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The analysis contained in this report is derived from all data made publicly available by the WHA and WRI up to and including 10 May 2000. It includes responses to requests for more detailed information from local people and district councillors. This independent report is written in the public interest with the intention of opening up the data and information provided to public scrutiny and debate.

Glossary of abbreviations used

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ACAD	Ambulatory Care and Diagnostic Facility
FBC	Full Business Case
FCE	Finished Consultant Episode
FM	Facilities Management
HDU	High Dependency Unit
NHS	National Health Service
OBC	Outline Business Case
PFI	Private Finance Initiative
SPV	Special Purpose Vehicle
WHA	Worcestershire Health Authority
WRI	Worcester Royal Infirmary NHS Trust
WTE	Whole time equivalents

DEFICITS BEFORE PATIENTS

A report on the Worcester Royal Infirmary PFI and Worcestershire hospital reconfiguration

Background and Summary

National

Across the UK, financial deficits are driving the reconfiguration and downsizing of health services in the NHS. Lack of capital for investment is evident in its dilapidated, poorly maintained buildings and hospitals. But underfunding has also resulted in cuts in services and in 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 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 services have become the main focus of cost management strategies.

In 1992 the introduction of capital charges into the NHS compounded the problems of underfunding, making new claims on budgets for patient care. For the first time the NHS has to pay a charge for its use or consumption of capital, i.e., land and assets. 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. This charge amounts to an average of 8% of the annual income of NHS trusts.

NHS bodies unable to cover both the costs of patient care and the costs of capital have seen their deficits spiral. These deficits have in turn fuelled further cost cutting measures, usually staff redundancies and closures of services which masquerade under service reconfiguration and NHS modernisation.

Worcester

This pattern is reflected in Worcester. In 1997, Worcestershire Health Authority (WHA) was told by its financial consultants that “maintaining the status quo is not affordable” because of the deepening financial crisis.¹ In 1997-98 the authority calculated that the accumulated deficit for all NHS services in the area was £15 million and that it was increasing year by year.² According to the management consultants, this deficit was a direct result of capital charges on assets.

In 1997, alarmed by the prospect of growing debt, the West Midlands NHS Executive told the authority to give “utmost priority” to its plans to reform health services in the area in order to save money.³ “I fully agree,” wrote the regional

director, “that the issue of configuration of services and the financial picture in Worcestershire [are] intimately connected”.

In an attempt “to secure its financial future and position in the internal market” the Worcester Royal Infirmary (WRI) announced in 1996 it would cut its own costs by building a new, more efficient hospital funded entirely out of its existing income⁴ and financed through the private finance initiative (PFI). As this report shows, under the PFI the costs of the new hospital escalated by 118% during negotiations, from £49 million in 1996 to £108 million in 1999, thereby exacerbating the financial crisis.⁵ Much of the 118% cost increase was due to the extra costs of financing which would not have been incurred under a public sector option. The very policy designed to ease financial pressures had made matters worse.

In 1998, WHA undertook an urgent strategic review in an attempt to resolve the deficit and find the extra money to pay for the WRI. The proposals turn on axing inpatient services at one of the area’s three district general hospitals (Kidderminster), cutting bed numbers in a second (Alexandra), and giving a local private hospital an enhanced role in NHS provision.

WHA intends that the catchment area of the new WRI will increase by 36% from 280,000 to 380,000 residents to serve the residents of Kidderminster when inpatient facilities close. The new hospital will, however, have 12% fewer acute beds than in 1994-95 by the time PFI comes on stream. Based on WHA data, residents will compete for admission since the closure of 219 Kidderminster acute beds will leave the level of hospital provision across the area below the national average, with inpatient acute bed capacity at two fifths of the English average 1998-99. Acute hospital inpatient admission rates are projected to fall to 59% or around two thirds the average hospital admission rate for England in 1997-98. There is no extra money for parallel support services in the community.

The dramatic countywide service cuts, which will leave Worcestershire with one of the lowest levels of hospital provision in the country, are the result of the PFI exacerbating the deficit. In this report, we examine Worcestershire Health Authority’s and WRI’s financial strategies and we show why it has led to the closure of Kidderminster hospital. We also raise serious questions about the risks to the population of curtailing NHS services on the scale envisaged.

- **1** Worcestershire Health Authority. *Financial Review of Health Services – Report on the Financial Position*. Report to board meeting 27 November 1997, paragraph 1.5.5.
- **2** Worcestershire Health Authority. *Investing in Excellence. A Consultation Document on the Future of Health Services in Worcester*. 1998, p.31.
- **3** Personal communication. Mr Stephen Day, Regional Director, West Midlands NHS Executive to Mrs P Archer-Jones, Chief Executive, Worcestershire Health Authority, 10 November 1997.
- **4** Worcester Royal Infirmary NHS Trust. *Outline Business Case*, February 1996. Hereafter, *OBC*.
- **5** Worcester Royal Infirmary NHS Trust. *Proposals for a New Hospital in Worcester. Full Business Case as Approved by NHS Executive and HM Treasury on 19 March 1999*. April 1999. Hereafter, *FBC*.

Part One: The Financial Analysis

1. The deficit

- 1.1. Management consultants brought in by WHA in 1997 reported that the health service in Worcestershire was spending £9 million more than it received in income⁶, a figure subsequently confirmed the following year by the health authority’s strategy document, *Investing in Excellence*, which showed an annual recurring deficit of £9.5 million at 31 March 1998.
- 1.2. The figure of £9.5 million combines the deficits of the health authority and its local trusts. Table 1 shows an underlying deficit for hospital and community services increasing from £3.1 million 1995-96 to £5.4 million in 1997-98. In 1999 the health authority reported that the acute trusts were contributing an annual deficit of £7.6 million to the total annual deficit. In other words trust income did not cover patient care costs and the capital charges requirement.

Table 1
The underlying deficit, Worcestershire acute and community NHS trusts, 1995-96 to 1997-98 (estimated)

Trusts	1995-96 £m	1996-97 £m	1997-98 £m
Alexandra Healthcare	1.70	1.80	1.50
Kidderminster Healthcare	-	0.97	1.40
Worcestershire Community	-	-	0.70
Worcester Royal Infirmary	1.40	0.90	1.80
Annual hospital and community deficit	3.10	3.67	5.40

Source: SECTA, *Financial Review of Health Services Across Worcestershire - Report of the Financial Position*. WHA, 27 November 1997.
 WHA, *FBC*. 1999.
 WHA, *Trust Merger Consultation Document*. 1999.

- 1.3. The deficits were mainly outside the control of local NHS providers and the health authority. The Full Business Case (FBC), Vol.1, p.12 attributes the cause of the deficits to the following factors:

- **costs of continuing care**
- **the extent of physical estate and associated capital charges**
- **emergency admissions and extra contractual referrals**
- **reduced flexibility through high levels of fundholding**

- 1.4. NHS trusts attempt to bring the books back into balance by cost cutting measures. Most commonly this involves cutting the costs of labour through staff reductions, other efficiency measures including not

replacing obsolete equipment, saving on maintenance, or selling off bits of land. It may also mean an injection of cash from the health authority and region. As WHA observed, however, these are usually one-off measures, which will not prevent the deficit from recurring the following year.

- 1.5. WRI, in common with many trusts, went one step further. It attempted to guarantee its future and resolve both its deficit and need for capital investment by embarking on a hospital building scheme using PFI. In 1996 the WRI published a business case that claimed it would cut costs by building a new, more efficient hospital funded entirely out of its existing income⁷ and financed through the private finance initiative (PFI). As this report shows, however, under the PFI the costs of the new hospital escalated by 118% during PFI negotiations, from £49 million in 1996 to £108 million in 1999 thereby exacerbating the financial crisis.⁸ Much of the cost increase was due to the extra costs of financing that would not have arisen under a public sector option. The very policy designed to ease financial pressures had made matters worse.
- 1.6. In early 1997, before the PFI costs had registered, the health authority was now looking to make cost savings from the closure of hospital beds and the release of staff. The subsequent bed model calculated that bed closures at Kidderminster and Alexandra hospitals would “release” £2 million in savings, whereas savings from bed reductions at the WRI could be recycled to pay for the new hospital.
- 1.7. By late 1997, as the true cost of the PFI emerged, the health authority realised that more draconian action was required to resolve the accumulating deficits. It undertook a strategic review of the whole area’s hospital services with the sole objective of cutting the deficits and bringing the authority back into financial balance as required by the Secretary of State. Complete closure of one of the three general hospitals rapidly became the only option and the regional office of the NHS was quick to press the authority into a decision. The result was the health authority’s 1998 services review document, *Investing in Excellence*, recommending the replacement of acute inpatient services at Kidderminster general hospital with an “ambulatory centre” and the transfer of income from Kidderminster to meet the escalating costs of the PFI at WRI.

2. How the PFI exacerbates the deficits

What is the PFI?

- 2.1. Since 1992, most major capital investment in the NHS has involved the PFI. Under the PFI the private sector

⁶ Worcestershire Health Authority. Consultants’ report. *Financial review of health services across Worcestershire – Report on the financial position*. Worcester Health Authority agenda item, November 1997

⁷ *OBC*.

⁸ *FBC*.

designs, builds, finances, owns, and operates services. Hospitals funded by the PFI are leased back to the public sector for periods of up to 60 years. Capital for investment is raised by the private sector instead of the government. Specially formed PFI companies (consortia of builders, financiers, and other contractors) borrow on the financial markets in order to fund construction costs. In the case of WRI the companies that make up the special purpose vehicle (SPV), Catalyst Healthcare Ltd, comprise Bovis Ltd, The British Linen Bank Ltd, RCO Support Services Ltd, and SG Project Investment Ltd.⁹

Table 2**Change in total capital cost during PFI negotiations**

	1996 OBC £000	1999 FBC £000	Change £000	1996-99 (%)
Total capital costs	53,861	112,197	58,336	(+108)
Construction costs and fees	53,861	82,302	28,441	(+53.8)
"Other" (financing costs)	-	29,895		
Land sales	(4,500)	(4,500)		
Total funding required	49,361	107,697	58,336	(+118)

Source: FBC Vol. 1, table 32; OBC Vol. 2 Appendix 1

Note: Prices not adjusted for inflation. They are inclusive of VAT.

What caused the cost increases?

- 2.5. The full business case attributed cost increases of 53% to building costs with an increase in the number of beds from 380 in the OBC to 452, and the inclusion of a new cost of £29.9 million described as "other" in the FBC. Despite its significance, this new cost item is not properly explained but is probably due to "financing costs". Financing costs generally include fees paid to financing agencies and interest paid on loans during the construction period, that is, in the period before annual payments by WRI begin.
- 2.6. These financing costs are unique to PFI and would not be paid under traditional procurement. They arise from the PFI financing mechanism. The capital outlay of £108 million required for the new hospital was raised in four different ways, bonds; equity, loan stock, and subordinated debt, the proportions of which are shown in table 3.

Table 3**PFI financing model**

Financing model	£000
Bond	97,190
Subordinated debt	7,290
Loan stock	3,157
Equity	60
Total	107,697

Source: FBC Vol. 2, Appendix 1

Note: 1998/99 prices

- 2.7. Each of these financing arrangements attracts fees. On past experience, the largest financing cost will be "rolled up interest", the interest that has to be paid to lenders and investors during the construction period. WRI has not released this figure.
- 2.8. The capital raised by the private sector is considerably

- 2.2. In 1996, the board of WRI committed itself to rebuilding the Worcester Hospital using the PFI. Contrary to the way it is often presented the PFI is not a new source of funding for the NHS, but a method of financing or borrowing large sums of capital upfront. The borrowing, however, has to be paid for out of the public purse or through user charges.

- 2.3. At the outset WRI and the health authority decided how much they could afford to pay the PFI consortia annually. The annual charges are funded out of hospitals' annual revenue budgets, the amounts allocated to them by health authorities to pay their normal running costs. The total capital cost of a PFI hospital determines its annual cost to an NHS trust because all private finance has to be repaid by the trust in annual instalments within the life of the PFI contract. The contract period is usually about 30 years.

Cost escalations under the PFI: from £49 million to £108 million

- 2.4. One of the striking features of all hospital PFI schemes is the cost escalation that occurs during the procurement process.¹⁰ The new Worcester PFI hospital is no exception. The cost increases are revealed in the two "business cases" that inaugurated and concluded the negotiations. Table 2 shows that total capital costs more than doubled between the 1996 outline business case (OBC) and the 1999 full business case (FBC). The funding required for the new hospital rose by 118% in three years, from £49 million to £108 million, excluding £4.5 million derived from land sales.

⁹ "Catalyst Healthcare Limited is a special purpose company that has been established to design, build, finance and operate new hospitals including the provision of related services. The sponsor shareholders are Bovis Ltd, the British Linen Bank Ltd., RCO Support Services Ltd and SG Project Investment Ltd... Equipment services are to be provided by Siemens Healthcare limited [which is] not an equity partner..." Source: FBC p.43.

¹⁰ Gaffney, D., Pollock, A.M., Price, D., and Shaoul, J. NHS capital expenditure and the private finance initiative - expansion or contraction? *BMJ* 319, 1999, pp.48-51; Gaffney, D., Pollock, A.M., Price, D., and Shaoul, J. PFI in the NHS - is there an economic case? *BMJ* 319, 1999, pp.116-119; Pollock, A.M., Dunnigan, M.G., Gaffney, D., Price, D., and Shaoul, J. Planning the 'new' NHS: downsizing for the 21st century. *BMJ* 319, 1999, pp.179-184; Gaffney, D., Pollock, A.M., Price, D., and Shaoul, J. The politics of the private finance initiative and the new NHS. *BMJ* 319, 1999, pp.249-253

greater than the construction costs of the new hospital. This is because part of the capital raised, £29.9 million in the case of WRI, goes to meet various financing costs. In other words, capital is raised in order to meet the cost of raising capital. Thus a large part of the increase in costs is the payments made to bankers and shareholders, payments which would not be incurred under a publicly financed scheme.

3. How the PFI is paid for

The composition of PFI payments

3.1. PFI contracts combine two basic types of transaction, one for the provision of assets such as buildings and equipment and one for the provision of *services* such as facilities management and catering. The payment for the provision of assets is called an *availability charge*; the payment for the provision of services is called the *service charge*.

The “unitary charge”

3.2. Other charges may be levied in addition to the availability charge and the service charge. For example, a variable payment known as a “volume” or “usage” charge is usually a minor part of the total PFI payment. Together, all these payment streams constitute what is called the *unitary charge*, that is, the payment made by the public sector client to the PFI contractor. The unitary charge is usually fixed for the period of the PFI arrangement at contract signature. Normally the contract allows for an annual uplift for inflation, and the services component of the charge may vary as a result of benchmarking and market testing.

What does the availability charge pay for?

- 3.3. The availability charge is a fixed cost which can vary only if new requirements outside the terms of the contract arise or if the PFI company fails to meet its performance requirements under the contract. It has to meet three types of cost.
- 3.4. First, it funds interest and principal payments on the debt taken out by the PFI contractor. This claim has to be settled before any others, and generally accounts for the bulk of the availability payment. The lending institutions have an interest in ensuring that this payment stream is clearly identifiable and protected.
- 3.5. Second, the PFI contractor has to build up reserves for various purposes, the most important of which is to meet “lifecycle” costs, that is, capital expenditure that may be required in later years in order to maintain the

value of the assets. (This “lifecycle” reserve will usually be the property of the PFI contractor and will only be spent to the extent it becomes necessary. Any unused funds are passed over to the shareholders at the end of the contract period.)

3.6. Finally, once these costs have been met, the availability payment funds returns to shareholders in the form of dividends. As debt is paid off over the contract period, an increasing proportion of the availability payment consists of profit to shareholders.

The unitary charge and availability fee at WRI

3.7. The unitary charge at WRI will be £16.9 million. The availability charge will be £7.2 million. The service (or performance) charge will be £8 million. The remaining £1.7 million will be volume or usage (variable) charges (see Table 4).

Table 4
Breakdown of the PFI annual unitary fee (1998/9 prices)

Catalyst fee year 1	£000
Availability	7,196
Performance	7,991
Variable	1,711
Total	16,898

Source: FBC Vol. 2, p258; Vol. 1, p57.
Note: 1998/99 prices

Meeting the unitary charge in WRI

- 3.9. After land sales, what sources of income does the trust have to fund these payments? Most hospital trust income is committed to providing clinical services and paying for labour and supplies. Since 1992, however, trusts have been required to run an annual surplus of income over expenditure, which is used to pay “capital charges” to the Treasury. This surplus is the first source of funding for PFI availability payments. Under the capital charging policy, NHS trusts are obliged to operate in such a way as to produce annual surpluses equivalent to 6% of their existing capital assets, i.e., buildings, land, and equipment. When a trust signs a PFI contract and transfers its assets to the private sector, it is no longer obliged to pay charges to the Treasury, and can use its annual surplus in order to pay the PFI debt and returns to shareholders.
- 3.10. The accounts of WRI show that in 1998-99 capital charges and depreciation came to £5.6 million. This sum represents the amount the WRI board was supposed to set aside each year to pay for capital from its annual income. But the WRI did not have enough

money to pay for patient care *and* meet its capital charges. According to the health authority's financial consultants the trust could only meet its costs by relying on special, as yet undisclosed, financial measures. The consultant's report shows that in 1998 WRI took on the extra costs of PFI when it was already experiencing an annual funding shortfall (underlying deficit) of £1.8 million (table 5).

Bridging the affordability gap

3.13. By the time the PFI had been negotiated, the annual capital cost of the new hospital was £5.6 million ie double the surplus available to pay the capital charges of the WRI NHS capital costs in 1998-99. Practically speaking, WRI had to increase by £5.6 million the surplus left after paying hospital running costs in order to bridge the affordability gap. This rate of surplus could only be achieved by an increase in WRI's revenue or by cutting other costs.¹¹ Under the PFI, WRI pursued both strategies.

Table 6
Source of WRI income under PFI

Sources of income	1998/9 Base £000	PFI 1998-99 prices £000	Change £000	%
Smoothing money	nil	763	+763	
NHS Executive	nil	2,061	+2,061	
WHA:	49,420	58,032	+8,612	+17.4
<i>Investing in Excellence</i>	-	(7,292)	(+7,292)	
Other purchasers	2,115	2,115	-	-
Other income	8,038	5,380		
Total income	59,573	68,531	+8,958	+15

Source: FBC Vol. 1, p.65, table 42

Increasing revenue

3.14. From table 6 it can be seen that there are three new sources of funding:

- “The smoothing mechanism”. Smoothing monies are paid by the government to reduce the impact of PFI annual costs. In the case of Worcester, the government has put in £763,000 per annum for the life of the contract, which effectively reduces the impact of the unitary payment on the income and expenditure account from £16.89 million to £16.135 million.¹² Additional revenue from government for this purpose amounts to a total of £21 million over the life of the contract.
- The NHS Executive contributed an extra £2 million.¹³
- Health authority funding of £8.6 million per annum, 17.4% more than in 1999 from the diversion of income from Kidderminster inpatient beds.

3.15. The health authority decision to divert funds from Kidderminster and other services in the area to the new hospital represented a radical change of policy. When the new hospital was first suggested, WRI said that it had “identified gross savings of £4.368 million” to cover higher capital charges and population growth¹⁴ and that therefore the health authority was not required to put extra money into the PFI scheme.

¹¹ FBC Appendix 4, Review of Financial Position and Recovery Plan in the Context of the PFI Scheme (5 November 1996).

¹² FBC Vol. 2, p.221.

¹³ FBC Vol. 2, p.220.

¹⁴ OBC, Vol. 1, p.iv.

Table 5
Cost of capital WRI, 1998-99 and when the new PFI hospital opens (1998-99 prices)

	Cost of capital (£m)	Cost of capital (% of income)
WRI (1998-99)	5.6	(9.4)
Underlying deficit ¹	(1.8)	
Cost of capital when the PFI hospital opens at 1998-99 prices	9.4	(15.8)
NHS capital charges on NHS assets (retained estate)	2.2	
Availability fee	7.2	
Affordability gap	5.6	

¹ Refers to 1997-98

Source: FBC Vol. 2, pp.220, 258; SECTA. *Financial Review of Health Services Across Worcestershire. Report on the Financial Position. Version 3.0.* WHA. 14 July 1997.

The affordability gap

3.11. WRI's main source of funding for the availability payment is its existing capital charges. If the availability payment is greater than existing NHS capital charges, or than the charges a trust can regularly pay, affordability problems arise. How do the annual PFI capital costs (the availability payment) compare with WRI's current expenditure on capital (NHS capital charges)?

3.12. The proportion of WRI income devoted to capital will rise from 9.4% of income to 15.8% of income when the new PFI opens, an increase of more than 50% (table 5). The increase results from the PFI availability payment of £7.2 million being £1.6 million greater than existing NHS capital charges. In addition to the PFI payments, capital charges of £2.2 million are still due on retained NHS estate. Table 5 shows that the annual costs of capital increase both absolutely and proportionately, from £5.6 million or 9.4% of income before PFI to £9.4 million or 15.8% of income after PFI. This creates an affordability gap of £3.8 million per annum between current and projected annual capital costs. Since WRI is already in deficit to the tune of £1.8 million, the affordability gap increases to approximately £5.6 million.

- 3.16. Furthermore at a health authority meeting on 23 January 1997, community health councils worried about the knock-on effects of PFI were assured that “the [PFI] proposals relate only to the needs of the population currently served by WRI and are designed to replace old, outdated and dispersed facilities.”¹⁵ But as we have seen, the costs of PFI took the authority by surprise and negotiations between WRI and Catalyst, the PFI contractor, were held up while a new county-wide strategy, *Investing in Excellence*, was compiled which would allow WRI’s income to be increased and resolve the overall deficit of the county.
- 3.17. *Investing in Excellence* recommends the downgrading of one of the area’s three district general hospitals (Kidderminster) to predominantly ambulatory provision, providing day case and not inpatient work. Inpatient activity from Kidderminster will be transferred to WRI, thereby increasing its catchment population by a third from 280,000 to 380,000.¹⁶ This strategy is central to the PFI business case because the “refocusing of Kidderminster Hospital as a specialist ambulatory care centre will require alternative provision for general acute inpatient activity, which will predominantly flow to Worcester.”¹⁷ This alternative provision will increase WRI’s income from £60 million per annum to £68 million per annum (table 6).

of clinical revenue formerly dedicated to other health services in the county (especially Kidderminster Hospital). This allocation forms the bulk of the additional increase in income and it is the only explanation for how WHA squared WRI’s requirement for additional revenue over and above the £51.5 million in current funding agreed by WHA (see appendix, letter from Pat Archer-Jones to Mark Butler).

- 3.20. As we will see in part two, however, while the health authority may have attempted to resolve the deficit, they have not yet resolved how and where patients will be treated and who will pay for care. An analysis of future clinical activity shows that the projected number of admissions to the new hospital does not increase to take account of the Kidderminster closure. This is perplexing and may suggest that the cost story has not yet been fully told. The King’s Fund report stated that “the financial information set out in *Investing in Excellence* and the supporting papers is insufficiently detailed to establish the viability of any of the Health Authority’s proposed options for service reconfiguration.”²¹ This is a fundamental gap in our information about the new hospital as is the absence of detailed clinical budgets and staffing plans in the published proposals.

Why does income increase by £8 million a year?

- 3.18. WRI income is increased in order to solve the PFI affordability problems which remain after WRI efficiency savings. We have shown that the original PFI proposal involved generating savings in order to pay for the new hospital. The savings involved reducing bed numbers by 28% and switching spending from clinical staffing budgets to capital budgets. The result is that clinical pay costs at the WRI have been reduced as a proportion of total costs from 63% to 54%.¹⁸ Total efficiency savings for the new WRI are estimated at £4.5 million.¹⁹ This leaves the PFI affordability gap at £5.6 million. A shortfall of at least £1.1 million remains.²⁰
- 3.19. WHA could not simply divert £1.1 million from other services since this would continue to exacerbate the overall deficit and destabilise other services. Accordingly during PFI negotiations, WHA agreed to a transfer of income and beds from Kidderminster. This affects the total bed reduction at WRI. During the negotiations the FBC appears to have increased bed numbers at WRI so that the total reduction in acute beds is 44 rather than the 115 outlined in the OBC and Table 15 of the FBC. The closure of Kidderminster, however, allows savings to be made thereby relieving the overall deficit and the problem of the affordability gap at the WRI. Thus *Investing in Excellence* allocates to WRI an additional £7.3 million

15 FBC Vol. 2, p.140.

16 FBC Vol. 1, p.15.

17 *Ibid*, p. 1, emphasis added.

18 FBC Vol. 2, table F2, p.220.

19 FBC Vol. 2, table F2, p.221.

20 The shortfall could be higher than £1.1 million because not all the efficiency savings may be available to set against the affordability gap. Also, the cost of providing services for Kidderminster patients at Redditch and Dudley has not been taken into account.

21 King’s Fund. *Building on Excellence*. May 1998. London: King’s Fund, p.23

Part Two: An Analysis of the Service Plans

Summary

The health authority expects that the new, smaller, PFI hospital will serve a catchment population that will increase by a third from 280,000 to 380,000. The new hospital will, however, have lost 12% of its 1994-95 acute beds by the time PFI comes on stream. With the closure of 219 acute beds in Kidderminster Hospital the level of hospital provision in the area will be far below the national average, with inpatient bed capacity at two fifths of the 1998-99 English average and inpatient admission rates projected to be at around 59% of the English average. It is likely that unless there is a radical change in plans and funding many residents in Worcester will have to go without hospital care or pay to go privately.

4. What information is required to judge the service plans?

Gaps in the data/information

4.1. WHA expects that the closure of the Kidderminster inpatient services will release sufficient service revenue to resolve the deficit and to meet the extra costs of the annual PFI payments to the WRI. In addition to its financial duties WHA has responsibility for planning and meeting the health care needs of its local population. We have therefore analysed the FBC and WRI and WHA's investment plans with respect to:

- the population to be served
- total acute inpatient bed provision by specialty and type of bed, i.e., daycase, five, and seven day beds
- alternatives to acute hospital provision, e.g.

community care beds and community health services for the population to be served

- projections of hospital admissions
 - clinical productivity, i.e., what the hospitals will be like for patients
 - staffing at the new WRI.
- 4.2. Table 7 shows that WHA does not yet have a proper plan to meet its population's needs for acute services, let alone other health services. There are no data on the total number of NHS beds by specialty, or on their distribution and location. Moreover WHA has still to provide information on where admissions from Kidderminster are to go and how many cases it expects its remaining hospitals to treat. Details of future staff plans are also absent.

Gaps in data on availability

4.3. There are no data on the total projected number of beds for all Worcestershire hospitals. Neither are there data on the projected numbers of NHS geriatric or community beds or alternatives to hospital admission. Without this information it is difficult or impossible to evaluate the impact of proposed reductions in acute hospital capacity.

4.4. A Parliamentary Question tabled by Christopher Gill MP, on 10 February 2000, asked for data on the projected bed numbers in Worcestershire hospitals when the new PFI hospital opens. On 2 May Yvette Cooper, the Under-Secretary of State for Health, replied that "approximately 1400 acute and community based beds would be available across Worcestershire". These figures, though, cannot be substantiated and are meaningless for NHS planning purposes.

Table 7
Clinical activity in acute specialties in Worcestershire acute hospitals in 1997-98 and projected activity following completion of the PFI contract for Worcester Royal Infirmary

	Available acute 7 day beds 1994-95	Available acute 7 day beds 1997-98 ¹	Projected acute seven day beds ²	Ordinary FCEs ¹ 1997-98	Projected FCEs ²	Throughput (Patients/bed/ year, 1997-98)	Projected throughput
WRI ¹	380	348		24,775		71.2	
PFI (WRI)							
Base model			265		21,939		82.7
Increased caseload			336		27,289		81.2
Alexandra Hospital ¹	239	234	n/a	15,204	n/a	64.9	n/a
Kidderminster Hospital ¹	219	192	none	9,928	none	51.7	none
Total	838	774	n/a	50,681	n/a		n/a

Source: 1. *Ordinary and Day Case Admissions; Bed Availability and Occupancy: England 1997-98*. Government Statistical Service.

2. *FBC*, Tables 15 and 16; *Investing in Excellence*.

Assumes increase in catchment population from 280,000 to 380,000 following closure of acute inpatient beds in Kidderminster hospital with transfer of all acute inpatient specialties to new WRI: *FBC*

Note: Acute specialties include acute surgical specialties and acute non-surgical specialties as defined in paragraph 3.8.8 of Annex C: Sources, Notes and Definitions.

Department of Health Statistical Bulletin. NHS hospital activity statistics. Geriatric, maternity, and well babies (Special Care Baby Unit) specialties are excluded from this definition.

n/a - not available

2. An Analysis of the Service Plans

4.5. The Health Concern district councillors wrote to the Chief Executive of WHA requesting data on service planning. In her response, dated 10 May 2000 (see appendix), she stated that the numbers of NHS beds in the county and the proportion of patients to be transferred from Kidderminster Hospital to other acute hospitals “both depend on the plans currently being developed by the Acute Trust following the advice of the clinical working groups. This work is currently ongoing and as the Acute Trust makes progress with plans this will be published in due course.” The Chief Executive adds, “I would expect that more detailed answers to your questions will be available after these service plans are produced.” This admission comes over a year after the FBC for WRI was signed off and on the day the acute trust board agreed to close inpatient services at Kidderminster Hospital in September 2000, two years before the new hospital will be ready.

5. What will happen to acute services and acute beds in Worcester?

Definitions

5.1. The greatest pressure on NHS beds is currently experienced in acute medical and surgical specialties. For this reason our analysis of changes in bed capacity in Worcestershire is particularly concerned with seven day acute beds as defined by the DoH's criteria. The present analysis is concerned with reductions in acute seven day beds which are available seven days a week. The DoH classifies NHS inpatient beds by standard criteria into acute, geriatric, maternity, and psychiatric categories with detailed specifications of the specialties included within these broad categories. In analysing changes in bed capacity over time and between areas, it is essential to adhere to these definitions.

Acute inpatient beds across the area - how many beds will there be?

5.2. *Investing in Excellence*, if implemented, will reduce acute inpatient hospital beds in the area served by WRI and Kidderminster by 44% from 1994-95, the baseline year of the OBC. These reductions result from the closure of 219 acute inpatient beds at Kidderminster Hospital (1994-95) to acute medical and surgical admissions and the loss of 44 acute beds in the new WRI based on the increased bed numbers of 474 (table 8). When the catchment areas of WRI and Kidderminster Hospital are combined for acute medical and surgical admissions, the catchment area of the new WRI will expand by 36% from about 280,000 to 380,000.

5.3. As a result of these bed reductions acute bed capacity per head of population in the area will fall to 41% of

the average NHS acute bed provision for England in 1998-99. There will be somewhere between 0.7 and 0.9 beds per 1,000 catchment population for the enlarged catchment area of WRI compared with 2.2 beds per 1,000 catchment population across the rest of England.

6. Acute beds at the new PFI at the WRI - how many beds will the new WRI have?

- 6.1. The health authority is to transfer income formerly used for inpatient care at Kidderminster to the new WRI. Will the patients from Kidderminster have the same access to acute hospital care as they do currently?
- 6.2. In her letter to the District Council dated 10 May 2000 the Chief Executive of WHA was unable to provide a response to the question of the total number of beds in the Worcestershire Acute Hospitals NHS Trust and the proportion of admissions that will transfer to the new WRI from Kidderminster.
- 6.3. This is regrettable since the FBC is rather ambiguous on how many beds the new WRI will have when it opens. The FBC presents two different sets of bed numbers, a base model bed number and a revised bed number based on increased caseload. These are shown in tables 15 and 16 of the FBC as 390 and 474 respectively. On the basis of Pat Archer-Jones's reply 10 May, we are working with the assumption that the new PFI and refurbished beds at the WRI will provide a total of 474 beds (increased caseload model).

Table 8
Worcester Royal Infirmary: Numbers of beds by specialty 1997-98 and FBC predictions base model

	1994-95	1997-98 ¹	Base model ²	Increased caseload ³
Acute beds	380	348	265	336
Geriatric	110	82	56	56
Obstetric		50	45	52
Special Care Baby Unit			12	18
5 day beds			12	12
Total	490	480	390	474

1. DoH, *Beds Availability and Occupancy, England, Financial Year 1997-98*, DoH Publications, 1998, Table 2, p.165

2. FBC Table 15, p.27

3. FBC, Table 16, p.28

Staffing the new PFI at the WRI

- 6.4. The only details of future staffing projections in the new PFI hospital are contained on page 166 of Appendix D of the FBC, labelled Outline Business

Case Sensitivity Analysis. It is essential that public and staff ask whether more up to date staff plans and budgets are available. These, in common with other PFI FBCs, show that the business case is predicated upon major reductions in ancillary workers and nursing staff in the order of 31% and 17% respectively (table 9).

Table 9
Planned change in staff numbers WTE baseline 1995-96 adjusted to 2001-02 (OBC)

Staff/category	1995-96 WTE*	2001-02 PFI	% change
A&C	289.27	254.21	-12
Ancillary	147.67	101.35	-31
General & senior managers	48.46	49.21	+1.5
Maintenance	39.00	35.00	-10
Medicine & dental	160.60	170.90	+6
Nurses	858.92	715.25	-17
PAMS	84.81	90.34	+6

*mental health staff excluded; includes agreed developments from 1996-97
Source: FBC p.166

- 6.5. The table shows that the major staff reductions will occur mainly among ancillary and nursing staff from a baseline of 1995-96. The baseline WTE figures have been adjusted to exclude mental health staff transfers from the neighbouring acute trust and to include staff developments agreed for 1996-97 and the transfer of Paediatrics from Kidderminster.
- 6.6. WRI, in common with other PFI schemes, has offset its greatly increased costs of capital by cutting service capacity in the beds and staff. These reductions have serious implications for access and quality of care since the new PFI hospital, with much reduced service capacity, will be expected to handle a greatly increased caseload for its projected complement of beds and staff. It is essential that updated staff figures and budgets are provided.

What will the WRI hospital experience be like?

- 6.7. Although the new WRI will have fewer beds, its workload will not reduce proportionately. It must, therefore, treat patients more quickly, admitting and discharging patients faster than ever before.
- 6.8. Throughput is a measure of the speed at which a patient passes through the hospital as determined by length of stay and bed occupancy. The throughput figures shown in table 7 suggest that currently Kidderminster Hospital receives a different case mix from the acute beds in WRI and probably includes a

higher proportion of older, sicker people requiring longer lengths of stay and more rehabilitation. WRI acute beds are being used selectively. The reason for this is that the WRI has designated 110 of its acute inpatient beds as geriatric or elderly care beds (table 10). The effect has been that whereas throughput has increased across the acute beds in the hospital, there has been a halving of the rates of throughput in the geriatrics sector, with patients having longer lengths of stay being selectively admitted to geriatric beds.

- 6.9. Thus WRI increased productivity targets (increased throughput and decreased length of stay) have in recent years have been offset by having slower stream beds into which groups of patients with higher care needs can be selected. In the future, however, the new PFI hospital will be expected to accommodate patients from an increased catchment area with the loss of 44% of the acute beds formerly available (1994-95 base) (table 7).^{22,23}
- 6.10. Attempts to achieve the benchmarks for projected clinical activity in the full business case are likely to be associated with severe disruption to the delivery of efficient clinical care and a nightmarish experience for patients and staff.

Care of older people and people requiring rehabilitation at the WRI

- 6.11. The plans for the new PFI hospital provide little reassurance for older people or those groups requiring longer periods of admission. Under the new proposals, geriatric beds which currently accommodate the slower stream of patients requiring longer periods of care and rehabilitation will no longer be available. This is because geriatric beds are to be dramatically reconfigured (table 10). First, their capacity is being reduced by 49% from 110 beds in 1994-95 to 56 beds. Second, despite having fewer beds, this sector will have to accommodate almost two and a half times more caseload than in 1997-98, based on a reduction in average length of stay to around the current national average for *acute* beds. Thus slower stream rehabilitation beds will disappear from the WRI.

7. Where will patients from Kidderminster and the increased catchment area of WRI go for care?

- 7.1. The new PFI hospital at WRI will receive an increase in income on the basis that inpatients from Kidderminster Hospital will transfer to the new WRI. The FBC for WRI states that "for general acute services, for example, General Medicine and General

²² FBC, base model projection.

²³ FBC, "Increased caseload" projection.

2. An Analysis of the Service Plans

Table 10
Worcester Royal Infirmary NHS Trust: Clinical activity between 1994-95 and 1997-98 and projected activity following completion of the PFI contract

Geriatric seven-day beds					
Year	Available beds	Ordinary FCEs	Throughput (FCE's/bed/year)	Beds/10 ³ population	Admission rates FCEs/10 ³ population
1994-95	110	2,297	20.9	0.4	9
1997-98	82	1,159	14.1	0.3	4
Projected activity Base model	56	2,716	48.5	0.1	7
Increased caseload model	No projections available				

1. DoH, *Beds Availability and Occupancy, England, Financial Year 1997-98*, DoH Publications, 1998, Table 2, p.165

2. FBC Table 15, p.27

3. FBC, Table 16, p.28

Surgery, the catchment population for inpatient services at Worcester would increase from the existing 280,000 to in the order of 380,000 to take account of the predominantly ambulatory acute health care provision in the Wyre Forest locality” (FBC, Vol.1, p.15).

- 7.2. There are two key questions. First, how many extra patients will the WRI need to treat as a result of the closure of Kidderminster and of the increase in its catchment population? Second, will it be able to cope with the existing caseload, let alone the extra caseload, given the reduction in numbers of acute beds? Unless we know this we cannot get a clear picture of the significance of the projected capacity reductions.
- 7.3. The King’s Fund report *Building on Excellence* (May 1998) projects that up to 8,110 elective and emergency admissions in acute specialties will transfer from Kidderminster to “other hospitals”.²⁴ More recently (May 2000), unconfirmed reports suggest that only about half of the present Kidderminster acute caseload (about 5,000 FCEs per annum) may be transferred to the new WRI and the remainder to the Alexandra Hospital in Redditch and hospitals in Dudley. This leaves the question as to whether any of these hospitals have the capacity to deal with the additional caseload including beds and staff and if so how the health authority will pay for the increased workload without going into deficit?

Vanishing caseload: what will happen to residents who require admission?

- 7.4. As table 7 shows, it is not clear where displaced caseload from the Kidderminster will go after acute beds close since the WRI plans are premised on caseload either decreasing or remaining virtually static. On the basis of its additional income WRI should have to cope with an additional caseload due to the transfer

of all Kidderminster’s acute admissions of 9,928 FCEs in 1997-98. But its admission projections do not compensate for demographic forecasts which include an ageing population and caseload transfer from the Kidderminster Hospital. If WRI accommodates extra caseload from Kidderminster, future admissions from the rest of the WRI catchment area must fall by 30% (1997-98 base) to 17,361 admissions (FBC increased caseload model; table 7) and up to 21% of the combined Kidderminster and WRI caseload in 1997-98 is expected to vanish.

- 7.5. The Health Concern district councillors have yet to receive a response to their request for detailed information on the numbers and specialty breakdown of total hospital beds in the county in 2002-03, and on the proportion of acute admissions to go to each of the county’s acute hospitals following the closure of Kidderminster Hospital.
- 7.6. It is not at all clear what will happen to the increasing numbers of patients requiring care, including those from Kidderminster. Information on the number of projected acute inpatient beds (acute and geriatric) in the Alexandra Hospital is incomplete and may be unreliable. No information is available on the numbers of post-acute geriatric/community beds projected by WHA following the completion of the PFI contract. But as can be seen in table 10, geriatric beds will be reduced in number and redesignated in an attempt to increase productivity and discharge rates. Furthermore the health authority has been reticent in making any announcement about private care provision. This information has now been requested from WHA, by Health Concern and Independent councillors on Wyre Forest District Council.

8. How will care be paid for?

- 8.1. As we have seen, Worcester’s PFI depends on redirecting Kidderminster’s inpatient revenue to

24 *Building on Excellence*, p.19.

Worcester but plans for transferring Kidderminster's acute inpatient services and hospital admissions remain obscure.

- 8.2. Kidderminster is to become an ambulatory care centre and diagnostic unit as part of a county-wide emphasis on development of community hospitals and "specialist community teams designed to prevent unnecessary admissions to hospital and keep people at home".²⁵ A strategy based on the earlier discharge of patients into the community and on averting some inpatient admissions altogether ought to be accompanied by resource plans for community services. But the authority is less than clear about its community investment plans. It says that "the development of primary care and community services will be a major focus for all health and social services agencies within Worcestershire... Our intention is that these services will be the first call on any growth monies which are available to the Health Authority in the foreseeable future – funded either from Central Government or out of savings made from other service changes in the County."²⁶
- 8.3. However, the authority knew that no "growth monies" were in prospect when it wrote this. At the time, Worcestershire was a net loser under the move to capitation funding, with the implication that the health authority could only expect very limited real terms growth in funding compared to the growth available for the NHS as a whole.²⁷
- 8.4. The King's Fund and the London Health Economics Consortium have suggested that the "step-down" beds in the new ambulatory centre at Kidderminster can be funded from, among other sources, the "budget for complex packages of care; elements of Social Services budgets for home care, complex packages and residential care; the continuing care budget; [and] a budget based on the variable costs and staffing components for the proportion of bed days in main hospitals where patients have ceased to benefit from acute care."²⁸
- 8.5. Since no other sources of funds are identified and all existing free sources have been diverted into the new hospital, the Kidderminster Ambulatory Care and Diagnostic facility (ACAD) appears to be premised on a shift of financial responsibility from the NHS to the local authority and self-pay sectors. This shift from NHS to self funded long-term care is reflected in the scale of closure of geriatric beds in the PFI hospital, a change masked by WRI's decision to merge the data on elderly care and general medicine.²⁹

9. Worcestershire's levels of acute care provision compared with the national average for England

- 9.1. Are the planning assumptions, such as they are, feasible and realistic? It is useful to compare current and projected acute bed provision and projected acute admissions per 1,000 of the catchment population³⁰ with the English average.

Table 11
Clinical activity in acute specialties in Worcester Royal Infirmary in 1997-98 and following completion of the PFI contract, and clinical activity in acute specialties in England: 1997-98

	Available beds (10 pop) ³	Admission rates (FCEs/10 pop) ³	Throughput FCEs/bed/year
England: 1997-98	2.2	123	56
WRI 1997-98 ¹	1.3	94	71.2
Alexandra Hospital 1997-98	1.4	94	64.9
Kidderminster Hospital 1997-98	1.9	96	51.7
WRI Projected			
base model ²	0.7 ³	58 ³	82.7
Increased caseload Model ²	0.9 ³	72 ³	81.2

Source: 1. DoH, *Beds Availability and Occupancy, England, Financial Year 1997-98*, DoH Publications, 1998, Table 2, p.165

2. *FBC* Table 15, p.27

3. *FBC*, Table 16, p.28

1. Population denominators:

a) WRI: assumes increase in catchment population from 280,000 to 380,000 following closure of acute inpatient beds in Kidderminster Hospital with transfer of all acute inpatient specialties to the new WRI. *FBC*, Vol.1, p.15.

b) Alexandra Hospital: *Investing in Excellence*, p.1.

c) England: 2001 *Office of Population Censuses and Surveys*

Current bed provision

- 9.2. Currently the residents of Worcestershire have fewer acute beds per 1,000 population compared with England as a whole (table 11). The lower rates of utilisation and bed provision in the WRI, Alexandra, and Kidderminster catchment areas may be a result of different demographic circumstances, for instance people could be healthier or there may be unmet need, or the rates may reflect the fact that people have more access to alternative NHS services, private health services, or social services than people in Kidderminster or the rest of England. The health authority should undertake further analysis to ascertain the causes of the lower provision and admission rates currently in Worcestershire.

25 *Investing in Excellence*. p.13.

26 *Investing in Excellence*. p.13.

27 *FBC* Vol. 1, p.12.

28 *Building on Excellence*, p.15

29 *FBC* Vol. 1, p.20.

30 The fall in capacity becomes more dramatic when the removal of acute inpatient specialties from Kidderminster Hospital is factored in. The catchment population for acute inpatient medical and surgical specialties in WRI is projected to rise from 280,000 to about 380,000 by 2006 following the transfer of all acute specialties from Kidderminster Hospital (*FBC* base model). Remaining inpatient beds in Kidderminster Hospital will act as second line/geriatric beds for inpatients initially admitted to Worcester Royal Infirmary. Kidderminster Hospital will function as an ambulatory care and diagnostic unit (ACAD) for outpatients and daycases.

Future bed provision

- 9.3. Under the health authority plans for the increased catchment area of WRI, there will be two fifths of the average hospital beds normally provided for a population of equivalent size in England, and the population will have access to hospital beds at about three-fifths or 59% the frequency of comparable populations (table 11).
- 9.4. An indication of how serious this scenario is for local residents is illustrated by comparing planned bed numbers and caseload against the average for England. The number of beds per 1,000 population will fall to 4% of the English 1994-95 to 1998-99 average (i.e., 0.9 v 2.2 acute beds per 1,000 catchment population; FBC base model³¹). Acute inpatient admission rates will fall to just over three-fifths (59%) of the English average on the basis of the planned admissions.³²
- 9.5. It is unclear from the FBC how these reductions in capacity and inpatient admission rates can be achieved even if half the caseload from the Kidderminster Hospital catchment area is transferred elsewhere.
- 9.6. Capacity reductions on this scale are contrary to national trends. Inpatient acute bed numbers (108,000) have not fallen in English acute NHS trusts for five years (1994-95 to 1998-99; 2.2 per 1,000 population) because of the rising number of admissions to acute specialties and little further reduction in length of stay.³³
- 9.7. The strategy runs counter to the recommendations of the National Beds Inquiry, which projects an increase of 4,000 acute and intermediate care beds in England between 1999-2000 and 2003-04. The National Beds Inquiry findings confirm that, as noted above, national bed numbers and throughput rates have been static in the last five years with little or no reduction in average lengths of stay in acute specialties. Moreover the National Beds Inquiry has already stated that further bed reductions can not safely occur without further community and post-acute services being put in place.

10. How safe is the ambulatory care model?

- 10.1. The WHA document *Investing in Excellence* intends that Kidderminster Hospital become an ACAD with the transfer of acute inpatient specialties to WRI following completion of the PFI contract for a new hospital. The new ACAD will be “free-standing” and will not be adjacent to a fully equipped district general hospital although it is envisaged that it will carry out a wide range of elective daycase surgery and an unspecified range of investigative diagnostic procedures. Is this a safe arrangement?

- 10.2. There are growing concerns about the safety of free-standing ACADs in the absence of immediate access to Intensive Care and Coronary Care Unit facilities with full anaesthetic and laboratory backup (blood transfusion, haematology, and biochemistry).
- 10.3. At a recent day conference³⁴ on the future of ACADs, most surgeons and radiologists present said that a free-standing day surgery unit as part of an ACAD was less safe than a day surgery unit within a fully resourced district general hospital. The Central Middlesex representatives pointed out that their ACAD was next to the main hospital and they too had reservations about a stand-alone day surgery unit as part of an ACAD. The ACAD in Kidderminster Hospital would be 18 miles from WRI.
- 10.4. No reservations about ACADs are expressed in the King's Fund report although a question is raised about the desirability of having a limited hours High Dependency Unit of unspecified size and resources on the Kidderminster site. The authors comment that even a limited hours HDU “may not be a cost effective use of skills or equipment and will require a relatively large critical mass of work. If such a unit is really an HDU, it may require overnight anaesthetic cover”.³⁵ An HDU is not a fully equipped Intensive Care Unit and lacks full anaesthetic support.
- 10.5. *Investing in Excellence* does not mention the potential safety hazards of having day surgery in a stand-alone ACAD. Instead it refers glibly to a “state of the art” ambulatory care centre that “offers an exciting new pathway for the development of hospital care in the north west of the county into the 21st Century”.³⁶ Without a safety evaluation it is irresponsible to establish a day surgery unit with the object of carrying out “from 65 to 95% of elective surgery on the Kidderminster Hospital site”³⁷ without the immediate backup of the resources available in a district general hospital.
- 10.6. In May 2000 in response to concerns about safety in the ACAD to be built on the Kidderminster site the Chief Executive wrote “operational policies for this are currently being developed by the clinical staff in the Trust and the safety aspects will be considered in detail within those protocols. In particular, the nature of the emergency facilities available at Kidderminster and the selection of patients will both be key elements within the clinical policies”. In normal planning, safety policies come first and are not left until after a decision to build has been finalised.

31 Bed numbers in FBC, table 15.

32 *Ibid.*

33 Projected activity following completion of the WRI PFI contract also envisages a possible 7.6% increase in caseload from a 1997-98 base with an additional 71 acute beds (a total increase of 84 beds). This “increased caseload” model would provide acute inpatient beds equal to 41% of the 1997-98 English average and hospital inpatient utilisation equal to 57% of the 1997-98 English average (table 10). It is uncertain whether the “increased caseload” model is funded by the present PFI contract.

34 Held in the Health Resource Centre of the Scottish Management Executive in Edinburgh on 30 November 1999. It included representatives from the Central Middlesex ACAD.

35 *Building on Excellence*. p.8.

36 *Investing in Excellence*. p.21.

37 *Building on Excellence*. p.8.

CONCLUSION

Across the UK health care modernisation is being driven by financial deficits that result from underfunding, capital charging, and PFI cost escalation. In Worcestershire the Kidderminster Hospital has been sacrificed to cure the deficit and to pay for the escalating costs of the new WRI. But the remaining inpatient capacity in the Worcester catchment area will fall to 41% of the English average and hospital admissions are projected to fall to three fifths (59%) of English levels (1998-99). Moreover the rate of throughput will increase across all specialities making the hospital experience stressful for patients and staff.

The Worcester hospital rationalisation and reconfiguration proposals, which have been drawn up in unaccountable trust and health authority boardrooms, have unravelled. Instead of providing a service “fit for the 21st century”, the health authority is embarking on an ill-advised attempt to cure the deficit, a strategy that will decrease the availability of NHS care, forcing residents across the area to compete for care, to go privately, or to do without services. The losers will include the elderly and those who cannot afford to go privately. Worcester Royal Infirmary NHS Trust has joined the growing list of ill-judged public-private partnerships which are destabilising the NHS. A town has lost its hospital in the process. The residents of Worcestershire and South Shropshire will all pay dearly for the costs of private finance and a plan which is built around affordability and not the health care needs of local people.

APPENDIX

Letter from Mrs P Archer-Jones, Chief Executive of the Worcestershire Health Authority, to Mr Mark Butler, Chief Executive, Worcester Royal Infirmary NHS Trust, 11 February 1999

Dear Mark

Health Authority Support for Worcester PFI

Further to my letter of 4 February 1999, I am pleased to forward the formal resolution of the Authority and this is reproduced below. As you know, the discussion was held in the confidential session of the meeting held on 29 January 1999.

17/99 IT WAS RESOLVED

- (i) that the Health Authority confirms its support to the development of the new hospital on a single site and recognises that this is essential to achieve a high quality of clinical care.
- (ii) that the Health Authority confirms its support to the recurrent funding of the baseline cost of £51.47 million (at 1998/99 pay and price levels) - or such lesser sum that may prove necessary - in return for the 1998/99 level of contracted activity (this includes fundholding and total purchasing project expenditure previously accounted for separately).
- (iii) that precise details of additional revenue associated with future service developments will be determined with the Trust as part of detailed implementation plans.

Yours sincerely

Mrs P Archer-Jones

Letter from Health Concern Councillors to Mrs P Archer-Jones, Chief Executive of the Worcestershire Health Authority, 14 April 2000

Dear Mrs Archer-Jones

We write to inform you that the Health Concern Councillors and four of the Independent Councillors have joined forces under the name "Independent Kidderminster Hospital and Health Concern". You will know that at the forthcoming WFDC elections the future of the hospital service is a major concern of the electorate.

We are particularly anxious to be in possession of accurate, complete and up-to-date facts as confusion is arising because some of the information being officially quoted seems to be incompatible and inconsistent with what is understood to be the Health Authority's plan consequent to "Investing in Excellence".

Public confidence depends on reliable information to make the position quite clear. May we therefore appeal to you for an accurate, authoritative and up-to-date statement in answer to the following questions? We would be grateful for a rapid answer so as to be able to ensure that the position is quite clear in advance of the election.

Bed numbers and case load projections

1. The final business case for the new hospital states the total number of beds in the hospital will be 474, an increase of 84 from the 390 in the outline business case. Can you confirm that all the financial figures of affordability are based on the figure of 390 rather than 474?
2. Have any changes in the planned bed numbers been made in the months since the final business case was released? If so what are they and what are the funding arrangements?
3. May we have a breakdown of **total hospital beds in the county** in 1997/8 and those planned to remain the county in 2002/3? It would be helpful to use bed designations as defined in paragraph 3.8.8 of Annex C: Sources, Notes and Definitions. Department of Health Statistical Bulletin. NHS hospital activity statistics. Maternity beds, Intermediate care beds, GP beds and day case beds should be specified as such with exact locations in acute hospital, community hospital or in private sector hospital and nursing homes within each of the towns in the county.
4. In order to understand the practicality of a reduction in acute bed numbers please confirm your projected case loads for each of the county's hospitals? Please cover particularly:-
 - a. What numbers or proportion of present acute medical admissions, elective and emergency are planned to go to Worcester, to Redditch or to Dudley? This does not include the tertiary admissions that already go to major centres in

Birmingham and elsewhere and will presumably be unchanged.

- b. What proportion of urology and orthopaedic admissions is planned to go from Kidderminster to Redditch, Kidderminster to Worcester, Redditch to Worcester and Worcester to Redditch?

The planned Ambulatory Care and Diagnostic Centre (ACAD) at Kidderminster

In addition there is significant concern about safety aspects of the ACAD 18 miles distant from acute hospital beds and facilities. What is the evidence for the safety of the Kidderminster ACAD divorced from adjacent emergency and overnight support?

Please note the urgency of this enquiry.

Yours sincerely

John Gordon, *Chair, Wyre Forest District Council*
Frank Baillie, *Leader, Independent Kidderminster Hospital and Health Concern*

Dick Barton, Irene Dolan, Brian Glass, David Gourley, Andy Morgan, Jane Paterson, Pat Rimell, Ken Stokes, Ron White
Councillors, Independent Kidderminster Hospital and Health Concern

Letter from Health Concern Councillors to Mrs P Archer-Jones, Chief Executive of the Worcestershire Health Authority, 4 May 2000

Dear Mrs Archer-Jones

We, the Independent Kidderminster Hospital and Health Concern Wyre Forest District Councillors, wrote to you on 14 April asking for urgent information. This letter was delivered by Recorded Delivery on 18 April. We have had no reply and not even an acknowledgement. We are writing on behalf of our colleagues to request a reply now. We enclose a copy of the original letter for your convenience.

As you know we had hoped to have this information before the local elections. This is now impossible but we request a reply within seven days so our actions after the elections can be fully and accurately informed.

Yours sincerely

John Gordon, *Chair, Wyre Forest District Council*
Frank Baillie, *Leader, Independent Kidderminster Hospital and Health Concern*

For Councillors Dick Barton, Irene Dolan, Brian Glass, David Gourley, Andy Morgan, Jane Paterson, Pat Rimell, Ken Stokes, Ron White
Independent Kidderminster Hospital and Health Concern

Letter from Mrs P Archer-Jones, Chief Executive of the Worcestershire Health Authority, to Councillor J Gordon, Chair, Wyre Forest District Council, 10 May 2000

Dear Cllr Gordon

Thank you for your letter of 14 April. I am sorry we did not reply immediately but some of the information you requested is not easily available. We welcome your desire to have accurate and up to date information and to avoid confusion over this issue.

In answer to your questions, I can confirm that all the financial figures of affordability for Worcestershire's new hospital were based on the current bed figure of 474. Secondly, no changes in planned bed numbers have been made since the business case was agreed. The Acute Trust is currently looking at contingency plans for winter pressures and if this results in any proposed changes they will be debated by the Health Authority in due course.

The answers to the questions of total hospital beds and on the proportion of admissions which will transfer both depend on the plans currently being developed by the Acute Trust following the advice of the clinical working groups. This work is currently ongoing and as the Acute Trust makes progress with plans this will be published in due course.

I would expect that more detailed answers to your questions will be available after these service plans are produced.

In relation to the Ambulatory Care Centre the operational policies for this are currently being developed by the clinical staff in the Trust and the safety aspects will be considered in detail within those protocols. In particular the nature of the emergency facilities available at Kidderminster and the selection of patients will both be key elements within the clinical policies.

I am sorry I cannot give you the full answers at this stage but we are working with the Acute Trust to ensure that accurate plans are available as soon as possible.

Yours sincerely

Mrs P Archer-Jones