



## Memorandum of Evidence to the Health Committee

### Inquiry into NHS Deficits

1. Amicus is the UK's second largest trade union with 1.2 million members across the private and public sectors. Our members work in a range of industries including manufacturing, financial services, print, media, construction and not for profit sectors, local government, education and the NHS. The union's membership in the NHS extends across all professional and technical grades, estates employees and community practitioners and nursing staff. Amicus is the third largest trade union in the National Health Service with a membership working in primary care trusts, mental health trusts, and acute trusts.

2. Amicus welcomes the Health Select Committee's enquiry into NHS deficits and is pleased to submit evidence for the committee's consideration. *Amicus would be happy and welcome the opportunity to expand more fully on this submission in oral evidence, if invited to do so.*

### 3. Reasons for the deficits

3.1. Amicus believes that there is evidence to suggest that the causes of these deficits arise from both systematic and local effects. The systematic causes relate to certain government policies specifically dealing with aspects of privatisation (PFI contracts) and 'additionality' policies.

3.2. The PFI policy has resulted in the extra cost of using private finance having to be paid for out of hospitals' current income. This debt, known as the annual PFI charge, is met from the hospitals' operating budget, which in also pays for staff and patient care. To meet this, hospital managers have had to cut services. But reduced services mean reduced income. Even the most capable executives and directors of finance find it impossible to close the resulting 'affordability gap'. Amicus draws the Committee's attention to the recent case of the Queen Elizabeth Hospital in Greenwich as a clear example. An accountants' report for the Audit Commission showed that the trust would have a

deficit of almost £20 million in 2005-06, in spite of having achieved an efficiency level above the national average. Half of the deficit was due to the extra cost of the PFI.

3.3. In the case of the St Bartholomew's and London Trust's huge new PFI project, the extra annual cost of using the PFI will be over £48 million. A sample of eight other PFI schemes shows that the share of their annual revenue that had to be devoted to servicing capital costs rose from an average of 4.5 per cent to 16 per cent after the completion of their PFI projects<sup>1</sup>.

3.4. An example of the principle of 'additionality' failing to provide value for money can be seen by the under use of Independent Sector Treatment Centres (ISTCs) where there is evidence that the supply outstrips demand. A recent example of this was highlighted in a debate in the Houses of Parliament when Kevin Jones, MP for North Durham<sup>2</sup>, cited a letter that he had received from the Chief Executive of University Hospital North Durham in which he stated "The MRI scanner at University Hospital North Durham is considerably under employed and had been for some time, and it is the case that had the "Alliance Medical" money been direct to us, at the University Hospital North Durham we would have been able to put on a large number of scanning clinics, which would have almost eliminated in total our waiting times and waiting number". He went on to say, "It was a disappointment for us when the Department of Health said that providing individual hospitals with additional resources was not an option, the additional resources had to be made available to the private sector." Considering this example it is difficult to see how, in this case, the system provided value for money for the health service, or reflected the needs and capacity of the local NHS trusts.

3.5. Similarly there is evidence of work outsourced from NHS Hospitals to ISTCs where more procedures were paid for up front than undertaken which is bound to contribute to the overall NHS deficit. An example of this occurred when the contract signed by 28 PCTs in Trent and South Yorkshire for the services of Partnership Health Group Limited (PHG) at both its interim sites at Bassetlaw and Ilkeston, and then its purpose-built £7.5 million site at Barlborough, created a huge financial burden in its first year of contract. The value of which for 2004-05 was £13.4 million with the actual uptake being worth

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<sup>1</sup> Mark Hellowell, *What problems does PFI present for Barts and the London NHS Trust?* Centre for International Public Health Policy, University of Edinburgh, 2006.

<sup>2</sup> HC Deb, 19 October 2005, Col 270WH

£10.1 million. This shows a loss of £3.3 million for operations that PHG never performed.

3.6. The introduction of a new internal market system, Payment by Results (PBR) since last April, for elective surgery, and by 2008, for most hospital treatments, was suspended earlier this year due to unforeseen difficulties. Subsequently the tariff was adjusted with a consequential outpouring of protest from NHS finance managers that this amounted to moving the goalposts thus pushing future financial planning into chaos. Instead of having secure revenue for blocks of work commissioned in advance, hospitals will be paid in arrears for the work they do on every individual patient; and with patient choice, to be fully introduced by 2008, some of this work will fluctuate unpredictably. The requirement on PCTs to place 15 per cent of elective surgery with private providers, adds to the intractable by proposing to transfer £4 billion from the hospital sector – about 10 per cent of hospital revenues - to primary care. Amicus believes that as a result of these policy decisions, NHS hospital finances have been critically destabilised.

3.7. Amicus is also concerned about the potential impact that Practice Based Commissioning (PBC) could have on the deficit problem. Given the experience to date of the Payment by Results outlined above, it does seem to us that it would have been more prudent to test this idea by pilots. Our own consideration of PBC is that the transfer of budget from hospitals to the community inevitably means that there is further pressure on hospital budgets. An example of this could be that a Practice with 25,000 patients would have about 750 people with diabetes. Many of those patients would traditionally go to diabetes out-patient clinics. But if practices use the money currently spent on diabetes hospital services for a specialist nurse based in the practice, whilst this may reduce costs, when expertise is needed for some patients where will the funds come from to pay for the diabetes consultant and specialist nurses? It is this type of consideration that Amicus believes has not been thought through and which ultimately could be a further cause of pressure on finances and, equally important, standard of care.

3.8. Overall Amicus believes that a combination of debt incurred by PFI and historic debts, plus the new internal market mechanisms probably accounts for the lion's share of deficits.

3.9. Turning to the potential contribution of local management to deficit problems Amicus is not aware of any analysis of Trusts in serious deficit or whether health inequalities have been a common factor among the

majority. This could lead to Trusts facing more complex health needs or a population where demographic factors are relevant. Amicus would be reluctant to lay blame at the doors of local management without such analysis first taking place.

3.10. The implementation and rollout of a new national pay, conditions of service and training agreement, Agenda for Change (AfC), represents major pay reform for the majority of NHS employees, excluding doctors and dentists. The Department of Health and Ministers have consistently stated that AfC is fully funded. However towards the end of 2005 it became apparent that one or two aspects were understated. Subsequently the tariffs were adjusted to allow for the restoration of full funding. NHS finance managers are likely to be sceptical about this as job evaluation has different outcomes depending on the starting point of organisations – for example one 'AfC Early Implementer NHS Trust' (the test bed sites) typically placed staff on the lowest possible pay due to local labour market factors and in some cases a failure to properly recognise role development. This means the step from the old pay regime to AfC would be greater than an organisation that properly valued staff albeit within the constraints of the pre-existing pay system. In any case AfC funding was not ring-fenced and it may well be the case that funds have been diverted to meet other costs. Given the prolonged roll-out of AfC it seems possible that this is the case thereby creating a false impression that AfC is a factor contributing to the deficit.

#### **4. The effects of 'top slicing'**

4.1. Top slicing is a crude mechanism which can only lead to cuts in services now and into the future, many of which will be in areas of care highlighted as priorities in the government's own recent White Paper. Attacking PCT's which are not in deficit has the inevitable result of pleasing "none of the people none of the time".

4.2. In providing evidence of the effects of this policy, Amicus would draw attention to a recent announcement in Waltham Forest PCT. This Trust has decided to top slice its budget to the tune of £3m, the consequence of which when linked to a deficit of £2m and an inherited deficit of £2.1m is to declare redundancies of 15 Health Visitors/School Nurses reducing the complement from 42 whole time equivalents to 24 W.T.E. The trust has said that this will be managed by the introduction of a skill mix plan which, in effect, will mean that less experienced health professionals will be providing a service currently met by Health Visitors.

## **5. The effect on care**

5.1. We have specific examples where we can show service reduction or elimination and in particular services that the government's White Paper 'Our Health, Our Care, Our Say' state will be at the forefront of government policy to shift focus from curative acute services into primary preventative care.

5.2. However, our own evidence points to real cuts in the services to patients across the NHS. An Amicus survey last year (Amicus/CPHVA), showed that services such as health visiting are especially vulnerable to job cuts and that our warning last summer to government that this was the tip of an iceberg were ignored. Consequently health visiting is now literally in melt-down. 18% of health visitors – total headcount in England was 12,818 in September 2005 – are over the retiring age of 55 and could leave their jobs tomorrow. However, the number of health visitors under 35 – the next generation – suffered a nine per cent drop from 1,140 in September 2004 to 1,037 in September 2005. This has not been helped by the reduction of the number of training places for new health visitors at colleges and universities in recent years. The number of whole time equivalent (WTE) health visitor jobs has slumped to a 12-year low of 9,809 for England. In 1988, there were 10,680 (WTE) jobs.

5.3. Amicus is concerned that the proposed shift of 10% of funding from acute to primary care (White Paper) will be poorly managed and further worsen the deficits faced by acute Trusts without introducing service benefits in primary care unless very serious consideration is given to the inherent risks of this strategy. Of prime importance seems to be the culture that the NHS is about 'doctors and nurses' with targets being entirely focussed on acute care.

5.4. There is growing evidence that mental health services are vulnerable to decline, despite improvements in these services being a government priority. One such example is the Hertfordshire Partnership Trust which is being forced to make 5% savings to help other NHS Trusts in Hertfordshire. Rather than take a top slice across services the Trust has opted to target a range of mental health services including an 11% cut in psychological services. A Direct Access Service, a successful psychological referral service for people suffering mental health problems is planned to close shortly despite clients being part way through treatment. The Trust say the only reason they are not cutting posts is because they cannot afford to make redundancy payments but no one

knows how or where the psychologists will be able to work following the closure. The Trust says it can save £150,000 by closing the service.

5.5. Acute services are also subject to the current 'slash and burn' approach to the deficit problem. Amicus was recently served formal notice of 1,180 job cuts by Nottingham University Hospitals NHS Trust. The cuts include 479 nursing and midwifery posts, 75 pharmacists, cancer screeners and laboratory technicians, 83 junior medical staff, 99 ancillary staff and 191 administrative and clerical staff plus what looks like the entire maintenance team. The Trust which employs 11,556 staff and has an income of £565 million a year is trying to make a £60 million saving in the next two to three years. The proposed cuts represent a more than 10 per cent cut in staff and cannot help but impact on patient care and services.

5.6. Similar cuts to services are being repeated across the country with inevitable impacts upon the standards and levels of service available. Amicus will be happy to present further verbal evidence on these cuts if invited to do so.

## **6. Conclusion and summary**

6.1. Amicus welcomes this inquiry and urges that the Committee considers all the evidence in the context of the myriad of changes currently being implemented across the NHS. Amicus believes that issues relating to funding and the deficits which have arisen, for a variety of reasons, over a long period need to be addressed in the context of the objectives set out in the government's own White Paper and through the fullest consultation with all stakeholders.

6.2. Our evidence in this submission has sought to highlight by example some of the real consequences resulting from panic measures reflecting a 'management by crisis' approach of Strategic Health Authorities and Hospital and Community Trusts.

6.3. Amicus in its evidence to this Committee in March on workforce needs and planning identified the need workforce planning as one of the missing ingredients from a "joined up" approach to health service reform. We said then *"In a people based service like the NHS we cannot allow effective workforce planning to be the sum total of decisions on this issue by NHS trusts. However at the same time we should avoid grand plans and instead provide strategic and indicative planning, assessing trusts on how well they*

*improve the health and well being needs of the population that they serve in line with the government's set health priorities."*

6.4. The almost daily announcements of cuts, top slicing and deficit management is the exact opposite of what is needed if the objectives of achieving a joined up approach to health service reform are to be achieved. Amicus would therefore urge that a moratorium on all job cuts be established pending the outcome of the Inquiry and possible identification of alternative solutions to the deficit problem. We hope that the Committee's findings will assist in the contribution to a "joined up" approach to health service reform.

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