

PFI, Buildings & Infrastructure

The Thatcher government introduced the private finance initiative (PFI) as a way to raise money for crumbling hospitals and other public sector buildings. In opposition Labour castigated PFI, but went on to embrace it and greatly extend PFI as part of New Labour's 'Third Way', leaving a massive legacy of unsustainable debt.

In 2017, The Naylor Review has raised the spectre of a new wave of Public Private Partnerships (PPPs) to create the new buildings and infrastructure set out in the Government's Five Year Forward View (FYFV).

Private Finance Initiative (PFI) ¹

The Private Finance Initiative (PFI) and its successor, PF2 have been a widely used and extremely expensive way to fund public buildings and infrastructure including schools, roads and hospitals. One Treasury committee analysis estimated the cost of a privately financed hospital to be 70% higher than a public sector comparator².

The National Audit Office has calculated that even if no new deals were entered into, future charges for PFIs across all sectors, which will continue into the 2040s, amounted to £199bn (€225bn; £275bn).

Around 100 NHS hospitals have been built under the Private Finance Initiative. Ownership of these hospitals has undergone dramatic shifts over the last decade, with nine out of ten of these assets now effectively owned by international investment funds. The sale of equity in PFI companies has generated big profits for investors. Six international investment funds control the majority of this equity and all of them have dealings with offshore tax havens.

The twenty hospital PFI schemes in London cost £2.7bn to build, but will require payments totalling £20.2bn from the fifteen NHS trusts that are involved in these contracts. The annual cost of PFI to London's NHS trusts was £477m in (14/15) but will rise to £542m by (2019/20).

The way that the contracts are set up means that PFI payments will increase year on year throughout their term. This escalation is one reason why PFI schemes offer poor value to the public and yet have generated large profits for the PFI consortia and their shareholders.

Some trusts are allocating a significant proportion of their operating revenue to PFI. In 2013/14 – the last year that all accounts are available – nine of London's acute trusts ended the year in deficit, six of these have PFI debts. The two most indebted, are spending over 10% of their income on PFI.

NHS trusts across London are overpaying for the capital that they are borrowing. On average the schemes in London could have borrowed 1.5 times more capital if they had been financed through public lending (discounting at 4%), such as a municipal bond. This equates to a waste of around £2.7bn across the lifetime of these projects. For an individual scheme

¹ <http://www.nhsforsale.info/database/pfi-report.html>

² <https://publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/114602.htm>

³ National Audit Office. PFI and PF2 (Jan 2018). <https://www.nao.org.uk/wp-content/uploads/2018/01/PFI-and-PF2.pdf>.

like Barts this could amount to an over payment of between £600-900m compared with public borrowing.

Newham University Hospital project (now part of Barts Health) appears to have one of the poorest deals on finance in London, paying back over four times more than the public option (discounted @4%) – overall £735m on a project that cost £35m to build. Barnet and Chase Farm (now part of the Royal Free London Trust) are paying back over 3.5 times more than the public option (@4%) – £775m on a project that cost £54m to build.

Paying the PFI charges is the first call on a public body's budget. PFI costs have to be met before a single nurse, doctor or teacher is employed. So as budgets have tightened, hospitals have been forced to close beds and cut staff first and have not been able to cut the costs of their buildings. Even when a PFI facility is closed, the charges still have to be met⁴.

In 2014, Margaret Hodge, then chair of the Commons Public Accounts Committee, described the huge profits as “a total scandal”⁵ The extra cost of PFI was justified on the grounds that the private expenditure didn't count against public expenditure totals. But the ONS changed the rules and all PFI expenditure is now included in the public expenditure totals, so that justification no longer holds good⁶.

PFI maintenance and safety issues

Lewisham and Greenwich Trust applied for £48m to repair a PFI hospital with patient safety problems. Failures included failure of stand-by-power to high-risk clinical areas following a power outage, loss of water supply, flood damage and lack of radiation protection in operating theatres. A report found these failures were caused by ‘cost cutting at construction’ and ‘failures in specification and design standards’. On taking legal advice the CCG found that not only was it too late to seek legal redress from the PFI companies, but also that they had no choice but to award the repair contract to Meridian, the ‘project company’ that built, maintains and provides facilities management services for the PFI hospital⁷.

Many other PFI projects have been bedevilled by dangerous construction practices, including the notorious scandal of 2016 in which 17 PFI schools in Edinburgh were closed after a collapsed wall revealed potentially lethal construction standards⁸.

PFI and tax avoidance

⁴ <https://www.theguardian.com/commentisfree/2017/sep/26/private-finance-initiative-pfi-labour-rip-off-ideology>

⁵ <http://www.independent.co.uk/news/uk/politics/exclusive-how-private-firms-make-quick-killing-from-pfi-9488351.html>

⁶ <https://www.theguardian.com/commentisfree/2017/sep/26/private-finance-initiative-pfi-labour-rip-off-ideology>

⁷ <https://www.hsj.co.uk/lewisham-and-greenwich-nhs-trust/trust-faces-48m-repair-bill-for-pfi-hospital/7021166.article>

⁸ <http://peoplevspfi.org.uk/2017/01/20/edinburgh-schools-inquiry-no-whitewash-please/>

According to one report, twelve offshore infrastructure funds have equity in 74% of the current UK PFI or PPP projects⁹

Alternatives to PFI

At the Labour Party conference in September 2017, Shadow Chancellor John McDonnell promised to bring PFI contracts back in-house, an initiative warmly welcomed by campaigners against PFI¹⁰

The Five Year Forward View and NHS sites

A major focus of the 5YFV is to cut annual costs by £22bn a year by 2021, compared with 2015 spending levels. Selling off valuable NHS sites looks like a quick win – bringing in a quick boost of extra cash for the NHS. However, the main focus is a long-term drive for NHS ‘efficiency’ – regardless of any resulting loss of convenience for patients.

The 5YFV considers how healthcare providers can deliver services as cheaply and efficiently as possible from a provider perspective. This involves delivering more NHS care out of hospitals, including through GP hubs. The 5YFV makes frequent references to ‘care nearer home’, which sounds desirable, and one major aim is for GP hubs to take over many minor procedures that are currently carried out in hospitals. However more often than not the references to *care nearer home* actually means self-care using digital apps, or caring responsibility transferred to family carers at home.

The overriding impact of the 5YFV is that many smaller local hospitals, A&Es, GP and community facilities will be closed, to be replaced by fewer hospitals and distant specialist facilities. Local GPs will be replaced with GP hubs (all in the context of cuts of £22bn compared with NHS spending in 2015).

The fact that closing local facilities results in greatly increased travelling time for patients and visitors, involving enormous difficulty, expense and inconvenience, especially for many elderly and disabled people and those with young children. However these factors are irrelevant in this depersonalised view of ‘efficiency’. Little wonder the public has been effectively completely excluded from development of either the 5 Year Forward View or in local plans.

The 2016 Carter Review of operational productivity in acute hospitals

The 2016 Carter Review¹¹ of operational productivity in acute hospitals proposes basing performance on a hypothetical: *‘model hospital, which with associated best practice guidance will give trusts a single version of the truth on what good looks like from board to*

⁹ <http://peoplevspfi.org.uk/2017/09/25/the-people-vs-pfi-back-shadow-chancellors-call-to-end-pfi-extortion-and-propose-nationalisation-of-pfi-spvs/>

¹⁰ <http://peoplevspfi.org.uk/2017/09/25/the-people-vs-pfi-back-shadow-chancellors-call-to-end-pfi-extortion-and-propose-nationalisation-of-pfi-spvs/>

¹¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

ward, to help trusts understand what good looks like. NHS Improvement should continue to develop the model hospital and its underlying metrics, so that there is one source of data, benchmarks and good practice’.

Carter proposes that a single set of productivity and efficiency indicators should apply to all NHS Trusts across a wide range of services. He recommends metrics (performance indicators), around for instance, numbers of Care Hours Per Patient Day (CHPPD) or how much time pharmacists spend on work with patients. He proposes that pathology labs not meeting certain cost or other criteria should be outsourced and that where trust administrative costs are above 7%, they should be outsourced. The reasons for variations in cost or type of work done are not explored and not considered relevant. Nor is any evidence produced that outsourcing will prove either a good idea or cheaper.

However, in developing a crude set of measures of ‘operational efficiency’ NHSE creates the ability to demonise ‘inefficient’ providers and justify demands for outsourcing.

Estates: Carter also makes very specific recommendations about the efficient use of estates and facilities, proposing that trusts should have *‘a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner’*. This recommendation takes no account of the use that may be made of ‘non-clinical space’. This could be a consequence of outdoor space or extra-wide corridors or lobbies in old buildings; it could equally involve facilities that are useful for patients and relatives, including play space for children, rooms for relatives or accommodation for parents of sick children. It could be pathology labs or sterile units based on site or much else. The point is, this efficiency review is intended to provide a basis for declaring that premises are not being used efficiently, which in turn might be justification for being sold off and replaced with ‘more efficient’ premises – which are likely to lack other important facilities.

The Naylor Review and Project Phoenix

In March 2017, the Government published the Naylor review¹² into NHS Property and Estates, which *‘presents the opportunity to rebuild NHS infrastructure to meet modern standards of service delivery for the future. Without investment in the NHS estate the Five Year Forward View (5YFV) cannot be delivered, the NHS estate will remain unfit for purpose and will continue to deteriorate. The form of the estate must follow the service strategies evolving through local Sustainability and Transformation Plans (STPs) – a process that needs acceleration and incentives’*.

Naylor suggests there is a **backlog of between £5bn-£10bn of maintenance work required to bring facilities up to standard.**

In addition, the report estimates it will **cost around £10bn to develop premises required for the new models of care in line with 5YFV requirements.**

¹² <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

Naylor's proposals rest extensively on estate proposals in the Carter review (see above). The report notes that most of the 'underuse' comes from 'land efficiency' rather than 'buildings efficiency' (ie, unbuilt-on land surrounding hospitals). But in either case, Naylor suggests that 'underused' estate should be sold off.

He suggests that the sale of NHS estate that is either unused or used 'inefficiently' will release £2.7bn for reinvestment and deliver land to provide 26,000 homes. The proposal for homes will also encourage co-operation from local authorities, especially those in London.

However '*An effective programme of interventions in high value propositions in London ... could significantly increase the property receipts to a figure exceeding £5bn in the longer term*'. The 'interventions' would include securing appropriate planning permission from local authorities to maximise land value rather than prioritising any NHS or local need.

The report suggests potential for significant additional sales from NHS Mental Health Trusts.

New Public Private Partnerships (PPPs) involving up to £5bn of private capital will be introduced to develop the new infrastructure needed for the NHS.

One of Naylor's recommendations – to establish a powerful new **NHS Property Board**, 'a strategic organisation at arms length from the DH and structured so it empowers speedy executive action', has already been implemented. **Project Phoenix**, involving proposals for 6 regional PPP to sell off and develop 'surplus' NHS estate and covering North East, NW, East Midlands, West Midlands, South East and South West, is also underway.

However there are obstacles in the way of this grand plan. The NHS Property Board only controls a small proportion of total NHS estate since '*significant areas of NHS-funded services are provided out of facilities over which the government has neither a freehold nor leasehold interest*': NHS provider trusts hold the freehold for most of the estate.

Naylor calls for a range of requirements and incentives – both carrots and sticks – that will encourage all NHS organisations to bring about the new models of care required by the 5YFV.

- **STPs must develop robust plans for the use of their estate.** In doing this, they must take account of the 'efficiency ratings' proposed in the Carter review.
- **NHS providers:** 'if provider plans are not embedded in STP plans which maximise disposals, address backlog maintenance, and deliver the 5YFV, then they would not be eligible to access public capital funding'.
- **GPs and other community services** pose a particular problem. According to the report, the 30% of GP surgeries with a list size under 4,000 patients are *unlikely to be large enough to meet the vision set out in the 5YFV*. But GPs, dentists, charities and other providers account for around a quarter of the NHS budget but only a small proportion occupy NHS premises (including just 1,500 out of 7,600 GP practices). Naylor proposes incentives involving 'substantial private sector investment' for GPs to move to new facilities' alongside reduced payments to GPs operating from 'properties not meeting the future service strategy'.

- **Naylor also proposes a 2-for-1 offer** (for a limited period only to encourage quick bids) where providers are given additional capital to match their disposal proceeds.

What will new PPPs mean for the NHS?

The companies involved deny that the proposals for £5bn of private investment will amount to a repeat of the PFI scandal. It has been estimated that the NHS will be paying an extra £200m per year in rent under the group's plans. The group insists that, despite this, the plans could save more than £270m per year. Even if these costings are true, this will be at the expense of local people having to travel further for healthcare, and loss of facilities that may be extremely valuable to patients but are not considered to represent 'efficient use'.

There is an urgent need for independent scrutiny of the plans for new estate, both at national and local level, and particularly for local people to be given a real say in where their local healthcare will be provided.

As of November 2017, plans for radical transformation of the NHS estate are still under wraps. Meanwhile, NHSE does give details of NHS estate that has been publicly declared surplus to need¹³ - although the chart excludes details of buildings deemed too sensitive to list!

¹³ <http://digital.nhs.uk/catalogue/PUB23972>