State for Health, regarding bed viability in Worcester and Herefordshire, 20 September 2001.
65. Dunnigan M. *The downsized hospital hypothesis: value for money? The results of reducing staffed bed capacity on clinical activity in Lothian Health Board and other Scottish NHS hospitals between 1991 and 2000*. Glasgow: NHSCA 2001.
66. SOC para 2.48 refers to a model that "takes account of local hospital admission rates and recent trends," but does not provide any data.

the targets for their performance measures. We have used the DoH statistics which are gathered on the trust to describe throughput, length of stay, and bed occupancy (Table 10). These data show that further improvements have been exhausted. This is confirmed by the national analysis, which also shows a levelling out of improvements in bed occupancy. It is striking that current bed occupancy is higher than that projected in the model, despite there being more acute beds currently.

Where will patients go?

I. HOW MANY PATIENTS WILL BE DISPLACED FROM THE HOSPITALS TO OTHER LOCATIONS AND SETTINGS?

Although the strategy turns on major reductions in acute beds and the diversion of caseload to intermediate care settings and to other parts of the NHS including primary care and intermediate care settings, and as well as to social services, no estimates are provided of the volumes and caseload. However the SOC implies that a significant number of patients will have to travel out of the district and to alternative non-acute hospital settings.[67]

II. INTERMEDIATE CARE SETTINGS

The SOC hospital reconfiguration is premised on centralising and reducing acute services across the three hospitals in Pontefract, Wakefield, and Dewsbury, and shifting caseload into community and hospital-based intermediate care settings.

However, the SOC states that the investment and capacity needs of the 'care closer to home' model have yet to be developed: "A detailed intermediate care strategy is being developed involving key stakeholders, and the range, scale and disposition of services will be determined and consulted upon as part of this process in 2001".[68] A draft intermediate care strategy was published in May 2001. It describes "the strategic framework for the development of intermediate care services". It says that "underlying responsibility for residential and intermediate care" will not be determined until March 2002.[69]

SOC projections also include "additional, limited-life, G&A [general and acute] bed capacity in retained and refurbished accommodation at Pinderfields and Pontefract hospitals".[70] But this capacity will only be determined by independent evaluation in 2004-05.

In other words the SOC does not make clear what

Table 10. Length of stay, throughput, occupancy, and day cases by trust from 1995/96–2000/01

	Pinderfields & Pontefract				*Dewsbury*			
Year	*Mean LOS**	*Throughput*	*% Occupancy***	*Day cases*	*Mean LOS**	*Throughput*	*% Occupancy***	*Day cases*
2000-01	*6.1*	*49**	*84.0*	*28,931*	*6.3*	*53***	*87.6*	*10,846*
1999-00	*6.2*	*47*	*81.9*	*27,195*	*6.1*	*51*	*85.0*	*9,894*
1998-99	*6.0*	*49*	*84.2*	*24,685*	*6.1*	*53*	*85.9*	*9,795*
1997-98	*n/a*	*47*	*86.6*	*23,611*	*n/a*	*50*	*85.0*	*9,069*
1996-97	*n/a*	*46*	*n/a*	*22,914*	*n/a*	*46*	*83.8*	*15,403*
1995-96	*n/a*	*46*	*n/a*	*23,345*	*n/a*	*47*	*n/a*	*12,788*

**LOS = length of stay*

Throughput = Number of ordinary general and acute finished consultant episodes per General and acute bed

***% Occupancy applies to General and acute*

67. The SOC is not explicit on this point. However, Newchurch & Co concluded in 1987 that 5-6,000 more patients would inevitably travel out of district if acute services were centralised on Wakefield.
68. SOC2, para 2.23.
69. WHA. *Strategic framework for intermediate care*. Draft May 2001. Executive summary. At time of going to press we have no information about the proposals.
70. *Ibid*, para 5.2.

will happen if the necessary new capacity does not emerge to compensate for the planned reduction of 25% in general and acute capacity by 2007. It merely notes that: "contingencies have been identified which allow the retention of some extra bed capacity in the longer run if the planned assumptions are not realised".[71] This undertaking is vague.

III. INTERMEDIATE CARE BEDS

The SOC's long term intermediate care projections include an additional 328 intermediate beds by 2006/07 and an unspecified further increase in 2007/08. Medium term projections show plans for 148 additional intermediate care beds throughout the SOC area by 2003/04, of which 128 will be in North Kirklees and possibly in non-NHS funded settings.

WHA's strategy is to substitute intermediate care beds for general and acute beds. Even assuming that this type of substitution can be safely undertaken, the nature, location, and funding of this provision is not indicated.

While the SOC claims to be re-providing 1.5 bed days for each acute bed day lost, it is not apparent that the increase in intermediate care beds will compensate for the closure of acute beds or whether they will fall under the remit of the NHS or become to some extent fee-paying.

IV. NEIGHBOURING AUTHORITIES

The Newchurch report also estimated that the hospital caseload would be further reduced by 8-14% as a result of 5,000-6,000 more patients travelling out of the health authority's area for their secondary health care following centralisation of acute facilities at Pinderfields. The income required to pay for these patients has not, however, been identified in the SOC. Moreover, other health authorities have stated that they do not have the capacity to take additional caseload. A note prepared for the WHA in 1999 shows that neighbouring health authorities are not planning for additional inflows from Wakefield. Barnsley said that "additional workflow to A&E and elderly care would cause difficulties. In Doncaster "there is very limited potential for Doncaster Royal Infirmary to absorb additional capacity". Leeds Health Authority "would not want to see ... significant changes in patient flows". North Yorkshire repeated the concerns of residents in the Selby area about travel times and accessibility to centralised services in Wakefield. Calderdale called for a study of the pros and cons of the basic options.

What will the effect on patients be?

In the West Midlands a capacity crisis is already hitting home as a result of general downsizing policies to overcome deficits and PFI costs. In September 2001 no beds of any sort were available in Gloucester, Herefordshire, Redditch, Selly Oak, or Solihull. In effect, the NHS in the West Midlands was closed to new admissions. Similar problems are ongoing in Edinburgh, Durham, Carlisle, and Norwich, all hospitals which accepted capacity reductions to pay for the extra costs of PFI.

Conclusion

Absent from the SOC is community needs-based planning and a whole-system approach to care. The proposals hinge on a radical downsizing in acute bed capacity, the success of which turns on alternative re-provision. However, the nature of the displaced caseload, and the funding, location, and staffing of substitute provision for acute hospital beds is not provided.

71. *Ibid*, para 2.61.

Chapter 7. Is there any evidence to support the downgrading of existing hospitals?

The DoH and the SOC state that Pinderfields, Pontefract and Dewsbury hospitals have insufficient critical mass to be viable in the longer term, since in each case the catchment population is less than 200,000.[72] But no evidence is cited for this statement because no such evidence exists.

Pontefract Infirmary and Pinderfields Hospital have over 400 acute beds each. In 1997-98 one in seven (15%) acute hospitals in England fell into the same category, and only one in three (35%) had more than 500 acute beds.

A report by the Royal College of Surgeons of England, which asserts that mega-hospitals with catchment populations of 400,000-500,000 provide optimal clinical outcomes, is unsupported by available evidence. The most comprehensive study of the relationship between hospital size and caseload volume and clinical outcomes was carried out by the Centre for Health Economics at the University of York.[73] The study concludes:

> *there is no compelling reason to believe that further concentration of hospital services will result in improved efficiency through exploiting economies of scale, or automatic improvements in the quality of clinical outcomes. In assessing the potential negative effects of increased concentration on access and utilisation, the implications for disadvantaged groups in particular should not be overlooked.*

Furthermore, the implied threat by the Royal College of Surgeons to withdraw specialist recognition from smaller hospitals is not based on evidence that smaller hospitals (catchment areas of 100,000-200,000) provide poorer clinical outcomes. The fact that a hospital is relatively small does not exclude the possibility of service rationalisation, for example for specialist cancer services, where this has been clearly demonstrated to produce superior clinical outcomes, as the York study recognises. Evidence of this kind is not available for most secondary acute specialties.

A conference held by the NHS Management Executive in Cambridge on 3 November 1998 confirmed the paucity of evidence relating acute hospital size and caseload to costs and clinical outcomes. Barbara Stocking, the leader of the DoH's working party on hospital configuration, stated that evidence of this type was "incredibly thin", and insufficient to produce a blueprint on optimum size. She concluded that "while new district general hospitals should not be built for catchment populations of 150,000 or less, there was no evidence to say that 250,000-300,000 was wrong" or that it was desirable to move to 450,000-500,000 catchment areas.

An alternative model to that of the mega-hospitals favoured by the Royal College of Surgeons integrates clinical services among small, medium, and highly specialised teaching hospitals in managed clinical networks. This model provides the benefits of clinical specialisation while retaining the benefits of accessibility to local hospitals for their catchment populations.[74,75] A working group set up by the Royal College of Physicians of London and the NHS Confederation to consider improvements in handling emergency admissions to acute hospitals has recently expressed similar views.[76] With rapid improvements in information technology, combined with cross-hospital integration of services, the physical aggregation of services in large hospitals may appear increasingly inappropriate in the 21st century.

72. *Ibid*, para 1.2.
73. Ferguson B *et al. Concentration and choice in the provision of hospital services: summary report* CRD Report 8. University of York, 1997.
74. The Scottish Office Department of Health. *Acute service review report*, 1998.
75. Northern Ireland Department of Health, *Social services and public safety*. Acute Services Review Group, 1998.
76. Smith R. How best to appraise acute hospital services? *British Medical Journal* 2001; 323, pp.245-6.

The private sector paradox

Furthermore, small hospitals are the norm in the independent private health care sector. The private sector is undertaking an increasing proportion of NHS elective surgical procedures as part of the government's concordat to reduce waiting lists. In Greater London, out of 29 independent private hospitals which provide acute medical and surgical services, 41% (12 hospitals) have fewer than 50 beds, 31% (nine hospitals) have fewer than 100 beds, 24% (seven hospitals) have fewer than 200 beds and one hospital has 247 beds.[77] Most of these hospitals carry out a wide range of surgical procedures. Several perform complex cardiac surgery, including paediatric surgery and neurosurgery.

Neither the Royal College of Surgeons nor the government has publicly expressed any reservations about the expansion of elective surgery in these very small private hospitals, most of which have only a single medical officer on call for 24 hours. It is a paradox that NHS hospitals with more than 400 beds should be closed on the grounds that they are 'non-viable', while an increasing proportion of elective surgery is being hived off to small private hospitals, most with less than 100 beds.

Conclusions on service plans

All of the business cases for first-wave PFI schemes promised an efficient 're-engineering' of acute care to divert patients to post-acute and community settings. Given the exhaustion of efficiency improvements, and the appearance of static or rising lengths of stay in acute specialties in the mid-1990s, further reductions in acute bed capacity will inevitably result in reductions in acute caseload through the displacement of elective admissions by emergency admissions.

Experience of PFI-related downsizing to date suggests that the substitution of non-acute care for acute geriatric care is an unreliable method of reducing the acute inpatient caseload of older patients after their episodes of acute care have been completed. In its treatment of intermediate care the WHA has failed to undertake of whole system planning recommended by the DoH. Given that the role of intermediate care is to make room for the reduction in hospital size on which the plan depends, this is extremely worrying.

In the light of this evidence, the projected loss of a quarter of general and acute beds in WHA by 2006/07, coupled with the vague and unquantified commitments to the provision of new 'intermediate' care bed capacity, is a high-risk strategy. It is based on a 'vision' which is unsupported by evidence of past trends and contradicted by abundant evidence of insufficient acute capacity in NHS acute hospitals at present.

The York study on the size of hospitals concluded:

> *The burden of proof must be with those who propose change to quantify the expected costs and benefits, to demonstrate the process by which benefits will be realised in practice, and to explain the way in which efficiency gains will be assured and monitored. In interpreting the results of this research there are inevitably qualifications, and some of these are noted here. However, despite these qualifications this broad conclusion remains valid.*[78]

Despite lack of evidence that the quality of clinical services will improve, the Wakefield SOC projects the removal of inpatient services from Pontefract Hospital, which will become a stand-alone ambulatory care and diagnostic unit with outpatient, day case, rehabilitation, and intermediate care facilities. Communities do not welcome the closure of an accessible local hospital. It is important that they are made aware that their desire to retain their local hospital is based on rational grounds.

QUESTIONS TO ASK OF THE SERVICE PLANS

1. Will the overall proposed reductions in acute and overall levels of bed provision meet the needs of the population, given its high levels of deprivation and needs?

77. *Laing's Health Care Market Review 2000-01*. Laing and Buisson. London.
78. Ferguson B *et al. Concentration and choice in the provision of hospital services: summary report* CRD report 8. University of York. 1997.

2. Will the intermediate bed and other care provision support the patients displaced from the reduced acute sector? The current problem is alleged to be bed blocking and inappropriate use of beds. But although the health authority intends to replace acute care with intermediate care, the overall provision will still be less than it is currently. Given that there will be fewer beds overall, and that intermediate care beds will not be staffed to such high levels, how will reducing the beds increase efficiency and decrease bed blocking while ensuring that health care needs are met?

3. Will the alternatives to hospital care – that is, home and day care services – be sufficient to support displaced caseload from acute and intermediate care settings as a result of overall reductions in numbers of beds? The closure of Clayton Daycase Centre and the reconfiguration of community services are based on the policy of bringing services "closer to home". The local authority and WHA have not provided in their strategy an account of the level of resources, staffing, and inputs into day care and home care services.

Conclusions

Financing new capital investment through PFI is extremely costly and results in service cuts. Wakefield is no exception. Local residents will see their acute hospitals downsized in return for new investment but the effect will be fewer services at increased cost. Funding hospital investment by switching internal resources from clinical care to capital spending is increasingly discredited. Opting for the highest possible capital cost option, PFI, is a policy without a rationale.

But it is characteristic of plans like this they are short on detail. Although the plans are premised on service cuts, they omit projections of the number of patients affected. One cannot tell from the SOC how many patients the authorities expect to gain admission to hospital in the Wakefield area in the future or how many are expected to be transferred to intermediate care (where, after six weeks, they may be expected to pay).

The deficits that have plagued the area for more than seven years are the result of underfunded patient care. The new strategy, far from resolving the financial deficits, will deepen the financial crisis across Wakefield and the surrounding areas. At the same time it will reduce services and have a major adverse impact on the elderly, the sick, and those with chronic illnesses.

Appendix

Table 11. Finished Consultant Episodes by year, length of stay, and bed days by trust from 1995/96-2000/01

	*Pinderfields and Pontefract**			*Dewsbury*		
	Ordinary FCE	*Day case FCE*	*Total FCE*	*Ordinary FCE*	*Day case FCE*	*Total FCE*
2000-01	*56,159*	*28,931*	*85,090*	*30,868*	*10,846*	*41,714*
1999-00	*55,213*	*27,195*	*82,408*	*29,683*	*9,894*	*39,577*
1998-99	*57,599*	*24,685*	*82,284*	*29,386*	*9,795*	*39,181*
1997-98	*57,519*	*23,611*	*81,130*	*28,125*	*9,069*	*37,194*
1996-97	*58,490*	*22,914*	*81,404*	*26,141*	*15,403*	*41,544*
1995-96	*59,825*	*23,345*	*83,170*	*26,765*	*12,788*	*39,553*

**FCEs summed from two separate hospitals, Pinderfields Hospital and Pontefract Hospital for 1995-96 and 1996-97*

Sources: For 1995-6 to 1997-8, Department of Health, Ordinary and Day case admissions for England, tables 3 & 4. For 1998-9 onwards, Table 8 in Hospital In-Patient Data, Hospital Episode Statistics, website http://www.doh.gov.uk/hes/standard_data interfaces

Resources

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Written for UNISON by the Health Policy and Health Services Research Unit at the School of Public Policy:

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Deficits before Patients: A report on the Worcester Royal Infirmary PFI and Worcestershire Hospital Reconfiguration by Allyson Pollock, David Price, Matthew Dunningan (June 2000)

Useful Websites:

Health Policy and Health Services Research Unit
www.ucl.ac.uk/spp/about/health.htm

UNISON has a special page on its website devoted to its Positively Public campaign, including PFI and Public Private Partnerships:
www.unison.org.uk/positivelypublic

Catalyst, an independent think-tank, has published: Public Services and the Private Sector: A Response to the IPPR by Allyson Pollock, Jean Shaoul, David Rowland and Stewart Player. (November 2001)
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