House of Commons
Health Committee

NHS Deficits

Sixth Report of Session 2005–06

Volume II

Written evidence

Ordered by The House of Commons
to be printed 8 June 2006
The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Rt Hon Kevin Barron MP (Labour, Rother Valley) (Chairman)
Mr David Amess MP (Conservative, Southend West)
Charlotte Atkins MP (Labour, Staffordshire Moorlands)
Mr Ronnie Campbell MP (Labour, Blyth Valley)
Jim Dowd MP (Labour, Lewisham West)
Sandra Gidley MP (Liberal Democrat, Romsey)
Anne Milton MP (Conservative, Guildford)
Dr Doug Naysmith MP (Labour, Bristol North West)
Mike Penning MP (Conservative, Hemel Hempstead)
Dr Howard Stoate MP (Labour, Dartford)
Dr Richard Taylor MP (Independent, Wyre Forest)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Eliot Wilson (Second Clerk), Christine Kirkpatrick (Committee Specialist), Ralph Coulbeck (Committee Specialist), Duma Langton (Committee Assistant) and Julie Storey (Secretary).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182. The Committee’s email address is healthcom@parliament.uk.
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Written evidence

Evidence submitted by the Department of Health (Def 01)

NHS DEFICITS ENQUIRY

The memorandum of evidence for the enquiry into NHS deficits is enclosed. This addresses the specific questions your Committee directed to the Department of Health.

As stated in Question One of the memorandum, I will be making an oral statement to the House on 7 June with the provisional outturn position for the NHS in 2005–06. I will also make available the figures for individual NHS organisations. This information will be passed to the Health Committee at the same time.

To coincide with my statement to the House, we are publishing a report on NHS performance by Sir Ian Carruthers, and a detailed finance report by the Department’s Finance Director. The Committee may also find it helpful to consider the detailed analysis in these reports as part of their deliberations, so we will also make these available to you as soon as they are published.

YEAR END FIGURES

1. Based on the unaudited accounts, what was the outturn financial position for the PCTs, NHS Trusts and SHAs as at 31 March 2006?

1.1 The Secretary of State for Health will inform Parliament of the position on 7 June. This additional information will be provided to the Health Select Committee on the same day, along with a report from the Department’s Finance Director to the Secretary of State for Health providing supporting detail and analysis.

1.2 The figures have been subject to additional checking, but they have not yet been audited and are still subject to change.

2. Based on the latest data available from Monitor, what is the projected financial position for all Foundation Trusts as at 31 March 2006?

2.1 The Health Committee have requested this information directly from Monitor.

MOVEMENTS BETWEEN MONTH 12 AND FINAL AUDITED ACCOUNTS

3. What steps has DH taken to assure itself that the discrepancy between the 2004–05 FIMS data and the audited outturn figures will not recur in 2005–06?

3.1 The following paragraphs explain the changes in 2004–05 and the action taken on by the Department of Health to prevent a recurrence.

3.2 2004–05 was the first year in which there was a significant movement between the final in-year monitoring information collected by the Department of Health (based on the draft accounts) and the final audited accounts (see answer to question 4 below).

3.3 The Department became aware of the movements in early August 2005 following submission of final accounts. Each of the Strategic Health Authorities was contacted by the Department to ascertain the reasons for the changes and the action that was being taken. The changes can be broadly categorised as:

(i) difference of opinion between Boards and auditors on accounting treatment and estimates. The main areas here were:

(a) the underestimation of prescribing creditors—as PCTs do not receive confirmation of their actual expenditure from the Prescription Pricing Authority until after draft accounts are prepared, they must make provision for expenditure for the final 2–3 months of the year.

(b) the understating of the provision for the costs of implementing agenda for Agenda for Change (AfC). The new AfC pay system was rolled out from 1 December 2004, backdated to 1 October 2004. During 2004–05 NHS bodies had the task of assimilating staff onto the new pay system, and making provision for the expenditure. Some organisations incorrectly disclosed a contingent liability in their draft accounts instead of a provision.

(c) capitalisation and asset valuation—this relates to expenditure which had been classified as capital in draft accounts and subsequently reclassified as revenue, and also understating charges relating to the down revaluation of assets.

(ii) differences between organisations concerning the amount of income due—including within this category adjustments made to service level agreements and levels of support.
## Table 2

### CHANGES FROM DRAFT TO PUBLISHED ACCOUNTS BY STRATEGIC HEALTH AUTHORITY

Reasons explaining the differences between Month 12 FIMS data and the final accounts.

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<th>Organisation Name</th>
<th>2004–05 Final Accounts surplus/deficit (£000)</th>
<th>2004–05 Month 12 Change £000</th>
<th>Agenda for Change £000</th>
<th>Change in levels of Support £000</th>
<th>Changes to Income/Expenditure involving non NHS Bodies £000</th>
<th>Changes to Stock £000</th>
<th>Changes to Asset Values £000</th>
<th>SLA Adjustments £000</th>
<th>Primary Care GMS Changes £000</th>
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3.5 As a result of the investigation the following actions were taken by the DH:
— clarification and tightening of standing accounting guidance;
— re-emphasis with SHA Finance Directors of their professional responsibility for standards of accounting;
— inclusion of the issues arising from the investigation in the formal guidance issued to the NHS requesting the 2005–06 Month 12 FIMS data; and
— regular liaison with the Audit Commission to identify any concerns that they or their auditors have.

3.6 Where the audit changes moved an organisation from breakeven/surplus to deficit the Chief Executive/Permanent Secretary and where appropriate the Secretary of State wrote to the Boards.

3.7 Discussions with both the Audit Commission and the SHA Finance Directors have not identified any systemic issues that are likely to lead to changes between draft and final accounts on the scale that occurred in 2004–05. Nevertheless, it needs to be recognised that across the 566 statutory organisations submitting accounts there will always be some organisations where there will be a difference between Boards and auditors on matters of accounting judgement.

4. Based on historical data, what is the potential discrepancy between the figures reported through FIMS and those reported in the audited accounts?

4.1 The historical variances set out in Table 1 below demonstrate that the extent of changes in 2004–05 was exceptional. The measures outlined above are designed to prevent a recurrence.

5. Please provide the unaudited outturn figures for deficits provided in May and the subsequent audited figures for 2001–02, 2002–03, and 2003–04 and 2004–05.

5.1 The information requested is set out in Table 3 below:

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Surplus/(deficit) reported at Month 12</th>
<th>Surplus/(deficit) reported in audited accounts</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>53</td>
<td>71</td>
<td>19</td>
</tr>
<tr>
<td>2002–03</td>
<td>70</td>
<td>96</td>
<td>26</td>
</tr>
<tr>
<td>2003–04</td>
<td>88</td>
<td>73</td>
<td>−15</td>
</tr>
<tr>
<td>2004–05</td>
<td>−108</td>
<td>−221</td>
<td>−113</td>
</tr>
</tbody>
</table>

6. What is the value of planned savings that each trust has to make in 2006–07 to achieve balance? At 31 March 2007, which trusts are expected not to have recovered their deficit, including any cumulative deficit; and what is forecast to be the value of remaining cumulative deficit?

6.1 NHS bodies submitted their financial plans in early April. All SHAs were required to submit to the DH the financial plans for NHS Trusts and PCTs in April. This was slightly later than initially anticipated because of the need to correct the national tariff.

6.2 The plans have not yet been agreed, so we are not yet in a position to provide figures on the level of planned savings or the expected outturn for each organisation.

6.3 The original planning assumption for 2006–07 was an efficiency improvement across the NHS of 2.5%. The different starting positions and the overspending in 2005–06 means that some organisations will need to make savings that are higher than 2.5%.

6.4 We aim to ensure that in aggregate across the NHS the plans and supporting actions deliver financial balanced position. All the plans are subject to detailed scrutiny covering:
— overall plan viability;
— deliverability of cost improvement plans;
— consistency of workforce and financial plans;
— affordability and financing of access targets;
— cash flow forecasting;
— financing of capital programmes; and
— consistency of assumptions between PCTs and NHS Trusts.

6.5 The aim is to achieve the best possible performance from every organisation, and minimise the level of risk.

6.6 The response to DH scrutiny is being led by the newly appointed Chief Executives of the transitional SHAs. We are not treating the agreement of plans as an end in itself. We are treating the discussion of financial plans as a continuing part of the performance management process.

6.7 It is unlikely that balanced financial plans will be delivered in three of the 10 SHAs—these are East of England, London, and South East Coast. For these SHAs, we are providing further intensive support led by a SHA Chief Executive on secondment to DH, and supported by four SHA Directors of Finance from elsewhere in the country. This exercise aims to drive further cost savings. In those SHAs where we believe there is the greatest scope for improvement, we expect to work very closely with the new management teams for several months. This will include, for example, ensuring that the cost improvement programmes are consistent with the plans developed as part of the turnaround process. We are committed to getting these organisations into long term balance.

6.8 We intend to achieve financial balance across the NHS in 2006-07, so any overspending in one organisation will need to be matched by underspending elsewhere. At this stage in the process it is not possible to say precisely which PCTs and Trusts are likely to over-spend.

**Turnaround**

7. Have all Trusts identified now been visited by the turnaround teams? Please send us the reports provided by the turnaround teams. How much have you paid the turnaround teams.

7.1 To date, the SHA Regional Turnaround Directors have visited the vast majority of organisations (c 98%) within the turnaround cohort. The two organisations which have not yet been visited do not now have current or forecasted deficits.

7.2 In addition, SHA Turnaround Directors have identified or have received requests to visit other organisations outside of the cohort that require turnaround support. They have visited 33 organisations to date and provided advice.

7.3 The following paragraphs explain the Turnaround process in more detail, including: organisation; action taken; turnaround plans and; costs of turnaround.

**Organisations**

7.4 Following the analysis of organisations with some of the largest deficits (the “Turnaround Cohort”) referred to as the “Baseline Assessment”, a National Programme Office (NPO) for turnaround was set up at the Department of Health (February 2006). The role of the NPO is to provide co-ordination, review, monitoring and scrutiny of all turnaround projects within the cohort.

7.5 The NPO provides an independent and qualified view as to whether Trust/PCT turnaround plans are viable and quantifiable and, critically whether implementation translates into improved financial results. The objective of the NPO is not to micromanage or to add management layers to the running of turnaround programmes but to ensure they are:
— being developed for challenged organisations;
— sufficiently robust;
— rigorously detailed to allow measurement and progress to be tracked; and
— implemented within the planned time scales and with the intended outcomes.

7.6 The baseline assessment of the financial position of organisations with significant deficits identified 98\(^1\) organisations within the turnaround cohort and categorised them in terms of their support requirements as follows:
— Category 1: Immediate priority. Urgent intervention required to drive turnaround.
— Category 2: Additional expertise/resource needed to support turnaround.
— Category 3: Drive/focus. Maintain high priority of actions.
— Category 4: Encourage to share what works and deliver easy wins.

\(^1\) There are 102 (48 Trusts and 54 PCTs) statutory organisations within the Turnaround cohort but Ipswich PCT and Suffolk Coastal are under joint management and are treated as one organisation, as are Fareham & Gosport PCT and East Hampshire PCT, and the Cumbrian PCTs (of which there are three).
Figure 1

The chart below shows the number of organisations under each category (as at 16 February 2006)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>15</td>
</tr>
<tr>
<td>PCT</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>1234</td>
<td>0</td>
</tr>
</tbody>
</table>

Action taken to date

7.6 The top priority for the national turnaround work is to deliver a recurrent balanced monthly run rate in individual organisations (ie when expenditure equals income on a sustained basis and the deficit has therefore stopped growing). As part of the infrastructure to support the delivery of turnaround, private sector Turnaround Directors were appointed to each of the SHA regions across England.

7.7 In summary2 the role of the regional Turnaround Director is to:

- manage and co-ordinate the turnaround initiatives of organisations within the region (in agreement with the SHA CE) and to facilitate the delivery of comprehensive turnaround plans;
- ensure there is no trade off between achievement of financial targets and delivery of national clinical service priorities;
- support management in assessing and managing the performance and delivery of turnaround resources within challenged organisations;
- support line management in agreeing a turnaround action plan with challenged organisations;
- work with Boards (especially Chairs and Non-Executive Directors) to understand the need for and ownership of turnaround; and
- work with the NPO to put in place a process for the SHA to monitor and assess progress against plans.

7.8 The initial focus of the NPO in conjunction with the SHA regional Turnaround Directors has been to ensure that organisations in the cohort identified as requiring “urgent intervention” or “additional expertise” source the appropriate external support in order to assist them in the development of robust credible turnaround plans.

7.9 The progress of “support status” for organisations across the cohort has been measured at a high level by applying a Red, Amber, Green assessment, where:

- Green: Organisation has appropriate resource/support to deliver required turnaround plan.
- Amber: There is a clear process in place to procure appropriate resource/support or review is in progress to assess support requirements.
- Red: Additional resource/support is required to deliver required turnaround plan and is not yet in place, or assessment of support requirements is not yet complete.

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2 A detailed Turnaround Director job specification is available.
7.10 As at 18 May 2006, of the 26 category 1 organisations requiring “urgent intervention”, 25 Trust/PCTs have in place or have already received turnaround support from a combination of professional turnaround advisors from the big four accountancy firms and/or independent Turnaround Directors. The remaining organisation is actively in the process of sourcing support. Of the 37 category 2 organisations requiring “additional expertise/resource” to support their turnaround effort, 32 currently have support or have received support in the form of a Turnaround Director (independent or internally sourced) or have professional turnaround advisors in place.

7.11 Across the cohort, there are 31 Trusts/PCTs with independent Turnaround Directors working with them and a further 17 organisations with a dedicated internally sourced Turnaround Director leading turnaround (as at 18 May 2006). This number may increase over the next few weeks as organisations continue to clarify their support requirements.
The following table shows the number of organisations who currently have (or have had) turnaround support in place (as at 18 May 2006).

<table>
<thead>
<tr>
<th>TURNAROUND DIRECTOR</th>
<th>EXTERNAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EXTERNAL</td>
</tr>
<tr>
<td>CAT 1</td>
<td>13</td>
</tr>
<tr>
<td>CAT 2</td>
<td>14</td>
</tr>
<tr>
<td>CAT 3 &amp; 4</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
</tr>
</tbody>
</table>

**Turnaround plans**

7.12 The NPO have received a number of draft outline Turnaround plans from organisations within the cohort. The NPO are reviewing the appropriateness of plans, which includes for example:
- evidence of robust process behind the development of plan;
- engagement of external stakeholder group;
- clarity and definition of projects;
- process and structure for delivery of plans;
- evidence of external challenge/experience;
- risk assessment and risk management strategy; and
- insight into implementation plan.

7.13 Once all plans are received and underway, it will be possible to report the projected savings across the cohort and by each region.

7.14 The NPO will be monitoring, managing and challenging the implementation of the Turnaround plans and will be tracking for example:
- cost savings achieved against target;
- progress against milestones;
- risks/issues relating to implementation; and
- overall financial performance against the plan (including monthly run rate information, year to date/outturn performance and deficit information).

**Cost of Turnaround**

7.15 The DH has covered the costs set out in (i) to (iii) below:

(i) Baseline Assessment (ex VAT and Expenses):
- Phase 1—£1,493,500
- Phase 2—£1,092,400

(ii) National Programme Office (ex VAT and Expenses):
- Average £177,000 per month (since February 2006)
(iii) SHA Turnaround Directors (ex VAT and Expenses):
£390,000 per month (since February 2006)

7.16 We do not yet have finalised figures for the local cost of turnaround support.

8. How has progress on implementing KPMG’s recommendations been monitored and measured? Please provide a summary of what progress has been made to date?

8.2 As explained in answer to question 7, a National Programme Office (NPO) was set up following the baseline assessment of those organisations with significant deficits. The NPO have programme management disciplines in place to monitor and manage turnaround organisation within the cohort and produce weekly reports on progress of these organisations.

8.3 The NPO produce a written weekly report to the Turnaround Task Force (TTF) summarising turnaround progress and highlighting key risks and issues. There is also an accompanying weekly status report which provides more detail of the status and turnaround progress of all organisations within the cohort (eg status of turnaround support, progress of development and approval of turnaround plan, appropriate mechanisms in place for the implementation of plan). Regular reports are made to ministers and progress and actions challenged.

8.4 Progress to date is summarised in response to Question 7 above. Copies of progress/status reports created since the establishment of the NPO have been provided.

WORKFORCE REDUCTIONS

9. To what extent were the SHA’s and DH aware of trusts’ redundancy plans? If they were planned, how many more redundancies will be expected? If they were not planned, what implications does this have for the quality of 2006–07 strategic plans?

9.1 NHS revenue resources are increasing in 2006–07 by 9.2% before adjustment to cover the 2005–06 deficit.

9.2 Although all NHS organisations will need to ensure that they are managing their workforce numbers within the overall resources available we do not anticipate major redundancy exercises across the NHS. Where NHS trusts are reducing posts as a means of generating savings to reach financial balance and provide optimum value for money they are focussing first on doing this through turnover, recruitment freezes, reducing the use of agency staff, and redeploying staff in different ways.

9.3 Some redundancies are inevitable, but nowhere near the levels recently highlighted in the press, and the balance of posts lost seems likely to be for managers and non-clinical staff. Employers recognise the need to handle workforce reductions sensitively and to ensure opportunities are also available for new nursing and medical graduates. NHS Employers are working with NHS Trusts to share best practice.

9.4 Overall, these changes are not just a result of local financial deficits, but are a reflection of increases in productivity due to more technology and better and more streamlined working practices. Productivity gains may mean that fewer staff will be needed in some areas to deliver the same healthcare outcomes. This will be balanced by an expansion in community services as outlined in the Our Health, Our Care, Our Say White Paper.

9.5 Between 1997 and 2005 there was an increase of 31% in the number of full time equivalent staff employed by the NHS, and an increase in 2004-05 of around 3%. After a period of rapid and essential growth in the workforce to fill gaps and increase capacity, we are now moving away from year-on-year growth in the NHS workforce and expect numbers to broadly stabilise over the next few years.

Patricia Hewitt
Secretary of State for Health
6 June 2006
Evidence submitted by Adur, Arun and Worthing PCT (Def 51)

INTRODUCTION

The purpose of this short note is to provide Health Select Committee Members with a brief background note about Adur, Arun & Worthing PCT ('AAW PCT').

BACKGROUND

AAW PCT was formed on 1 April 2002. It was created from five organisations: three primary care groups (Adur, Arun & Worthing), the Community Services element of Worthing Priority Care Trust and some of the statutory functions of the former West Sussex Health Authority.

The PCT serves an urban population of 220,000 along a narrow coastal strip in West Sussex. It is distinguished by a high proportion of older people (24% aged 65 years or over compared with 16% in England and Wales) and by higher levels of ill health and deprivation than is typical in surrounding PCTs, but has lower levels of mortality and morbidity than England and Wales. (Standardised Mortality Ratio for AAW in 2002-2004 was 95 and the age standardised ratio for limiting long-term illness in AAW in 2001 was 88). These overall rates mask significant variations in health within the PCT area, with life expectancy at birth ranging from 70.1 years to 84.8 years.

AAW PCT is structurally more complex than most PCTs by providing a number of major services to other PCTs and NHS organisations. In particular we manage Specialist Commissioning (£115,000,000 turnover), Sussex Acute Commissioning (£752,000,000 turnover) and Sussex Health Informatics (average 407 staff (full time equivalent), £24,000,000 turnover). These services, along with our own local PCT budget of £310,000,000, give a turnover in excess of £1 billion. However because AAW is acting as the “agent” of other NHS organisations for hosted services no financial advantage is conferred on the PCT by handling such a large turnover, indeed the opposite is the case.

During this period the PCT has achieved the following financial results:

<table>
<thead>
<tr>
<th>Year</th>
<th>Underspend against resource limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002–03</td>
<td>£968,000</td>
</tr>
<tr>
<td>2003–04</td>
<td>£1,690,000</td>
</tr>
<tr>
<td>2004–05</td>
<td>£3,653,000</td>
</tr>
<tr>
<td>2005–06</td>
<td>£2,972,000</td>
</tr>
</tbody>
</table>

There have been other improvements too. In service access despite rising levels of demand for emergency (16%) and planned (12%) care the number of patients waiting for an outpatient appointment reduced by 26% and 35% fewer waiting for inpatient care. The time patients wait has reduced across the board too, for outpatients, inpatient, A&E and primary care. New services have also been created, such as intermediate care, community matrons, specialist stroke services etc, many in partnership with Social & Caring Services.

The PCT has a workforce, excluding hosted services, of 960, of whom 860 are clinical staff and their support and management and 100 management and back office staff. The PCT runs two small community hospitals and a number of health centres and clinics.

Approach to Financial Management

PCT financial strategy was established in the preparatory phase of the creation of the PCT. Delivering good results has not been easy and has not been a consequence of benign circumstances. The strategy reflects six key inter-connected approaches:

1. A strong value base of financial discipline.
2. A strong financial and commissioning strategy.
3. A strong performance management approach with providers.
4. A strong grip of internal financial control.
5. A strong culture of openness and trust with staff and particularly with GPs.
6. A strong approach to governance and scrutiny by the Board.

Steve Phoenix
Chief Executive, Adur, Arun and Worthing PCT

June 2006
Evidence submitted by Advanced Medical Solutions (Def 34)

1. INTRODUCTION

1.1 Advanced Medical Solutions (AMS) is a British company, specialising in the research, development, manufacture and sale of wound care products for use in A&E departments and operating theatres, instead of conventional sutures and staples. We are developing on our successes in the branded wound care sector by launching our own range of generic advanced wound care products, ActivHeal®, for sale directly into the NHS. Independent clinical evaluation has shown that ActivHeal® significantly reduces the cost of treating wounds whilst still maintaining the quality of wound care.

1.2 In this submission, we intend to offer some observations based on the difficulties we have faced expanding our business into the NHS, in the context of the NHS deficits, as well as comment on some broader issues affecting the NHS procurement process which would have an effect on NHS deficits.

1.3 In particular, AMS believes:

— There is a disconnection between clinical decision-makers and budget holders within the NHS.
— There is a general lack of awareness and recognition of costs, even in a restricted funding environment.
— NHS staff need to become more aware of, and responsible for, cost effectiveness so that they prescribe cheaper versions of the same product, where this does not affect patient care.
— In the area of wound care alone, it would be possible to save £25 million nationally. This alone would not bring the NHS into the black but would go some way to alleviating the current financial crisis.

2. THE REASONS FOR THE DEFICITS

2.1 AMS believes one reason for the deficits is a disconnection between clinical decision-makers and budget holders and a general lack of awareness and recognition of costs, even in a restricted funding environment. There is a general lack of good business practices, because not all clinical gatekeepers, such as prescribing nurses, are accountable for their spending, particularly in areas like wound care.

2.2 In the case of wound care, independent clinical evaluation found that ActivHeal® reduces the cost of treating wounds whilst still maintaining the quality of wound care. ActivHeal® therefore offers real and immediate savings to the NHS. This is estimated to be the order of £25 million per year across England and Scotland at a time of severe funding pressures. This is based on a 40% saving on the annual wound care budget for the NHS of £60 million and has been verified by the NHS Purchasing and Supply Agency (PASA) for its portion of the market.

2.3 Since AMS began direct sales to the NHS in February 2004, AMS has converted ten NHS Trusts. On average, each Trust has saved approximately £25,000 per annum. The most recent conversion was the Oxford Radcliffe NHS Trust, which consists of four hospitals. Further Trusts are pending, some of which have the potential to save £50,000 or more.

2.4 ActivHeal® is also supported by a modern and effective training package consisting of Trust-specific educational materials. Advanced distance learning packages and individual access to qualified Clinical Support Nurse practitioners with specialist knowledge of Advanced wound care and Tissue Viability. In addition, a proportion of the savings made by using ActivHeal® could be set aside for the benefit of wound care nurses. At present, these nurses are dependent on the patronage of larger wound care companies for their professional development.

2.5 Independent assessment has shown that AMS products are as good as the branded versions, yet cheaper. However, despite the advantages of the products, AMS has been facing on-going difficulties in converting Trusts to using ActivHeal®.

2.6 The challenges faced by AMS include:

— Piecemeal approach: AMS currently has to approach each individual hospital, delaying projected cost savings throughout the NHS.
— Time efficiency: it has taken an average of seven months to convert each Trust.
— Patronage of clinicians by major companies, who provide a great deal of professional training, continues unchallenged and such training is rarely audited for value or relevance.

2.7 These issues make it difficult for small companies, like AMS, to compete with larger, more established companies. AMS and other small companies are competing on an unlevel playing field. This is not only detrimental to smaller players but also to the NHS, as it is not able to benefit from the lower prices that would result from more competition and business practices that did not involve the patronage of clinicians.

2.8 As the Health Select Committee’s inquiry into the Influence of the Pharmaceutical Industry highlighted, large, branded companies often provide inducements to clinicians to try to persuade them to use their products.
2.9 In the area of wound care, such practices are widespread. The selling model used by the major wound care companies usually involves large teams of reps who deliver what is effectively a consumer sell to individual nurses, the majority of whom have no knowledge of, or interest in, the cost of the products that they use.

2.10 In secondary care, effort is primarily directed at Clinical Nurse Specialists such as Tissue Viability Nurses (TVNs) or Vascular Nurses, who act as technical gatekeeper, and final arbiter for the products used in their trust, and have no financial responsibility.

2.11 In the lucrative primary care sector, the decision-making is more devolved than in acute, and usually individual Practice Nurses and District Nurses either self prescribe, or make a dressing choice which the GP then signs. Despite often being the budget holder, GPs very rarely make prescribing decisions relating to woundcare, incontinence or Stoma products. Although there are TVNs in post in primary care, their formulary choices can be overruled by individual nurses.

2.12 The selling process in primary care is therefore more akin to the pharmaceutical selling process, but involves selling to nurses with less experience in assessing products than GPs, and with much fewer controls on patronage and inducements that apply to medics.

2.13 Examples of such endorsements and inducements include:

— Funding for a general nurse to attend a wound care conference is often provided through sponsorship from a wound care company.

— Clinical Nurse Specialists such as TVNs are also sponsored to present to other nurses, thereby endorsing the products.

— A number of high profile TVNs and consultant TVNs are paid to lecture at conferences, and to publish clinical papers which are intended to influence the decision-making of less experienced clinicians. Such publications frequently contain product promotion.\(^3\)

— Social events and seminars are regularly sponsored by branded companies. Although not explicitly asking nurses to prescribe their dressings, it is hard for nurses to maintain complete independence.

— Training: the provision of education in wound care is often cited as being part of the added value inherent in the high purchase prices of the branded products. This can vary, but consists largely of the local rep providing lunch once a quarter and presenting the latest sales arguments loosely structured as training. No company provides independent non-product specific training and none of the training packages has been accredited by, for example, the Royal College of Nursing, although the mechanism to do so is available and relatively inexpensive. Neither does anyone evaluate the value of such training to the participant.

2.14 The Surgical Dressing Manufacturers Association (SDMA) imposes a Code of Practice on all of its members and arbitrates on complaints, usually from other members, about the activities of a member organisation. The code is prescriptive on matters such as gifts, inducements, business courtesies and the behaviour of reps, but the code does not include training provision and resources provided by companies. We believe these should be added to the list of disclosures and the code itself should be made more effective in stopping all these practices.

2.15 AMS does not sponsor nursing posts and we oppose such sponsorship. We would suggest that a clear and accountable declaration of any training provision and resources provided should be added to the list of disclosures required by a Code of Practice.

2.16 Training and resources, provided by companies, to educate clinical staff is often cited as justification for elevated pricing. Whilst the industry should provide training to ensure products are used safely and effectively, clinical training should be an internal NHS or technical nursing issue. If product offerings were to be stripped of their alleged “added value” components, or if these were precisely defined, the Trusts could take an informed view of the value of such components.

2.17 AMS suggests that savings made on unit prices could be available to give Tissue Viability Nurses (TVNs) financial control over nursing posts and their own training budgets. These savings would be greater than the cost of the training currently provided by companies and could be tailored to meet the needs of the nurses and NHS, rather than the requirements of the companies providing the training.

2.18 If such changes were implemented and there was a greater connection between prescribing and cost, the NHS would save significant sums of money. This would probably require Government policy although it could be implemented at the local level.

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\(^3\) Eg articles by K and P Vowden (TVN & Vascular Surgeon, Bradford), Elizabeth Scanlon (TVN Leeds) and Claire Williams (TVN North Wales), in “Moist Wound Healing: Achieving a balance”—a sponsored supplement to the “Wounds-UK” journal.
3. **THE CONSEQUENCES OF THE DEFICITS**

   3.1 The consequences of the deficits are clear in the numerous recent announcements of plans for NHS Trusts to lay staff off, close wards and/or reduce services.

   3.2 There seems to be an apparent preference for laying off operational staff and closing wards, rather than looking at ways to cut costs and resolving ongoing operational deficiencies. AMS would suggest that it would be possible to save significant sums of money by preventing the problems outlined above.

   3.3 AMS believes the only way to ensure early adoption and savings for the NHS for wound care and related products, such as stoma, is through a more central decision-making process along the lines of the generic pharmaceuticals model, which has delivered substantial savings.

4. **RECOMMENDATIONS**

   4.1 Companies selling to the NHS should be prevented from offering gifts, inducements, training provision and other resources provided.

   4.2 Before laying off staff and closing wards, there should be an assessment of ways for the NHS to save money through greater cost-effectiveness, such as with procurement. AMS believes such moves would save significant sums of money, without affecting the level of patient care.

   4.3 More responsibility for spending should lie with the prescriber. This could be achieved by checking all prescribing is relatively cost-effective.

   4.4 Procurement for wound care and associated products should be through a more central decision-making process, along the lines of the generic pharmaceuticals model, which has delivered substantial savings. This would make the process more efficient, enable the NHS to maximise savings and assist smaller companies to compete with the larger businesses. This approach would not mandate from above that clinicians should prescribe one particular product but should emphasise that there are usually several equivalent products to choose from, and where this is the case, decisions can be based on cost without affecting patient care.

*Advanced Medical Solutions*

6 June 2006

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**Evidence submitted by the American Pharmaceutical Group (Def 29)**

1. **INTRODUCTION**

   1.1 The current NHS deficit is reported as approximately £800 million. Although this amount is large, it is a small proportion of the overall annual NHS spend (1.2% of the NHS budget) and has been generated by a small number of NHS trusts. It should also be noted that the NHS has always had deficits. Greater transparency has lead to a clearer identification of where these deficits lie.

   1.2 Similarly the amount spent on prescribed pharmaceutical medicines is also a small proportion of the overall spend (11.2%). Pharmaceutical medicines are often viewed purely as a cost for the NHS. However, this is a relatively simplistic view and does not take into account the wider cost-saving effects a drug can provide. Pharmaceutical medicines may prevent patients from requiring more expensive hospital care, reduce the need for nurses’ care and help to keep patients at work. This has the knock-on benefit of helping to reduce costs in other government departments; for example if a patient is able to return to work this reduces the cost of incapacity benefits provided by the Department for Work and Pensions. If used effectively spending on medicines can save the NHS and government money in the long-term as well as helping to improve the health of the nation.

   1.3 The cost of pharmaceutical medicines in the UK is controlled by the Pharmaceutical Price Regulation Scheme (PPRS). The PPRS ensures reasonably priced medicines for the NHS and supports a successful British-based pharmaceutical industry. Supporting the pharmaceutical industry in this way promotes and funds research and development in the UK, leading to new and novel medicines for NHS patients.

2. **THE AMERICAN PHARMACEUTICAL GROUP**

   2.1 The American Pharmaceutical Group (APG) represents the ten leading research based US owned pharmaceutical companies who invest in the UK. The group was established in 1985 to improve understanding of the industry, and the healthcare contribution of the American companies in particular, among Government, Parliament and interested stakeholders.

   2.2 Collectively, we account for over 35% of UK sales of prescription medicines and employ over 17,000 highly qualified staff with over 4,500 working in research and development (R&D) and almost 4,000 in manufacturing. As a Group we invest over £1.5 billion a year in R&D and export more than £1.7 billion of prescribed medicines.
3. NHS DEFICITS

3.1 The current NHS deficit appears to be multi-factorial, caused by both systemic and local pressures and failings; as well as greater levels of transparency which has prevented such deficits from being hidden. It is often assumed that rising costs of pharmaceutical medicines has pushed the NHS into deficit. However, the pricing and distribution of medicines in this country is highly regulated and there has not been a rise in the price of medicines for over 15 years. In fact, in real terms medicines are cheaper now than they were ten years ago. In order for a medicine to be prescribed, it must first prove its clinical effectiveness and safety before it is given a licence by the Medicines and Healthcare products Regulatory Agency. The National Institute for Health and Clinical Excellence (NICE) may then issue guidance on whether this medicine or procedure is cost effective for the NHS.

3.2 We support the activities of the current Government to deliver care closer to patients’ homes and our members are researching new medicines to enable more home-based care across a wide range of disease areas. While it may be politically expedient to cut spending on medicines at a time of retrenchment in the service—this is a short-sighted approach, given the numbers of people whose health is maintained by pharmaceutical support. In the long-term this cut may result in many more patients needing hospital or nursing care: an ultimately more expensive scenario.

3.3 The greater part of the NHS budget is not spent on medicines (88.8%). This spending is not nearly as highly regulated as medicines spending which is controlled by the PPRS, the MHRA and NICE. NHS practices will need to be assessed on a similar cost-effective and clinical basis to identify inefficiencies, if NHS trusts in deficits are to turn things around.

4. THE COST OF MEDICINES

4.1 The cost of pharmaceutical medicines in the UK is controlled by the Pharmaceutical Price Regulation Scheme (PPRS). The PPRS acts to ensure reasonably priced branded medicines for the NHS on the one hand, and a competitive and innovative British-based pharmaceutical industry on the other. The PPRS allows for forward planning by the NHS and also ensures that regional discrepancies are removed. The last three PPRS reviews have seen pricing cuts—the last of which was a 7% price cut in January 2005.

4.2 The NHS currently spends £7.7 billion on medicines every year; this is only 11.2% of the overall NHS budget (£69 billion). The spend on branded medicines fell by 4.7% in the last year, despite an 4.6% increase in the number of prescriptions issued by doctors. There is a misconception that the UK pays more for prescribed medicines than other European countries. However, if fluctuations in exchange rates and differences in pack sizes, dosage and formulation, tax variations, rebate and discount schemes and wholesalers’ margin are taken into account; UK medicine prices move into line with European averages. In fact the UK spends less on medicines per head of the population than the majority of other European countries (approximately £200 a year per person)—mainly because the NHS spends the greater proportion of its money on older, generic medicines.

4.3 The UK has the lowest take up of new medicines across Europe, which can impact upon patient care. The reasons for this are complex but slow implementation of NICE guidance is increasingly an issue. A recent Audit Commission report (September 2005), found that implementation of NICE guidelines was erratic across the country due to a weakness in financial management and planning. In contrast, between 1993–2003 the USA was the site of first launch for 68% of novel medicines. This is clearly of benefit to US patients who can receive innovative medicines quicker than other patient populations. In addition; as a result of successive PPRS price cuts and the ending of many medicine patents, medicines are 21% cheaper in real terms now than they were 10 years ago. As a result, the UK has been steadily losing ground to the USA in terms of research and development, development of innovative medicines and worldwide sales over the last decade.

4.4 The UK pharmaceutical industry reinvests over 30% of its sales into research and development of new medicines. Further price cuts would threaten the pharmaceutical industry’s ability to research and develop new and innovative medicines in this country. This has been seen in Germany, Italy and Australia where cost containment policies have impacted on the industry’s ability to invest in the local economy; leading to job losses and plant closures.

5. THE VALUE OF MEDICINES

5.1 There is much evidence to support the cost effectiveness of pharmaceutical medicines, and in fact this is one of the main purposes of NICE. The APG has listed below some examples of the value of medicines for the committee’s information. It should be noted that these represent only a few ways in which medicines can provide a cost benefit to the wider community and economy.
**Coronary Heart Disease**

5.2 Coronary Heart Disease is currently the biggest killer in the UK for both men and women—more than 105,000 people a year in the UK die as a result of CHD (2004). The majority of these deaths are a result of a heart attack. 230,000 people suffered from a heart attack in 2004; 30% were fatal. CHD accounts for around 3% of all hospital admissions in England.

5.3 The economic burden of CHD is obviously vast. The costs for treating a heart attack or stroke are extremely expensive and are associated with further costs such as nursing care, and hospital bed usage. CHD costs the healthcare system £3,500 million per year. 79% of this is spent on hospital related care and 16% on buying and dispensing medicine. There are obviously wider cost implications such as working days lost by the patient or their carer. The cost to the UK economy every year due to CHD is £4,400 million.

5.4 Statins are preventative treatments that reduce cholesterol in the blood; one of the risk factors of CHD. They are used in the primary and secondary prevention of CHD. The NHS currently spends £769 million on statins per year.

5.5 The number of deaths from CHD in adults under 65 has fallen by over 44% in the last 10 years. The number of hospital admissions for CHD has also fallen. This is in part due to the continued increase in the use of statins—nearly 30 million prescriptions for statins and other cholesterol-lowering medicines are issued annually, almost 17 times the number prescribed ten years previously.

**Diabetes**

5.6 Diabetes is a condition in which a patient’s blood sugar levels are raised due to insufficient levels of insulin (which regulates sugar in the blood). There are two types of the condition: type 1 where the patient’s body is unable to produce insulin and type 2 where the patient’s body does not make enough insulin or makes insulin which does not work correctly. About 1.4 million people in the UK are diagnosed with diabetes—80% of those with type 2 and 20% with type 1. However, it is generally believed that up to 1 million additional people in the UK may suffer from undiagnosed type 2 diabetes.

5.7 The symptoms and complications associated with diabetes can be serious and debilitating including blindness, limb loss and kidney failure. The cost of the disease is a huge burden to the economy. The average reported yearly loss of earnings is £14,000 for a diabetes type 2 patient and £11,000 for their carer. The NHS spends £2 billion on the care of diabetic patients—this is 5% of its budget—and the rate of sickness absenteeism for the diabetic population is 2–3 times higher than the general population.

5.8 Diabetes is treated by a combination of lifestyle changes and innovative medicines. The management of diabetes with medicines can reduce or delay associated complications. This in turn reduces the need for acute care and provides a saving for the NHS. Proper regulation of blood glucose levels for the current diabetic population, using lifestyle changes and medicines, could save the NHS about 380,000 bed days a year.

**Schizophrenia**

5.9 Schizophrenia affects one in one hundred people at some point in their lives—approximately 250,000 people in the UK experience some type of schizophrenic illness. It can be a disabling condition, but for most people a meaningful recovery is a real possibility. The symptoms of schizophrenia are characterized by acute episodes of delusions and hallucinations and long term impairments such as low motivation, suppressed emotions and depression. Violence is often wrongly perceived as a symptom of the condition, whereas a person with schizophrenia is more likely to harm themselves than anyone else and up to 10% of people with schizophrenia take their own lives.

5.10 Schizophrenia can be effectively managed using psychosocial therapies and drug treatments. In 2002 NICE recommended the use of the newer atypical antipsychotics for people experiencing a first episode of schizophrenia and for those patients experiencing lack of efficacy or side effects with older antipsychotics.

5.11 Mental health is a key Government health priority. The Wanless report highlighted the greater use of atypical antipsychotics as a key factor in helping to create a world class mental health service. Evidence has shown that atypical antipsychotics can significantly reduce relapse and therefore reduce hospitalisation and the expense of costly inpatient treatment. Fewer side effects with atypical antipsychotics may result in better adherence to treatment, enabling patients to remain in the community, be more socially included and possibly return to work.

6. **Looking Forward**

6.1 NICE is a body which was established to prevent postcode lotteries, enable equal access to medicine across the country and bring cost-effectiveness to the NHS. NICE assesses a medicine’s clinical and cost effectiveness and issues guidance on how conditions and illnesses ought to be treated. Much NHS activity is not prone to the same level of scrutiny or assessment and so inefficient practice or management is harder
to identify and eradicate. In order to implement changes that will eliminate deficit in the long-term, it is vital that the Government and the NHS looks closely at current practices, in a similar manner to NICE, and stop those which aren’t working.

6.2 The recent demand for Herceptin, an expensive but potentially life-saving breast cancer therapy, from patients with early onset breast cancer, has posed problems for primary care trusts (PCTs) trying to balance their books. The APG recognises that demand for new medicines can present issues for the NHS and member companies are working to manage the entry of such medicines into the NHS through budget models and other tools. Ring fencing money for future innovative medicines, may also help to ensure that a sudden demand for a new medicine can be met.

6.3 In the examples given previously the APG has demonstrated the value of medicines and the cost benefits they can provide. There are already three systems in place to ensure the efficient use of medicines in the NHS. A further cut in medicines spending is a short-term solution that will cause greater problems long-term. Improving access to the best medicines will serve to reduce demands for expensive secondary care. Encouraging a fair return for the cost of developing new innovative therapies will serve to ensure medicine advances that could pave the way for better public health, a lesser need for recourse to hospital care and the balancing of NHS books.

Jennifer Mitchell  
American Pharmaceutical Group  
6 June 2006

Evidence submitted by Amicus (Def 11)

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% to 16% after the completion of their PFI projects.4

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,5 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

5 HC Deb, 19 October 2005, Col 270WH.
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 £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% of elective surgery with private providers, adds to the intractable by proposing to transfer £4 billion from the hospital sector—about 10% 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 £3 million, the consequence of which when linked to a deficit of £2 million and an inherited deficit of £2.1 million is to declare redundancies of 15 Health Visitors/School Nurses reducing the complement from...
42 whole time equivalents to 24 WTE. 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 9% 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 short whilst 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% 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 “We cannot afford 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.

Gail Cartmail
Head of Health, Amicus
2 June 2006

Evidence submitted by the Audit Commission (Def 25)

SUMMARY

1. The Audit Commission (Commission) welcomes the focus of the Committee and is pleased to submit evidence to this inquiry. The issue is important. In 2004–05, the NHS in England spent a total of £69.7 billion, with healthcare the fastest growing area of public expenditure. In addition, NHS organisations are experiencing a major programme of modernisation. In this context, first-class financial management and sound finance has a vital role to play in delivering improvements to patient services.

2. Our evidence is drawn from the work of the appointed auditors of Strategic Health Authorities, NHS Trusts and PCTs and from our national studies of NHS financial management, some of which have been undertaken jointly with the National Audit Office.

3. The majority of NHS bodies have adequate financial management arrangements and have not incurred in year deficits. The overall NHS deficit is also small in relation to total spend. However, there has been a steady increase in the last five years in the number of organisations incurring deficits. An increasing number of organisations are also reporting deficits of £5 million or more.

Figure 1

THE PROPORTION OF NHS BODIES WITH A DEFICIT OR OVERSPEND HAS BEEN INCREASING

Source: NAO analysis of NHS summarised account data/accounts of individual NHS bodies including Foundation Trusts.

4. We do not believe that there is a single cause of deficits. A number of NHS bodies have reported experiencing cost pressures arising from national initiatives such as the implementation of the new Agenda for Change pay system, the consultant contract, the new General Medical Services (GMS) contract and the need to meet performance targets for access and service provision. However, the ability of individual organisations to meet these pressures has varied. Poor or weak financial management has also played its part. The Commission has identified a number of weaknesses in NHS financial management both in general and in particular organisations. A welcome move towards greater transparency over deficits within the NHS has also contributed to the increase. Where deficits do occur, they can have significant effects on an organisation’s ability to improve or even maintain patient services.
5. The Commission and the auditors it appoints are currently undertaking a number of pieces of work which may be relevant to the Committee’s enquiry. First we are reviewing a sample of organisations which have experienced significant financial failure to identify any common themes and what lessons can be learnt from them. This is expected to be completed by early July. Second, the Secretary of State has asked that we review the current NHS financial management and accounting framework to see what improvements can be made. We will be reporting to the Secretary of State on this at the end of July. Third, appointed auditors are scoring the performance of each NHS Trust and PCT in five areas of financial management. This work will be completed in September and will form the use of resource rating in the Healthcare Commission’s annual health check. In each case we may have further evidence to submit to the Committee.

DETAILED RESPONSE

Introduction

6. The Commission’s submission to this inquiry is based on its knowledge and expertise in auditing NHS bodies in England for over 15 years. The Commission appoints auditors to PCTs, NHS Trusts and Strategic Health Authorities. About two thirds of the audits are undertaken by the Commission’s own staff and about one third by professional firms. The auditors have their own independent statutory powers but work to a statutory Code of Audit Practice. They are required to audit the accounts and also to satisfy themselves that the audited bodies have proper arrangements for securing economy, efficiency and effectiveness in the conduct of their affairs. Auditors appointed by the Commission also have discretionary power under section 8 of the Audit Commission Act 1998 which requires the external auditor to consider whether, in the public interest, there should be a report on any matter coming to his or her attention. Such reports are known as Public Interest Reports. Auditors are also required under Section 19 of the Act to refer any matter to the Secretary of State if he or she has reason to believe that an NHS organisation has made a decision that involves, or may involve, unlawful expenditure.

7. Officers of the Commission may also be appointed by NHS Foundation Trusts to audit their accounts. In such cases the auditors work to a Code of Audit Practice set by Monitor, the Independent Regulator of NHS Foundation Trusts.

8. The Commission also has a statutory responsibility to undertake national studies into financial management in the NHS. A number of such studies have been undertaken over the past two years, some jointly. These are listed at Appendix 1. Appendix 1 also includes studies that are currently underway, with their proposed publication date. This memorandum draws substantially on those studies as well as the work of local auditors.

Findings from National Studies into NHS Financial Management

9. The Commission has issued three reports which have reviewed NHS finances and financial management from 2002–03. They are:
   — Achieving First Class Financial Management in the NHS, published in April 2004;
   — Financial Management in the NHS: NHS (England) Summarised Accounts 2003–04 (joint report with the National Audit Office); and
   — Financial Management in the NHS: NHS (England) Summarised Accounts 2004–05 (joint report with the National Audit Office) [to be inserted].

Achieving First Class Financial Management in the NHS, published in April 2004

10. This report reviewed NHS financial performance in 2002–03 and the then current state of NHS financial management. It pointed to the financial management challenges which the NHS faced and identified what constituted good financial management.

11. The report noted that in 2002–03, most NHS organisations broke even. There was however a small increase from 16% to 18% in the number of NHS Trusts with in year deficits and a more significant rise in the overall total of those deficits from £70 million to £176 million although this constituted only a very small proportion (0.53%) of total operating expenditure. A number of Trusts also received financial assistance to enable them to break even. Without such assistance, 25% of Trusts would not have broken even and the deficit would have been increased by £116 million. 21 PCTs (7%) failed to keep expenditure within their resource limit with an overall deficit for those PCTs of £30 million. All PCTs had kept within their resource limit in the previous year. These deficits were balanced by surpluses made by other Trusts and PCTs and, overall, the NHS recorded a small underspend of £96 million.

12. In 2003–04 Auditors had also reviewed Trust and PCT Local Delivery Plans (LDP) which set out service plans for the next three years underpinned by financial strategies showing how resources will be deployed and value for money achieved. Auditors had concerns about future financial stability in the majority of LDPs.
13. In reviewing the state of financial management in the NHS, the report noted that although many NHS bodies were good at the basics, auditors had reported a number of concerns about the overall quality, specifically:

— the view that exists in some NHS bodies that central government targets are in direct competition with the achievement of financial balance. In particular there is insufficient prioritisation of funding to support organisational aims and objectives;

— the lack of focus on financial management issues during periods of restructuring. Most NHS organisations had experienced some restructuring, most recently as a result of the Health Act 1999 and the NHS Reform and Health Care Professions Act 2002 which in aggregate resulted in 413 new bodies being created. Such restructuring had additional implications for financial management. This is largely through the lack of a financial history, which makes financial forecasting more difficult as there is no comparable information from preceding periods and often a knowledge gap as staff have moved, lack of ownership of inherited financial problems and the development and integration of new financial systems;

— the lack of financial management capacity, particularly at PCTs which may not individually be big enough to manage any significant financial issues which arise. The lack of capacity was also reflected in the poor quality of accounts and supporting working papers received from many PCTs in 2002–03 although this was also very much influenced by the fact that they were often new bodies;

— cost improvement programmes being identified from non-recurrent sources which stores up problems for future years, coupled with over ambitious plans and failure to meet the targets set;

— an initial reduction in the quality of financial information as a result of the introduction of financial shared service organisations;

— problems caused by the late release of funds from the Department of Health (DH) to PCTs or from PCTs to NHS Trusts; and

— the demands placed on financial management and financial management capacity by PFI or Public-Private Partnerships, such as NHS LIFT.

14. The report also pointed to the challenges facing financial management in the NHS including through the introduction of patient choice, payment by results (on which the Commission has issued two separate reports), preparation for and implementation of foundation trust status, implementation of the National IT programme and implementation of new contracts of employment for consultants, GPs, dentists and, through Agenda for Change, for other NHS staff. The report particularly noted that accurate costing of the new contracts was likely to provide a significant challenge for NHS bodies which would also have to ensure that budgets and payroll systems were able to cope with the new requirements.

**Financial Management in the NHS 2003–04**

15. This report was prepared jointly with the National Audit Office. It reviewed financial performance in 2003–04, identified the main financial management issues faced by NHS bodies in 2004–05 and set out four key financial management and reporting themes.

16. As in 2002–03, most NHS organisations broke even, 106 did not. However, there was a further increase in the number of NHS Trusts which failed to break even in year from 50 in 2002–03 to 65 (24%) in 2003–04. The aggregate deficit of these trusts remained virtually the same at £175 million. 79 trusts received total revenue support of £344 million. The figures relating to financial support are not comparable with those for 2002–03 because of new requirements placed on NHS Trusts by the DH to increase the transparency of their accounts. The number of PCTs incurring deficits also increased from 21 to 41 (14%) with an aggregate overspend of £91 million. The report also noted that an increasing number of NHS Trusts and PCTs were incurring significant in year deficits (measured at 0.5% of turnover) with a small number (17 bodies in total) with deficits of over £5 million. These deficits were offset by surpluses elsewhere (largely in funds held by Strategic Health Authorities) and the NHS overall recorded a small underspend of £72 million.

17. The report reviewed a small number of key themes for improved financial management and made recommendations on each:

— the role of the Board, where examples of bodies incurring significant deficits illustrated the consequences of ineffective oversight or lack of financial acumen at Board level;

— forecasting and the problems created by inaccurate forecasting. The need for improvement was identified in budgeting procedures, the treatment and monitoring of cost savings targets and the need to agree funding earlier; and

— the preparation and transparency of accounts. There had been a significant improvement in the quality of accounts compared with 2002–03 with most NHS bodies producing good quality accounts and working papers. However, further improvements could be made to the transparency of accounts for PCTs, partly to enable Board members and managers to more readily understand their financial position.
18. The report noted that 2003–04 had been a relatively stable year in terms of challenges facing NHS financial management but even so, an increasing number of bodies had struggled to break even and manage their resources effectively. It also noted that the NHS faced increasing financial challenges in 2004–05 and beyond.

**Financial Management in the NHS 2004–05**

19. Our recently published further joint report with the NAO on financial management in the NHS reviews financial performance in 2004–05 and sets out the unaudited position for 2005–06.

20. Most NHS bodies broke even in 2004–05. However, there was a significant increase in the number of bodies which failed to do so and in the size of deficits. 171 NHS bodies out of 615 (28%) recorded a deficit or overspend in 2004–05. 68 out of 259 NHS Trusts (26%) failed to break even in 2004–05, 90 out of 303 PCTs (30%) failed to keep expenditure within revenue resource limits. One Strategic Health Authority failed to keep expenditure within its revenue resource limit. 28 PCTs had revenue resource limit overspends of over £5 million. 26 NHS Trusts reported a deficit of over £5 million. In 2004–05, NHS Trusts reported receiving a total of £393 million of support, either from the NHS Bank or from within their local health economy. In total, 73 Trusts reported receiving support, with 29 of those Trusts receiving £5 million or more. PCTs reported receiving a total of £204 million of support, either from the NHS Bank or from within their local health economy. In total, 77 PCTs received such support, with three receiving amounts of £10 million or more. The aggregate of deficits in NHS Trusts was £383 million and that for PCTs £335 million. These were offset by surpluses elsewhere (mainly in funds held by SHAs) but for the first time since 1999–2000, there was an overall deficit across the NHS of £214 million excluding NHS Foundation Trusts.

21. These trends have continued in 2005–06. On the unaudited figures the overall deficit increased to £512 million (£536 million including NHS foundation trusts). 31% of NHS bodies failed to break even. 102 PCTs and 66 NHS Trusts reported unaudited deficits greater than 0.5% of their total income. It is too early to give a detailed analysis of these figures and the causes of the deficits incurred. The Commission may submit further evidence to the Committee once the accounts have been audited.

22. We found no single cause of deficits in 2004–05. The reasons for the financial difficulties of NHS bodies are complex, and cannot be attributed solely to poor financial management, although this can be a contributing factor. In 2004–05, appointed auditors reported that the issues which caused financial pressures and left some NHS bodies unable to manage within their current resources included:

- implementation of workforce contracts (the new contract for consultants, Agenda for Change and the new GMS contract);
- additional activity—some NHS Trusts reported undertaking additional activity over and above that specified in contracts, for which they did not receive additional income. PCTs also reported increased costs as a result of over-performance;
- the requirement to meet waiting-time and other access targets. Some NHS organisations have made achieving, or indeed exceeding, access targets a higher priority than financial balance; and
- unrealistic savings targets and efficiency programmes which have not been delivered.

23. Whilst factors such as these may place greater demands on financial management, individual NHS bodies should ordinarily be able to manage a reasonable level of unforeseen cost pressures. This ability is a basic element of good financial management, reflecting organisational agility and responsiveness to changing circumstances. And while there are external reasons why NHS organisations cannot always exercise complete control over their activities, they all operate in the same environment and are subject to the same or similar cost pressures. Given this, the scale of variation in financial performance implies that some NHS bodies have financial management and governance arrangements which mean that, when faced with financial pressures like those identified above, they have coped better than others.

24. A contributory factor to the increase in the number and size of deficits over the last two to three has been a move by the Department of Health and the NHS to greater transparency, so that deficits are identified and not effectively covered over by brokerage or unplanned support.

25. Auditors assessed whether health bodies who had a year-end deficit position in 2004–05 had identified and understood the underlying causes of the deficit. Figure 2 shows that the vast majority of both NHS Trusts and PCTs had plans in place to address the underlying causes of the deficit. However, a significant proportion of these bodies with plans (86% for PCTs, 79% for NHS Trusts) were not delivering all the elements of their plans in practice. In auditors’ opinions, 2% of PCTs and 4% of NHS trusts had not identified the causes of the deficit and, at the time of the assessment, had not developed a plan to return to financial balance.

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6 The Department has estimated that in 2004–05 the Consultants’ Contract cost £90 million more than anticipated, and that the General Medical Services Contract exceeded their forecast by a further £300 million. Source: Uncorrected transcript of oral evidence [HC 736-i] Public Expenditure on Health and Personal Social Services 2005, Health Select Committee, 1 December 2005. Subsequent analysis by the Department suggests a slightly smaller shortfall of £284 million on the GMS Contract.
26. When reviewing financial recovery plans auditors have reported a number of frequently occurring weaknesses including:

— financial recovery plans are often viewed solely as the responsibility of the finance director and the finance department. If a financial recovery plan is to be successful it must be fully supported by the Board and senior management throughout the organisation;

— some financial recovery plans do not attempt to address the underlying financial problems, but instead aim to put in place short term non-recurrent measures that will leave underlying problems unaddressed;

— financial recovery plans often include unrealistic assumptions and unidentified or overly ambitious savings schemes;

— financial recovery plans are not always agreed with stakeholders. It is rare that an organisation can take the necessary recovery action without the support of key stakeholders; and

— financial recovery plans are not seen as “live” documents. Organisations may fail to update them to take account of changed circumstances or may fail to monitor progress against the plan and implement any necessary corrective action.

27. A number of “turn around teams” have now been introduced to organisations with significant financial problems. The Commission considers that it is too early to assess their impact but is keen that any lessons from the work of the teams should be widely disseminated.

28. Appointed auditors noted a significant reduction in the quality of accounts in 2004–05, particularly in the movement between unaudited and audited accounts. It is usual for amendments to be made to a body’s draft accounts as a result of the external audit. This can be to rectify mistakes or make adjustments to include additional, more up-to-date information which materially changes the financial position of the body. These adjustments tend to lead to increases and decreases in both income and expenditure, and therefore do not
generally result in significant changes to the national position. However, this was not the case in 2004–05. The unaudited accounts (including Foundation Trusts) showed an overall deficit across the NHS of £133.9 million, which increased in the audited accounts to £251.2 million (see Figure 3).

Figure 3

COMPARISON OF NHS BODIES' UNAUDITED AND AUDITED OUTFLOW FOR 2004–05

<table>
<thead>
<tr>
<th>NHS Bodies</th>
<th>Aggregate unaudited outturn £million</th>
<th>Aggregate audited outturn £million</th>
<th>Adjustment £million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Health Authorities</td>
<td>381.5</td>
<td>372.7</td>
<td>(8.8)</td>
</tr>
<tr>
<td>Primary Care Trusts</td>
<td>(202.7)</td>
<td>(265.3)</td>
<td>(62.6)</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>(282.9)</td>
<td>(321.7)</td>
<td>(38.8)</td>
</tr>
<tr>
<td>NHS Foundation Trusts</td>
<td>(29.8)</td>
<td>(36.9)</td>
<td>(7.1) *</td>
</tr>
<tr>
<td>Total</td>
<td>(133.9)</td>
<td>(251.2)</td>
<td>(117.3)</td>
</tr>
</tbody>
</table>

Source: Department of Health, NHS Foundation Trust consolidation returns and audited accounts of NHS bodies.

*Note: Of the £7.1 million overall adjustment for NHS Foundation Trusts, £5.9 million is attributable to audit adjustments at University College London Hospitals NHS Foundation Trust. No other NHS Foundation Trust required adjustments of over £0.7 million.

29. The National Audit Office and the Audit Commission are concerned about the level of audit adjustments required during the 2004–05 audit. The three most significant causes for movements between the two sets of accounts were prescribing expenditure, Agenda for Change and adjustments to service level agreements. Appointed auditors reported that there was evidence of inappropriate adjustments and/or omissions in 125 NHS bodies’ accounts (21%) in 2004–05.

30. At an individual NHS body level, not recognising the true financial position may mean bodies fail to take the necessary corrective action, or make decisions based on incorrect financial information. At Strategic Health Authority and national level it makes it more difficult to assess the financial situation and respond to it in timely fashion.

31. There is also a perverse incentive for NHS bodies (other than NHS Foundation Trusts) to underestimate the size of the deficit in their unaudited accounts. When an NHS body (other than an NHS Foundation Trust) overspends, the resources available to it may be reduced the following year through the application of Resource Accounting and Budgeting. This deduction is based on the unaudited deficit with any significant difference in the audited position being adjusted the year after. Until 2005–06, there was a further incentive for bodies to underestimate deficits in their unaudited accounts, since the Healthcare Commission’s “star rating” assessment for financial balance was based on unaudited figures. However, the Healthcare Commission’s annual health check will replace the “star rating” system from 2005–06 and will include the Auditors’ Local Evaluation score (see below).

32. The National Audit Office and the Audit Commission have been working with the Department to seek to ensure that large discrepancies between audited and unaudited accounts do not occur in 2005–06.

Public Interest Reports

33. There has been a significant increase in the number of Public Interest Reports issued. Since June 2005, over 20 Public Interest Reports have been issued by appointed auditors. This compares to four such reports in 2004–05, and one in 2003–04. All the Public Interest Reports issued have raised auditors’ concerns about financial standing and are listed at Appendix 2.

34. The circumstances leading to the auditor issuing a Public Interest Report are complex, and vary from organisation to organisation. There are, however, a number of common financial management issues, including:

- inadequate financial and strategic planning, including failure to agree a balanced budget at the start of the financial year;
- inadequate monitoring of the financial position, both at budget-holder and Board level;
- unrealistic savings and efficiency programmes that have not delivered what was required;

A prior-year adjustment was made to the outturn of Kensington and Chelsea PCT in 2004–05, the effect of which was to increase the overall overspend for PCTs by £7.1 million in 2003–04. The Department was not required to adjust for this in the NHS summarised accounts since the sum is not material by value in the context of those accounts. They therefore recognised all the £7.1 million of expenditure in 2004–05 rather than adjusting the figure for 2003–04. Thus the overall NHS deficit reported in the 2004–05 summarised accounts and consolidated accounts of NHS Foundation Trusts is £258.3 million (£221.4 million for the summarised accounts and £36.9 million for Foundation Trusts). However, we have adjusted the figures to ensure that the actual local position is accurately reflected in the detailed analysis.
— failure to agree and implement a robust financial recovery plan;
— weak governance arrangements, including inadequate challenge at Board level on the financial
information presented;
— failure by the Board to recognise the seriousness of the position in a timely fashion, and hence lack
of prompt recovery action; and
— weak or ineffective performance management by Strategic Health Authorities.

35. The increase in the number of Public Interest Reports is in part due to the deterioration in the financial
circumstances of some NHS bodies. It is also been influenced by guidance which the Commission issued to
auditors in 2004 following earlier financial failures and which clarified their responsibilities for public reporting.

36. The Commission has undertaken some further work to identify the causes of financial failure in a
sample of bodies which have been subject to Public Interest Reports to determine if there are common
themes and if so what lessons can be learnt from them. This work is currently being finalised and we may
submit further evidence to the Committee when it is complete.

PAYMENT BY RESULTS (PbR)

37. A number of commentators have suggested that the introduction of payment by results has been an
important cause of deficits. The Commission has issued two reports on payment by results and does not
believe this to be the case. It applied in full to only a minority of organisations in 2004–05 and 2005–06. And,
although there are instances of payment by results being associated with financial problems it cannot be
regarded as a major factor in many cases.

AUDITORS’ LOCAL EVALUATION

38. In order to help benchmark and help improve the management of financial resources in individual
NHS organisations, appointed auditors are for the first time in 2005–06 scoring the performance of each
NHS Trust and PCT in five areas: financial reporting, financial management, financial standing, internal
controls and value for money. The approach is analogous to that used in the Comprehensive Performance
Assessment of local authorities under the heading “Use of Resources”. Each area has a number of Key Lines
of Enquiry, underpinned by a series of criteria which distinguish relative performance. Work on scoring
financial management, internal controls and value for money has been completed. The remaining two areas
will be scored once the audit of the 2005–06 accounts has been completed at the end of July. The five scores
will then be combined into a single score which will then be passed to the Healthcare Commission and will
make up the Use of Resources rating for their “annual health check” (the successor to the star ratings). The
Commission will be producing a summary of the results and may provide further evidence on this to the
Committee once the work has been completed.

REVIEW OF FINANCIAL MANAGEMENT AND ACCOUNTING REGIME

39. The Secretary of State has requested that the Commission undertakes a review of the NHS financial
management and accounting regime. The review has been commissioned as a result of the current financial
position of the NHS as a whole and in particular the number of NHS bodies with deficits. The objectives
of the review are to consider and comment on the current regime and recommend changes that:
— enable and encourage the NHS and individual bodies within it to operate on a sound and
sustainable financial footing;
— support the identification of financial problems and facilitate recovery;
— promote clear and transparent accountability; and
— support individual organisations to develop the necessary financial management capacity and
capability to operate effectively.

40. The full terms of reference are at Appendix 3.

41. We will be reporting to the Secretary of State by 25 July 2006 and may wish to submit further evidence
to the Committee in the light of that review.

Audit Commission
June 2006

APPENDIX 1

AUDIT COMMISSION STUDIES INTO NHS FINANCIAL MANAGEMENT
— Learning the Lessons from Financial Failure, 2006 (This is likely to be published in June);
report with the National Audit Office;
— *Early Lessons from Payment by Results*, October 2005;
— *Introducing Payment by Results: Getting the balance right for the NHS and taxpayers*, July 2004;
— *Achieving First-Class Financial Management in the NHS*, April 2004;
— *Managing the financial implications of NICE guidance*, September 2005; and
— *Effective Financial Governance in Mental Health* (This is likely to be published in June).

**APPENDIX 2**

**LIST OF PUBLIC INTEREST REPORTS SINCE JUNE 2005**

Royal West Sussex NHS Trust (June 2005)
South Tees Hospitals NHS Trust (June 2005)
North Somerset Primary Care Trust (July 2005)
Weston Area Health NHS Trust (July 2005)
Kennet & North Wiltshire Primary Care Trust (July 2005)
Shrewsbury & Telford Hospitals NHS Trust (July 2005)
Southampton University Hospitals NHS Trust (July 2005)
New Forest Primary Care Trust (July 2005)
Hampshire & Isle of Wight Strategic Health Authority (July 2005)
Thames Valley Strategic Health Authority (July 2005)
West Wiltshire Primary Care Trust (August 2005)
Hounslow Primary Care Trust (August 2005)
Selby and York Primary Care Trust (September 2005)
Royal Wolverhampton Hospital NHS Trust (September 2005)
Hillingdon Primary Care Trust (November 2005)
Scarborough and North East Yorkshire Healthcare NHS Trust (November 2005)
Trafford Healthcare NHS Trust (November 2005)
Queen Elizabeth Hospital NHS Trust (December 2005)
Cambridge City and South Cambridgeshire Primary Care Trusts (December 2005)
Surrey and Sussex Strategic Health Authority (January 2006)
Maidstone and Tunbridge Wells NHS Trust (January 2006)
Cheshire West Primary Care Trust (January 2006)
North Tees and Hartlepool NHS Trust (January 2006)


**APPENDIX 3**

**TERMS OF REFERENCE OF REVIEW OF FINANCIAL MANAGEMENT AND ACCOUNTING REGIME**

**Audit Commission Report to the Secretary of State for Health on the Financial Management and Accountancy Regime in the NHS**

*Terms of Reference*

**Purpose**

The Secretary of State has requested that the Audit Commission undertake a review of the NHS financial management and accountancy regime. The review has been commissioned as a result of the current financial position of the NHS as a whole and in particular the number of NHS bodies with deficits. The objectives of the review are to consider and comment on the current regime and recommend changes that:

— enable and encourage the NHS and individual bodies within it to operate on a sound and sustainable financial footing;
— support the identification of financial problems and facilitate recovery;
— promote clear and transparent accountability; and
— support individual organisations to develop the necessary financial management capacity and capability to operate effectively.
Scope of Work

The remit of the review will include how these regimes work within Strategic Health Authorities, Primary Care Trusts and NHS Trusts. It is intended that the report will specifically cover:

— the current NHS financial regime, including how the resource accounting and budgeting regime is applied to NHS bodies;
— the financial reporting regime (as set out in the NHS Manuals for Accounts) and its transparency;
— the accountability framework;
— the financial management capacity and capability of NHS organisations, including the quality of reporting to Boards and the information available to them; and
— the role and work of internal audit.

The review will build on previous work undertaken by the Audit Commission and other bodies but will also involve additional research and analysis.

Constraints

The report and the recommendations made within it will recognise that the Department of Health and NHS bodies are required to operate within the overall accounting framework set by HM Treasury.

The overall level of NHS funding, the formula for allocating funds to Primary Care Trusts, or the development of a “failure regime” for individual NHS Trusts will not fall within the remit of the review.

The report will not consider the financial framework for NHS Foundation Trusts, other than from the perspective of preparing NHS Trusts for gaining Foundation Trust status or how lessons from that framework might be applied elsewhere in the NHS.

Governance Arrangements

The research and development of the report will be undertaken by the Commission with the assistance of external consultants, where appropriate. In doing so, the Commission will be advised by its NHS Financial Management Advisory Group (which includes representation from the Department, the NAO, Monitor, the Healthcare Commission and NHS bodies). The Commission will invite a representative from HM Treasury to join the Group and assist with the report’s development.

Reporting Arrangements

The Commission will provide a report to the Secretary of State. The report will make a series of practical recommendations to the Secretary of State on how the regime could be improved. The report will be published.

Timescale

It is intended that a report will be submitted to the Secretary of State before the Summer recess (25 July 2006). Where necessary it will identify where further work needs to be done.

Evidence submitted by Avon, Gloucestershire and Wiltshire SHA (Def 52)

BACKGROUND

— 12 PCTs and nine Trusts (excluding one Foundation Trust).
— Troubled financial history. £90 million overspend in 2001–02 and 2002–03.
— £41.5 million overspent end of 2005–06 including brought forwards from 2003–04 and 2004–05 but not earlier.
— 2005–06 Year-end forecast (made in September) was £24.8 million.
— “Control total” set by DH was zero.
— Outturn was £41.5 million overspent.

Turnaround Directors have been in place in three PCTs and one Trust/PCT combination since March 2006.

The problems in AGW are not evenly distributed between PCTs and Trusts.
5 PCTs and 3 Trusts broke-even or under-spent aggregate £10.9 million surplus
2 PCTs and 4 Trusts overspent by aggregate £10.2 million deficit
Between 0.1% and 1.7%
5 PCTs in 2 Trusts overspent by aggregate £53.5 deficit
Between 2.0% and 10.2%
The SHA HQ (and Workforce) under-spent £11.4 surplus
£41.5 deficit

Potential areas for oral evidence

1. Culture. Sometimes accepting forecasts of deficits is tantamount to sanctioning them. But refusing to accept deficit forecasts can lead to under-reporting. Service performance targets and financial balance are both priorities, but when conflicts arise these are dealt with “case by case” and not always with clarity.

2. Cause of deficits. Never one single cause. Cost of new policy commitments, plus pay deals is common across the NHS, and lessons need to be learned. But it’s usually other things on top which tip an organisation into deficit. For instance long-term underlying problems not tackled; cumulative impact of larger than average efficiency requirements.

3. “Efficiency” is not necessarily a way of avoiding job losses. Shorter lengthen of stay only saves money if translated into fewer beds and fewer posts.

4. Retrieval strategies. More difficult for PCTs than Trusts. Tendency to centralise (at Trust through vacancy committees; at SHA, top slice PCTs).

Few new ideas from turnaround Directors, but good on project management, posing tough questions and holding the line.

5. Once a balanced “run-rate” is achieved accumulated debt may need to be restructured into long-term debt.

Keith Ford
Finance Director, Avon Gloucestershire and Wiltshire SHA
15 June 2006

Evidence submitted by the British Medical Association (Def 33)

EXECUTIVE SUMMARY

— Deficits are not new in the NHS but the size of that projected for 2005–06 is unique in its scale.

— The favourable financial climate in which these deficits are being incurred is causing commentators to speculate on the underlying reasons for the deficits.

— These causes do not appear to be systemic and there is no apparent link between those PCTs in deficit and their distance from resource allocation target.

— Deficits are variously ascribed to local management problems, local health economy issues and the impact of national policies and decisions. In particular, targets and NICE decisions are cited.

— NHS organisations seem to be incurring higher levels of activity than expected and have inadequate risk management arrangements in place.

— Payments under PFI contracts are cited by some trusts as contributing to financial instability.

— Whilst NHS trusts are having to cut back on services, PCTs are still tied into overtly favourable contracts to independent sector treatment centres (ISTC).

— Commentators blaming deficits on unexpected consequences arising from new national contracts for nurses, doctors and others are being overly simplistic.

— There seems little doubt that one consequence of the deficits has been job losses in NHS trusts. The nature and scale of these seem open to interpretation.

INTRODUCTION

1. The BMA is pleased to contribute to the Health Committee’s inquiry into NHS Deficits, which is examining the size of and reasons for NHS deficits in 2005–06, the consequences of these in 2006–07 and the period of time over which balance should be achieved. The statistics in this document relate to England only.
BACKGROUND

2. The forecast outturn for 2005–06 for NHS organisations—strategic health authorities, primary care trusts and NHS trusts—at the mid point of the year was a net deficit of £623 million comprising aggregate deficits of £948 million and surpluses totalling £325 million. As Table 1 shows, deficits are not new in the NHS in recent years but the size of that projected for 2005–06 is unique in its scale. The Secretary of State has been at pains to point out that the projected deficit is small in relation to NHS turnover at less than 1% and that around two-thirds was due to just 37 organisations (7%, of the total number).  

3. However, the deficits are being incurred in a spending climate which is unprecedented in recent years. The 2002 Budget responding to the Wanless report, provided for a 7.4% real terms increase in UK spending on the NHS up to 2007–08. The Secretary of State has claimed additionally that the Gershon savings are running £200 million ahead of schedule in theory adding to the resources available to the service. This favourable financial climate is causing commentators to speculate on the underlying reasons for the deficits.

Table 1:

<table>
<thead>
<tr>
<th>NHS ORGANISATIONS NET DEFICITS AND SURPLUSES 1997–98 TO DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Net (Deficit)/Surplus (£ million)</td>
</tr>
<tr>
<td>1996–97 (460)</td>
</tr>
<tr>
<td>1997–98 (121)</td>
</tr>
<tr>
<td>1998–99 (18)</td>
</tr>
<tr>
<td>1999–2000 (129)</td>
</tr>
<tr>
<td>2000–01 112</td>
</tr>
<tr>
<td>2001–02 71</td>
</tr>
<tr>
<td>2002–03 96</td>
</tr>
<tr>
<td>2003–04 73</td>
</tr>
<tr>
<td>2004–05 (256)</td>
</tr>
<tr>
<td>2005–06 (Forecast) (623)</td>
</tr>
</tbody>
</table>

Commons Hansard 8 February 2006: Column 1319W

THE CAUSES

4. The underlying causes of the deficits do not appear to be systemic. There is for example no apparent link between those PCTs in deficit and their distance from resource allocation target (Chart 1). PCTs, which are significantly below target, could find their resources stretched relative to need. Conversely, PCTs over target could find differential increases in resources inadequate to meet ongoing commitments. However, whilst with few exceptions, those PCTs with the largest deficits are over target there is no correlation between size of deficit and distance from target. Neither hypothesis is therefore supported by the data.

5. The King’s Fund9 (using data from the Audit Commission’s annual audits of NHS bodies) attributes deficits to three main causes:
   — Local management problems.
   — Local health economy problems.
   — National policies and decisions.

6. Within this last category, the King’s Fund identifies implementing NICE guidance, centrally driven contractual changes for NHS staff and compliance with central targets. It cites some trusts as justifying spending in excess of income in order to meet targets to treat inpatients, outpatients and casualty attendees within a certain time limit. This has involved increased unfunded activity and in some cases the drawing up of contracts with the private sector to treat patients or hiring locum and agency staff.

7. The King’s Fund also identifies changes in accounting practices and financial regimes as having a substantial impact, in particular the introduction of resource budgeting.

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8 http://news.bbc.co.uk/1/hi/health/4489164.stm
8. At PCT level some annual audit letters for 2004–05 hint at higher levels of activity than expected and inadequate risk management arrangements. Some however suggest underlying problems in the local health economy. It is worth looking at one SHA by way of example. In this SHA—Bedfordshire and Hertfordshire—11 out of 17 NHS trusts reported deficits in 2004–05 and aggregate deficits totalled £65 million. There were clearly some accounting issues present since the pre-audited position showed deficits totalling £47 million. The position at mid-year 2005 had worsened considerably to a forecast deficit for 2005–06 of £90 million.10

9. Drilling down to trust level, one trust—Bedford Hospital NHS Trust incurred a substantial deficit of £8.5 million in 2004–05 but did meet the other financial targets for the year including remaining within its external financing limit.11 The reasons behind its deficit were diverse:

— overspent budgets and savings not delivered of £1.2 million;
— the need to continue access spend, and the lack of funding for additional activity £4.1 million;
— Agenda for Change and the new consultants contract were higher than budgeted by £1.3 million, and
— the PCTs and the Workforce Development Confederation did not have the resources to continue the support that had been available in 2003–04 of £1.6 million.

10. This pattern of contribution is not atypical and suggests that commentators blaming deficits on unexpected consequences arising from new national contracts for nurses, doctors and others were being overly simplistic. Indeed in answer to the Health Committee’s questionnaire, the Department of Health attributed 30% of the increase in revenue spending on the NHS in England to pay.12 This represented some £1.74 billion or 4.35% of the overall pay bill.

11. Incomes Data Services has analysed the labour market issues around the deficits in some depth and points out that, over the four years to March 2005, paybill per head in the NHS grew at 6.5% per year compared with 5% for the whole public sector—a period covering the implementation of the new consultant contract and additional awards to key nursing staff by the Nurses Pay Review Body. It also points out that there were 45,000 more jobs in the NHS in the 12 months to September 2005. It concludes that, whilst considerable resources had been invested in pay in the NHS over the last few years, most of it was planned

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to reward nurses and other front line staff and the service has expanded. The paybill and the reasons for its growth it argues should not be used as a scapegoat for financial crisis in the NHS.13 It remains the case that with average hours of work at around 50 per week and contracted programmed activities (PA) rewarding only 44 of these, consultants continue to prop up an inadequately resourced system at local level.

12. Another driver of deficits for some trusts is the expenditure stream to contractors under the Private Finance Initiative (PFI). This has the capacity to significantly distort trust finances. In its Public Interest Report (PIR) on the Queen Elizabeth Hospital NHS Trust, its auditors highlighted the impact of its PFI obligations on its financial status.14 The trust’s deficit was some £19.7 million. The fixed amount payable to the PFI partner is approximately £15 million per year, increasing annually with inflation. This amount cannot be reduced, even if activity levels fall significantly. There is also a variable element to the contract which the auditors quote the trust believing to be more expensive than the equivalent cost for a non-PFI trust. In all, the Trust believes itself to be facing excess PFI costs of £9 million. Without this excess, the Trust believes that it would now have a reference cost index of below 100 (the level at which a trust is as efficient as the national average) as against its current 103—down from 112 over the last four years.

13. Consultants also draw attention to the impact of private sector contracts for treatment on trust and PCT finances. Their fears about the sums earmarked for NHS treatment in Independent Sector Treatment Centres (ISTC) and the poor value for money some of these represent are borne out by the King’s Fund whose trawl through auditors’ PIRs identified contracts drawn up with the private sector to treat patients in order to meet targets as one contributor to trust deficits. Indeed, one trust spent £2 million in one year on private treatment, which accounted for a quarter of its deficit for that year.15 Whilst NHS trusts are having to cut back on services, PCTs are still tied into overtly favourable contracts to ISTCs, poorly coordinated and inadequately integrated with the needs of the surrounding NHS.

14. Although not directly related to local deficits, the high cost of system reform with its attendant transaction costs allied to substantial central expenditure (as on for example information technology) inevitably reduces the amounts available within the spending envelope for allocations to PCTs and makes it difficult to implement financial recovery plans. Management changes consequent upon reorganisation are also not without cost both direct and through inefficiency.

CONSEQUENCES OF DEFICITS

15. There seems little doubt that one consequence of the deficits has been job losses in NHS trusts. The nature and scale of these seems difficult to ascertain. Evidence collected by the BMA’s Communications Directorate from media reports (Appendix 1) suggests that job losses whether from natural wastage, redundancy or other mechanisms total over 11,000. NHS Employers has dissected press reports covering 3,700 reported job losses ascribing around 600 to actual redundancies.16 A systematic trawl through NHS trusts using the BMA’s Employer database showed that 16% of the trusts for which information was recorded had recently announced job losses. In almost a third of the trusts that had announced job losses, the trust had confirmed that the losses were to include doctor posts. The majority of the trusts losing doctor posts were acute trusts (65%, 13/20).

16. There is also widespread cutting of training. This has involved reducing study leave budgets and freezes on non statutory training. Budgets held by deaneries are also vulnerable with senior figures in strategic health authorities and deaneries being warned that their budgets for 2006–07 are likely to be cut by 10%.17

Sue Marks
British Medical Association
June 2006

15 Deficits in the NHS. Op cit.
APPENDIX 1

JOB LOSSES IN NHS TRUSTS BASED ON A SELECTION OF MEDIA REPORTS

<table>
<thead>
<tr>
<th>Trust</th>
<th>Detail</th>
<th>Job losses</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital North Staffordshire</td>
<td>Including 750 compulsory redundancies</td>
<td>1,000</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Co. Durham &amp; Darlington Acute Hospital NHS Trust</td>
<td>Consultants leaving or retiring may not be replaced</td>
<td>700</td>
<td>23/3/06</td>
</tr>
<tr>
<td>Worcestershire Acute Hospitals NHS Trust</td>
<td>Includes doctors, nurses and admin workers over next 12 months. Deficits accumulated are worth £31.5 million over several years</td>
<td>720</td>
<td>Guardian</td>
</tr>
<tr>
<td>Gloucestershire Health NHS Community Medway NHS Trust</td>
<td>Closing a string of Community Hospitals—deficits of £38 million Recruitment freeze and not replacing staff who leave</td>
<td>500</td>
<td>Trust PR</td>
</tr>
<tr>
<td>Surrey &amp; Sussex healthcare NHS Trust James Paget Healthcare Trust</td>
<td>Two year plan to eliminate its £41.2 million debt Hopes to reduce jobs through normal turnover and removing jobs that are currently vacant. Hopes to reduce budget by £4 million</td>
<td>400</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Royal United Hospital, Bath</td>
<td>650 bed hospital to axe posts. Will stop using agency staff, close beds “as soon as clinically possible”</td>
<td>300</td>
<td>5/4/06</td>
</tr>
<tr>
<td>York Hospitals NHS Trust</td>
<td>Cutting jobs to save £2.5 million. Partly blame Selby &amp; York PCT which buys services from the hospital as part of a plan to reduce total debts of £27.3 million in 2005</td>
<td>200</td>
<td>7/4/06</td>
</tr>
<tr>
<td>Royal Cornwall Hospital Trust</td>
<td>Secretarial and managerial roles to go as well as closing wards and theatres in a bid to tackle a deficit of £8.1 million. Claim the losses would be voluntary</td>
<td>300</td>
<td>7/3/06</td>
</tr>
<tr>
<td>Plymouth Hospitals NHS Trust</td>
<td>Derriford Hospital in Plymouth announcing cuts due to £22 million budget shortfall. Hopes to keep redundancies to a minimum “We have earmarked 74 posts for possible redundancy”</td>
<td>200</td>
<td>BBC Online</td>
</tr>
<tr>
<td>N. Tees &amp; Hartlepool NHS Trust</td>
<td>Need to balance budget by £10 million. Claim most will be through current vacancies and managerial &amp; support departments</td>
<td>74</td>
<td>23/3/06</td>
</tr>
<tr>
<td>Mid Staffordshire Gen Hospitals NHS Trust</td>
<td>Needs to save more than £10 million over the next year. Claim majority will go through natural turnover</td>
<td>150</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Brighton &amp; Sussex Uni Hospital Trust</td>
<td>Hope to cut budget by £2 million in the coming year via natural wastage from doctors to cleaners. Will shut an operating theatre</td>
<td>325</td>
<td>29/3/06</td>
</tr>
<tr>
<td>Peterborough &amp; Stamford Hospital NHS Trust</td>
<td>Aim to cut temp and reduce number of permanent staff. Debts of £28.6 million</td>
<td>185</td>
<td>BBC Online</td>
</tr>
<tr>
<td>West Herts Hospital NHS Trust</td>
<td>Wants to reduce costs by £20 million</td>
<td>800</td>
<td>PA 13</td>
</tr>
<tr>
<td>Sandwell &amp; W Birmingham NHS Trust</td>
<td>100 beds cut. £13 million deficit</td>
<td>480</td>
<td>FT p4</td>
</tr>
<tr>
<td>Royal Free Hospital, N London</td>
<td>£5 million deficit</td>
<td>250</td>
<td>BBC Online</td>
</tr>
<tr>
<td>East Sussex NHS Hospitals Trust</td>
<td>£38 million deficit</td>
<td>300</td>
<td>25 April</td>
</tr>
<tr>
<td>Royal Wolverhampton Hospital</td>
<td></td>
<td>300</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Princess Royal &amp; Royal Shrewsbury Hospitals</td>
<td></td>
<td>300</td>
<td>25 April</td>
</tr>
</tbody>
</table>

Debts of 12 April06 £28.6 million

25 April 2006
<table>
<thead>
<tr>
<th>Trust</th>
<th>Detail</th>
<th>Job losses</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital NHS</td>
<td>Save £10 million</td>
<td>100</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Trust, Woolwich</td>
<td></td>
<td></td>
<td>25 April</td>
</tr>
<tr>
<td>Queen Mary’s, Sidcup</td>
<td></td>
<td>190</td>
<td>BBC Online</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25 April</td>
</tr>
<tr>
<td>Western General Hospital (West.</td>
<td>£6 million overspend—close 56 beds</td>
<td>60</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Super Mare)</td>
<td></td>
<td></td>
<td>26 April</td>
</tr>
<tr>
<td>Norfolk &amp; Norwich University</td>
<td>£14.8 million budget deficit</td>
<td>450</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td>26 April</td>
</tr>
<tr>
<td>Norfolk &amp; Norwich University</td>
<td>Further announcements of job losses</td>
<td>145</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Hospital</td>
<td>inc between 65–80 redundancies</td>
<td></td>
<td>22 May</td>
</tr>
<tr>
<td>Kennet and W. Wilts PCT</td>
<td>Managerial and admin posts</td>
<td>80</td>
<td>BBC Online</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>28 April</td>
</tr>
<tr>
<td>Royal Wessex NHS Trust</td>
<td>£13.9 million deficit</td>
<td>200</td>
<td>Trust PR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 May 2006</td>
</tr>
<tr>
<td>Pennine Acute Trust</td>
<td>£21.3 million deficit</td>
<td>800</td>
<td>Trust PR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 May 2006</td>
</tr>
<tr>
<td>Southport &amp; Ormskirk NHS Trust</td>
<td>Must save £10 million this year</td>
<td>200</td>
<td>BBC Online</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11/5/06</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS</td>
<td>Need to save £84 million over next</td>
<td>430</td>
<td>BBC Online</td>
</tr>
<tr>
<td>Trust</td>
<td>three years</td>
<td></td>
<td>11/5/06</td>
</tr>
<tr>
<td>St Georges Hospital, London</td>
<td>Asked by Govt to speed up reforms and</td>
<td>100–150</td>
<td>Trust PR</td>
</tr>
<tr>
<td></td>
<td>balance books within one year</td>
<td></td>
<td>17/5/06</td>
</tr>
<tr>
<td>Oxford Radcliffe NHS Trust</td>
<td>Needs to make savings of £33 million</td>
<td>600</td>
<td>BBC Online</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25/5/06</td>
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**Evidence submitted by Dr Peter Carter (Def 15)**

1. I am the Chief Executive of the Central and North West London Mental Health NHS Trust (CNWL). I have been an NHS Chief Executive for 11 years and have worked in the NHS for over 30 years. I commenced my NHS career by training as a psychiatric and general nurse.

2. This submission is a personal perspective which has been made with the knowledge of the CNWL Trust Board but I wish to be explicit that the views are entirely my own.

3. The CNWL Trust is a large mental health trust that provides services primarily to the Central and North West London area but also has a number of regional and national services. The Trust employs approximately 3,000 staff and has an annual budget of £177 million.

4. The Trust’s financial track record has been exemplary and for 11 consecutive years has balanced its books and met all of its financial targets. I wish my submission to be considered as coming from an organisation that has an absolute commitment to stable NHS finances and the need to balance the books and account for the use of public money. I will be returning to this point later in my submission since I believe that it is important to highlight the context within which financial balance has been maintained.

5. Under the Healthcare Commission’s rating system for 2004–05 the CNWL Trust was awarded Three Stars and some of its services attract widespread respect both nationally and internationally.

6. The reason I am making this submission to the Health Committee is because I have very strong concerns about the current financial predicament in which the NHS finds itself. I am only too mindful that a precarious financial position impacts very quickly on the provision of clinical services to patients. I also believe that Trusts such as ours provide services to individuals who often have no voice and whose interests can be lost at times of crisis in the NHS.

7. Overall I find it a matter of serious concern that following a period of record investment since 1997 that the NHS should find itself in a situation where there are widespread service closures and redundancies across the NHS. I also believe that the declared redundancies and service closures do not tell the whole story and that many PCTs and Trusts are having to balance their books by deleting existing vacancies, by freezing recruitment or not carrying forward planned developments. Additionally I am aware that PCTs are also withdrawing, or reducing, funding to service providers in addition to NHS Trusts. This includes private provision, local authority section 28A agreements, non-statutory services and others. Therefore in calculating the extent of service reductions it is necessary to look across the health economy and not only at NHS Trusts. Put another way, there are a whole series of cuts, which are not declared, and therefore could be described as “cuts by stealth”. This will not necessarily be apparent to MPs or many of their constituents but will certainly be readily apparent to service users, carers and the staff of Trusts and PCTs.

8. To help the Health Select Committee understand my perspective, I thought it might be useful to outline what I believe are the antecedents of the current financial crisis in the NHS.
THE REASONS FOR THE DEFICITS

PCTs/SHA

9. I believe that there is a systemic underlying problem with the NHS structure, which is actually well known and currently acknowledged but nevertheless, for the purpose of this paper, is worth repeating. The government was poorly advised when, after being elected in 1997, they embarked on the abolition of the then Regional Offices and Health Authorities. At the time there were 100 Health Authorities and 303 PCTs were created in their place. In London, for example, there was one Regional office, which became five Strategic Health Authorities. This was ill considered for a number of reasons, as outlined below.

10. It is well chronicled that the NHS has a habit of re-organising in times of crisis, and that the government were too quick to do this on the back of what had been, for decade or more, a very difficult period within the NHS. The irony is that the 100 Health Authorities had begun to mature and had developed into good strategic and commissioning agencies, and the fruits of that maturity were beginning to be realised.

11. To move to 303 PCTs in a short space of time created a number of difficulties. The first was that it meant a massive expansion in the number of senior and middle managers, which overnight began to make a significant drain on NHS financial resources. In addition, there was a lack of recognition that there was not necessarily the talent to fill all of these posts; it presupposed that there were an additional 200 + Chief Executives, Directors of Finance, Directors of Commissioning and Directors of Public Health etc, in waiting. Quite aside from the fact that setting up these organisations in terms of headquarters and infrastructure resulted in a significant call on the new financial resources that the government was undoubtedly putting into the NHS. We therefore had a situation where new bodies were being set up, I believe, quite unnecessarily and then being led by a cadre of senior managers who, in many cases, were not of sufficient calibre to govern effectively. I was also aware that many PCTs could not fill some senior posts for several months, which meant that their Boards were simply not on top of a challenging and fast moving agenda. The folly of this expansion has been recognised and PCTs outside of London are now being merged.

12. It should also be noted that across the country new Regional Health Authorities are being established from July. This, for example, means that In London we have in the last four years moved from one London Regional office to Five Strategic Health Authorities and back to one London-wide office again. The money spent on these reorganisations, the energy expended and disruption caused to strategic planning, actively detracts against implementing the modernisation agenda effectively in order to deliver improvements to patient care. It has to be acknowledged that these changes have been driven centrally and therefore the DH must be held accountable for this.

13. The purpose, among others, of Commissioning a Patient Led NHS was to reduce significantly the number of PCTs. However, I understand that a lobby by some London MPs to the Secretary of State resulted in this decision being postponed. In my opinion this was a fundamental error and the reason I concentrate on the antecedents to the problems experienced by the NHS, with the creation of the PCTs, is that the result of that expansion is one of the fundamental reasons for the NHS’s current financial predicament.

14. The current structures are wasteful. For example, CNWL relates to five London Boroughs where we provide all mental health, substance misuse and related services and three other Boroughs where we provide substance misuse services. This results in CNWL having the same discussion with eight different PCT’s on substance misuse services and with five PCT’s on core mental health provision. Not only is there this considerable duplication, there is also significant variation in the calibre of the commissioners knowledge and understanding of mental health service provision. This could easily be avoided and I am suggesting, not only a demise in the number of PCTs but the creation of some overarching expert commissioning arrangements which would obviate the need for duplication. I find it interesting that the PCTs were quick to lobby for their own preservation when, last summer, it appeared there would be a diminution in their number but have not been so proactive in lobbying to preserve clinical services which I believe throughout the capital, in all specialties, are currently subject to cut-backs. I believe that the PCTs should be prepared to take a pro-active approach to merge with a view to realising financial savings, which could be used to obviate the needs for cuts in clinical services.

15. In summary, therefore, the result is an unhealthy combination of government policy decisions that had not been properly thought through in the creation and the role of PCTs, being compounded by too many PCTs having senior and middle managers that were not sufficiently experienced at working at that level. The lesson for the NHS must be never to undergo such a rapid expansion in services again without (a) being clear that the expertise is available to run these organisations and (b) ensuring that the tier of management above is in a position to adequately govern and manage.
16. I would like it noted that CNWL also has some excellent colleagues working in PCTs, some of whom have been highly effective and dedicated despite the challenges they have faced. However there has also been major turnover and change in key personnel in some PCTs, which has further compounded difficulties in delivering effective and efficient commissioning.

**Pay Awards**

17. The effect of pay awards is something I believe has been overstated and that whilst CNWL, like others, has been obliged to implement *Agenda for Change* and the Consultant Contract I certainly do not see this as the root cause of the current financial predicament. In fact CNWL implemented the Consultant Contract and *Agenda for Change* within the financial envelope it was allocated. However I do acknowledge that the increased pay bill has contributed to the growing financial pressures in the NHS because they have come on top of a loss of sound financial management in many organisations. It would also be accurate to say that the pay rises have not in most cases lead to an increase in productivity. For example, most of our consultants were already working extremely hard for the NHS.

**Turnaround Teams**

18. I understand why the Secretary of State thought that “Turnaround Teams” might be a sensible way forward in addressing the current difficulties. However, I believe the thinking is fundamentally flawed. The reason why I say this is that the Turnaround Teams do not meet with all of the constituent members of any local health economy. In the North West London area there are 2 PCTs that have Turnaround Teams, Hillingdon PCT and K&C PCT. Neither of these Turnaround Teams has met with the Trust to ask our views on why these 2 PCTs have overspent. Our only contact with them has been to discuss what money can be pulled out of mental health services.

19. The relationship between the funding formula, the allocation to Trusts and the size of the Trust and their deficits or surpluses has not been fully explored. I, and many others, are particularly concerned that capitation formula that include weighting for mental illness scores are not being applied when evaluating relative spend on services. Crude and misleading data is being used to make hasty decisions about levels of investment and therefore, ultimately, levels of service provision. Given the obvious pressure that PCTs are feeling from the financial imperatives and the presence of the Turnaround teams, I believe short-term crisis decisions are being made which will have negative long-term impacts on patient care. I ask the Committee to ensure that the importance of weighted capitation formula adjusted for mental illness scores, is highlighted. It should be applied to any bench marking or comparisons in the cost of services. If it is not routinely applied then inner city mental health services (which attract a very high incidence of mentally ill people) will be seriously disadvantaged. The same is also true of the application of the market forces formula.

20. Another key concern that I have about the Turnaround Teams is that they may not fundamentally improve the financial culture and management of the NHS. I believe that strong financial leadership and management must come from Trust Boards and permeate deep into organisations with managers and clinicians alike owning the need for tight financial accountability. Within CNWL, (as mentioned earlier), we have a strong track record of good financial management. This is not something that has just happened. At times it has been very tough. However, through the ownership and efforts of our managerial and senior clinical staff we have balanced our books. The Trust Board has been given significant support from our clinical staff in the belief that financial prudence would actually promote stability of service provision and, therefore, better care for patients. It is extremely concerning that despite our excellent track record we are now being pressurised from nearly all of our PCTs to reduce services.

21. For the purposes of demonstrating a point I will use the Kensington and Chelsea (K&C) PCT as a case study. The K&C PCT has a declared deficit of £24 million. As a consequence of their financial failure, an inquiry was commissioned and serious criticisms that are in the public arena have been levelled at the PCT.

22. To address the financial situation, a Turnaround Team has been brought in and the remedy is to seek to cut services across the board in order to present a balanced budget. This I believe, far from resolving the matter will compound it. In the financial year 2004–05 the K&C PCT set a budget in relation to the CNWL Trust, which amounted to £28.8 million. CNWL stayed within budget, met all of its financial targets and duties and met all of its clinical and activity targets. There were however a number of K&C PCT contracts which exceeded their budgets: some of these were the directly managed services from K&C plus others, particularly in some of their acute hospital Trusts. In addition the Inquiry concluded that there was a lack of financial control in the PCT. The suggested remedy is that all Trusts, with whom K&C PCT have contracts, should take a percentage reduction in revenue to redress this situation. This is not a solution because it does not actually address the root cause of the overspend and by simply spreading the agony there is no guarantee that the steps will be put in place that will actually solve the original cause of the overspend. It also flies in the face of common sense, not to mention good financial management. To penalise organisations that have stayed within budget, with high levels of support from senior clinicians, further
serves to fuel a growing lack of confidence in the DH to implement sound financial management. It frankly also makes the job of Boards, such as our own, more difficult because the reward for our successful financial management is to be penalised along with every other organisation (and in fact in many areas, more heavily).

23. The Secretary of State, has, in a number of public forums, repeatedly stated that Trusts who are performing well would not be affected by the financial crisis and that the days are gone when others should simply bail out poor performing trusts. In reality, this is exactly what has happened. Having done everything that has been asked of us, I find it quite wrong that front line mental health clinical services are being reduced to bail out difficulties elsewhere in the system. Of even more concern in recent weeks, there appears to be a growing view from some PCTs that, if we have stayed in budget, we must be over funded. It is as if the belief within the health economy is that it is only possible to break even if you have too much money. This does not bode well for some of the cultural change that I believe needs to take place within the NHS.

24. CNWL has just taken over responsibility for the mental health services in Hillingdon, which until 1 April this year were managed by the Hillingdon PCT. The declared deficit was £32+ million. This is an appalling state of affairs, which was built up over the past five years. There has been a change of Chairman and CEO of the PCT and a new senior management team has been appointed. However the Department of Health is insisting that the financial position is resolved in the financial year 2006–07; i.e. that the entire deficit is paid back within a matter of months. This is an ill-considered approach. The PCT should be placed on the equivalent of “special measures” and a 3-year rescue plan should be adopted. I believe both the Prime Minister and Secretary of State are not being properly briefed and do not fully appreciate, not only the root cause of the current problems but that the remedies far from resolving the issues will, in the not too distant future, be exposed as fundamentally flawed. I say this for the following reasons.

25. First of all, the investment in the health service since 1997 has been truly impressive. It therefore might be of some interest to the Committee that as a health service manager who had managed throughout the 80s and 90s, I would have never envisaged that a government would have actually made the level of investment that it has. Further, had I been asked to comment, on the net effect of this investment, never in my wildest fantasies would I have believed that after years of such sustained growth, the NHS would have found itself in such a financial mess. Therefore, having invested so heavily, and now discovering that the investment is not reaping the benefits that it should have, the solution appears to be a series of random cuts predominantly aimed at those Trusts, which have stayed within budget. The second, and in some ways, more important reason why the current remedy should be resisted is that the solutions offered, far from saving money, will result in costing the NHS more money. A dire consequence will be to ruin the legacy that the government deserves for being prepared to invest in the way that it has.

26. Mental health services in London and in various parts of the country are currently under severe pressure to reduce expenditure and there are widespread cuts in services. These cuts involve a reduction in the number of acute mental health beds and very worryingly the cessation or reduction of some of the new teams that have been set up under the very welcome government initiative, The National Service Framework for Mental Health. Additionally, mental health services are being cut and reduced in non-statutory and local government organisations. These services have become an increasingly important part of the spectrum of provision which helps avoid admissions to hospital. If this continues, we will see beds on wards being blocked, as there are insufficient community based services to which to discharge patients. This will then produce difficulties for consultant psychiatrists when wishing to admit patients, as the remaining bed stock will be over committed and Trusts will not have the resources available to cope with demand. Clearly demand will not cease. As a consequence of this, the Trusts will be forced to place these people in alternative facilities. Some of it may be in the NHS however it will ultimately be where beds are available, which could be far from where the person lives. A cursory examination of the problems with mental health services in the early to mid 90s demonstrates that patients were often placed hundreds of miles away from where they lived. For residents from the London Borough of Brent it was not uncommon for people to be placed in Birmingham, Bristol or South Wales. The placement was simply determined by bed availability. However, what I also predict will happen is that the use of the private sector will be an inevitable consequence and the private sector has historically been much more expensive than the NHS. Therefore, plans that are currently being made will very quickly be exposed as shallow and far from saving money, additional expenditure will be incurred, and the downward spiral of financial crisis will undoubtedly accelerate. This is at odds with some of the thinking of our highly pressurised PCTs who believe CNWL needs to become competitive with the private sector in order to bring out costs down, when it is the very fact that we are so competitive that has helped to stem some of their overspends in the private sector.

27. As stated above, this Government introduced the long-awaited National Service Framework for mental health services. Overall this was a very good and very welcome policy document. However its objectives are currently being seriously undermined and the advances that have been made in mental health services over the past nine years are very quickly being compromised. It is also ironic that, at the very time that the White Paper Our Health Our Care Our Say is being heralded by the DH as the driver for more choice, more services closer to home and more community alternatives, these are the very services which are proving to be the “soft underbelly” of mental health service provision and therefore at greatest risk of being cut. Experience has demonstrated that those same community services are essential in preventing demand for high cost hospital admissions.
28. I would urge the Health Committee to seriously question the judgement that is being exercised by the Department of Health in the approach that is being adopted. I further believe that Ministers should find avenues and speak much more directly with a broader range of NHS Trust Boards and clinicians. It appears to me that Ministers are not being adequately briefed and are therefore disadvantaged in fully understanding the current difficulties. This was demonstrated when the Secretary of State had very difficult encounters with members of UNISON and the RCN at their National Conferences. Whilst I do not wish to comment further on the events of those conferences, what was clear was that the Minister did not fully understand the depth of feeling, which appears to demonstrate that this lack of understanding is because of a lack of an adequate briefing.

29. CNWL is typical of many mental health trusts and the financial scenario that we have currently been confronted with is as follows:

— Inflation for the NHS is 6.5%.
— Only 4% of this was passed on to Trusts and therefore Trusts were obliged to work up saving requirements of 2.5% which in CNWL’s case amounted to £5 million worth of service rationalisation.
— This was then further compounded within the London health economy by each Trust being asked to work up a further surplus of 1%, which to CNWL was £1.8 million.

30. These two savings targets of £6.8 million were already making life for CNWL very difficult. However we felt that we could sustain that without a major impact on patient care.

31. It was then decided centrally that, in order to bring the London health economy back to a balance, all PCTs should be levied an additional 3%. Many PCTs were simply unable to cope with the impact of this and have attempted to pass it onto their provider Trusts. By way of an example, the K&C PCT in addition to what has already been delivered, now wish to pull an additional £2.5 million out of the mental health services budget. This is unacceptable and if it were allowed to continue would seriously destabilise the services. As stated earlier in this paper, the remedy has to be to look at the root cause of the overspends and tie off those overspends in order to ensure that the poor financial performance is not repeated.

32. One of the other dimensions that has not been mentioned in the root cause of the overspends in the NHS in addition to the creation of PCTs has been the growth in the number of regulatory bodies that have been set up, for example:

— The Healthcare Commission.
— The National Institute for Clinical Excellence.
— The Commission for Patient and Public Involvement.
— The Commission for Social Care and Inspection.
— National Institute for Mental Health in England.

33. I hasten to add that some of these bodies are necessary and I particularly applaud the development of NICE, which was long overdue for the NHS and is proving its worth. However, with regard to some of the other regulatory bodies, not necessarily the ones listed above, the evidence for their effectiveness, has not been demonstrated. Rather than cutting first line clinical services, the role, efficacy and the necessity of some of these bodies should be closely examined.

34. I also find it very worrying that Ministers have been briefed that one of the causes of the overspend has been the Consultant Contract and the GP Contract. Whilst it is undoubtedly true that it did cost more than had been anticipated it is simply untrue to attribute so much of the current difficulties to those two factors.

35. There are ways in which the current crisis can be averted without widespread cuts in clinical services.

36. I have already mentioned that in London there should be a reduction in the number of PCTs and the infrastructure that supports those PCTs. For London the role and size of commissioning teams could be significantly reduced concentrating on some of the big overarching strategic issues. I am also of the view that there are too many Acute Hospital Trusts and that these should follow the example of Mental Health Trusts during the mid to late 90s who took it upon themselves to merge thus creating far fewer bodies. In the North West London Strategic Health Authority area in 1997 there were six NHS Trusts that provided all or part of mental health services in this area. There are now two Trusts. The benefits of this can not only be viewed in financial terms but also in a coherence over service delivery that simply cannot be realised if there are too many organisations that do not have a corporate approach to the many difficulties and challenges that face us.

37. As long ago as 1992 the then very welcome Tomlinson Report, made strong representation about the need to rationalise acute hospital provision in London. It is unfortunate that the then government did not adopt these recommendations and it is equally unfortunate that the newly elected government in 1997 appeared not to look at Tomlinson to examine if this could be solution to a problem that had been well known and documented. The King’s Fund Commission on the Future of London’s Acute Health Services 1992 warned “... that health services in London may become unsustainable unless there is the political will to back a strategy of fundamental reform.” It recommends “A radical programme of investment and
restructuring to reshape services to meet the challenges of the new century.” The same report goes on to say “large groups such as elderly people and those with mental health problems are especially disadvantaged.” A further quote, “acute care should be located on fewer sites and the provision of specialist services should be rationalised.” Failure to adopt the Tomlinson and Kings Fund recommendations has resulted in the concerns expressed in those two inquiries now being realised.

38. The problems of acute hospital over provision in London remain. There are too many Acute Hospital Trusts, far too many Acute Hospitals are overlapping and either duplicate services or compete for the same services. Unless the government is prepared to grasp these very difficult nettles then for the foreseeable future the systemic underlying problems will remain.

39. CNWL is committed to doing everything it can, as its record will demonstrate, to assist in ameliorating the current difficulties in the NHS. However, I would be failing in my duty if I did not bring to the Committee’s attention the flaws in the current methodology, which will simply not result in the solutions which are intended and needed.

40. In the interests of openness and transparency I am copying this submission to all of the MPs whose constituencies we serve and to the Chief Executives and Chairs of the 8 PCTs with whom the Trust has its principal contracts and the OSC’s to whom the Trust relates.

SUMMARY

41. The consequence of these deficits will result in a serious and almost instantaneous deterioration in the quality of care provided for people with mental health problems. Services which have been carefully established, fully in line with the modernisation agenda, will disappear or be reduced over the next few months and it will take years to rebuild them. One final illustration of how ill conceived this would be is that in Kensington and Chelsea the mental health spend used to account for approximately 16% of all health expenditure. It now accounts for 12%. This figure alone helps to demonstrate the fact that mental health services have not had a disproportionate impact on the application of new monies, nor caused the current crisis. They should be protected from the brunt of problems caused elsewhere.

42. The number of job losses and service cuts will continue to rise.

43. I would be willing to give evidence in person to the Committee if this would be helpful.

Dr P J Carter OBE
Chief Executive, Central and North West London Mental Health NHS Trust
5 June 2006

Evidence submitted by the Chartered Society of Physiotherapy (Def 16)

INTRODUCTION

1. The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the 47,000 chartered physiotherapists, physiotherapy assistants and students in the UK. The CSP is pleased to give written evidence to the Health Committee and would wish to provide oral evidence if called upon.

CAUSES OF NHS DEFICITS

2. The CSP strongly refutes the allegations made in some quarters that the main reason for the financial deficits is the cost of implementing the Agenda for Change agreement, or that the costs of the consultants’ contracts is the real cause. As both the Health Service Journal and the former director of human resources at the Department of Health, Andrew Foster, have commented, “there is a series of urban myths of why we are in the situation we are in” and “quite a blame game going on” (‘Consensus on the reform agenda has broken down’, HSJ, 27 April). In his outgoing HSJ interview, Mr Foster described the current situation as follows:

‘Within the ‘commentariat’ [media commentators] you will see the assertion that pay reform has caused the overspend the NHS is suffering, that it has been badly thought out, was never properly modelled, that it was conceived of in the ivory tower of the DoH without involving NHS managers and that it has produced little or no benefits . . . Every single one of those is completely untrue. I’m very concerned that they are becoming too widely accepted.’

The CSP, having been involved in the Agenda for Change negotiations right from the start, shares this concern. One of the main aims of the NHS pay reforms has been to achieve fair and equal pay in the NHS and, as NHS Employers acknowledge, this has been “long overdue”. Pay modernisation must, therefore.

be fully funded by the Government and properly implemented by all NHS employers. In our view, it is essential that Ministers and NHS Trusts themselves take responsibility for allowing the NHS to fall into this state where the constant talk of financial “crisis” and failure is damaging staff morale and patients' confidence in the Service, and that they do not take the easy option of blaming pay modernisation for the deficit problems.

3. A less disingenuous view would acknowledge that the current financial situation has not been helped by the insistence that overspending should be paid for from the 2006–07 budgets. The CSP believes that organisations should be given a longer, more realistic timescale to address their deficits.

4. It should also be acknowledged that the Government’s new centrally fixed pricing system (payment by results) has also caused serious problems for Trusts in setting budgets for this financial year—because of delays in setting tariffs and the sudden withdrawal of the original tariffs at the last minute before implementation was due. This is illustrated by the experience of four children’s hospitals—Great Ormond Street, Alder Hey, Birmingham and Sheffield—who reported a shortfall of £22 million because of an “inaccurate and highly insensitive tariff” (“Children's hospitals warn ministers of £22 million funding crisis”, The Guardian, 18 April).

5. A further contributory factor to the cause of the NHS deficits is the siphoning off of NHS funds to the private sector as the Government constructs a competitive market in health. It is notable, for example, that Patricia Hewitt’s maiden speech as health secretary was to announce that £3 billion was to be made available to Independent Sector Treatment Centres to help reduce waiting lists. While supporting the objective of reducing waiting lists, the CSP is concerned over the broader policy of introducing greater competition into the health service and, more specifically, the future role of alternative providers in delivering NHS services and how this will further impact on NHS resources. We are unaware of any evidence-base to support the policy decision of introducing greater competition in the health service with the aim of improving quality. In the absence of such evidence, we do not believe that the risks—including financial risks—of introducing a multiplicity of service providers have been properly thought through. What will happen when outsourced NHS contracts come up for renewal, in a fully competitive market, is of particular concern. For example, the consequences of a social enterprise company employing staff transferred from the NHS under the TUPE Regulations losing a future contract have not been fully explored. This represents a massive gamble with precious NHS resources, a gamble which has potential implications for fragmentation and destabilisation of services; making joined-up care harder to provide; the erosion of local accountability, governance and standards; and the undermining of staff pay, jobs and training and development opportunities.

6. In the light of the consequences for the NHS of services and staff being cut back as a result of the current financial situation, we question the wisdom of the Government continuing with its policy of outsourcing work to the private sector at preferential terms, for example through Independent Treatment Centres which, in some cases, have been documented to be six times more expensive than the NHS rate (“PCTs paying ITC six times normal cataract rate”, HSJ, 23 March). The cost to the NHS of providing adequate rehabilitation—including physiotherapy—to patients who receive treatment such as hip operations from non-NHS providers needs to be taken into account when judging value for money and when assessing the appropriateness of the ITC programme.

7. Similarly, concerns exist over the cost of PFI projects and the long-term financial burden that they are posing to NHS organisations.

8. It is perhaps the case that the organisations of the NHS are suffering from not being sufficiently championed, and that the focus of debate is overwhelmingly on the negative. It should not be forgotten, amid all the concerns over the deficits, that the NHS possesses an established resource of highly skilled and experienced staff and we should concentrate on the many positives of the NHS, promoting and encouraging good practice, before we abandon the NHS for the road leading to greater ‘privatisation’. We therefore call on the Government to rethink its policy of introducing greater competition into the NHS. Private and voluntary sector providers should be used to enhance NHS delivered services rather than replace them.

**Effects of NHS Financial Situation on Physiotherapy Services**

9. During the early months of 2006 the CSP received strong anecdotal evidence from our members of the detrimental impact on services that NHS deficits were causing. As a result, we undertook a survey of CSP workplace representatives to establish concrete evidence of the extent and nature of the problem.

10. At the beginning of April 2006 questionnaires were sent to CSP trade union representatives in all 405 NHS organisations across the UK in which physiotherapists are employed. The representatives (workplace stewards) were asked to co-ordinate their responses locally to ensure that we received one completed survey form from each organisation. The survey was undertaken in conjunction with the Royal College of Midwives who undertook a similar survey of their members.

11. The CSP received responses from representatives in 199 organisations across the UK (a response rate of 49%) with the majority (172) coming from NHS employers in England.
12. Our survey revealed that across the UK, 65% of employers were heading for an overspend. This reflected the results for England (65%), but the situation was worse in Wales where 88% of those who responded reported that their organisation was going to be overspent. In Scotland and Northern Ireland, the situation was not quite as bad but still poses a serious cause for concern, with figures of 54% and 34% respectively.

13. In answer to questions about how much information stewards were receiving from their employer on the financial situation, we found that across the UK the majority of stewards (59%) felt that they had been kept very well informed, with only 7% saying that they had received little or no information. Northern Ireland had the worst record, with not one of the respondents saying they were very well informed and the vast majority (83%) saying that they would have liked more information.

14. Our survey also asked for detailed information about the impact that the financial situation was having on physiotherapy services. Only a tiny number of respondents said that there were direct threats of redundancies for physiotherapy staff—just three in England and one in Scotland (although several expressed concern that this could be a possibility in the coming 2006–07 financial year). Since carrying out the survey the CSP has become involved in consultations with NHS organisations about a number of potential redundancies and so we expect the numbers of physiotherapists actually made redundant to increase during this financial year.

15. However, the financial deficits are having an even more serious impact on vacant posts. One in five respondents to our survey across the UK and within England reported that vacant physiotherapy posts were being permanently lost from funded establishment. The situation in Scotland and Northern Ireland was only marginally better. Over a quarter of all respondents reported that vacant posts were automatically being frozen and this was having a particularly severe impact in Northern Ireland with 50% of respondents affected.

16. In the CSP’s written evidence to the Health Select Committee inquiry into workforce planning in the NHS earlier this year, we highlighted the fact that inadequate workforce planning had led to unprecedented numbers of newly qualified physiotherapy graduates being unable to find employment as junior physiotherapists in the NHS. Research undertaken by the CSP in the past has shown that over 95% of graduates take up employment in the NHS on qualifying in order to be able to undertake a range of rotational placements in various clinical areas to allow them to consolidate their undergraduate education.

17. Since 2004 the CSP has been tracking the employment status of all physiotherapy graduates in the UK. Our latest survey (undertaken in January 2006) has shown that of the 2,172 students who graduated in 2005, approximately one third have been unable to find work within the NHS. Each of these graduates has cost the taxpayer an average of £28,500 to train. The financial situation, the loss of vacant posts from funded establishments and the lack of flexibility that tight financial controls have brought about mean that it is likely to become even more difficult for physiotherapy managers to be able to fund junior posts for newly qualified physiotherapists. In 2006 approximately 350 more physiotherapists will be graduating than in 2005 and it is imperative that job opportunities are created for them otherwise these graduates are increasingly likely to seek alternative careers. The NHS is in danger of losing them altogether, which would result in an enormous waste of public money and talent that the NHS will need in the future.

18. Our survey into the NHS financial situation found that even where funding for posts was available there were severe delays in filling vacant posts. The majority of UK employers (52%) had instigated some form of control mechanism which was leading to delays such as setting up review panels to review all requests to fill these posts. One of the most significant impacts was the restrictions being imposed on the use of agency and locum staff, with two thirds of respondents’ organisations affected across the UK and within England and Wales and nearly half of Scottish respondents. The combination of these cutbacks is resulting in increased workload for remaining staff, with resulting increases in stress and sickness absence along with a significant deterioration in staff morale.

19. The CSP is also very concerned that physiotherapy training budgets have been hard hit with nearly half of UK and English respondents reporting that they had experienced cuts and two thirds affected in Northern Ireland. Several of our workplace stewards commented that the costs of training were funded from surpluses in budgets and with these disappearing so too was finance for training courses, highlighting the fact that many physiotherapy departments do not have money ringfenced for training purposes. This raises serious concerns about how physiotherapists will keep up to date with CPD requirements and how the Knowledge and Skills Framework (KSF), which the CSP strongly supports, can be properly implemented. The KSF underpins the whole Agenda for Change pay framework and the increased career development opportunities it would bring was one of the major reasons why CSP members voted overwhelmingly in favour of Agenda for Change in 2003. The long-term consequences of an easy, short-term expediency—a squeeze on training—should not be underestimated: training cuts are detrimental to NHS physiotherapists and their patients.

20. In terms of withdrawal or suspension of services as a result of the deficits, Wales reported the most severe impact with 38% saying that some specialist services had been suspended or withdrawn altogether. Across the UK as a whole this was reported in 16% of organisations, and again, we expect this impact to worsen during the 2006–07 financial year. Services which were particularly badly hit included those that have
traditionally suffered from a lack of investment such as care of the elderly, paediatrics and domiciliary services. Out patient services had also been badly affected in some areas and this can only have a detrimental effect on achieving the Government’s targets to reduce waiting times.

21. Further to our postal survey on the impact of the NHS deficits on physiotherapy services, and in order to put some “flesh on the bones” of our raw survey data, we undertook a follow up telephone survey of over 30 CSP stewards in England. The information received from the telephone follow up confirmed the picture initially obtained, namely:

— Significant increases in waiting times for physiotherapy treatment are being experienced, with musculoskeletal outpatients the worst affected, but also access to paediatric services, learning disabilities, older patients and those with long-term conditions. Examples include:
  — in North Staffordshire, waiting times for musculoskeletal outpatients were reported to have increased from 36 weeks to 47 weeks, and waiting times in respiratory from zero to four months;
  — one trust in the West Midlands reported community physiotherapy waiting times to have increased from one week to six weeks;
  — in Kent and Yorkshire, waiting times increased to six-seven weeks from two weeks previously, with musculoskeletal, rheumatology and neurology patients most affected;
  — a doubling of waiting times from four to eight weeks in Thames Valley, Kent and the North West;
  — in the North East, outpatient waiting times increased up to three months;
  — in the East Midlands, routine waiting lists reported to have increased to 43 weeks and rising
— In terms of services being cut or withdrawn, outreach community work in GP surgeries and patient homes were mentioned the most frequently, but also hydrotherapy services, women’s health, mental health, respiratory rehabilitation, amputees, falls and exercise clinics were also being affected.

22. In our telephone survey, we asked whether our stewards would be willing to go “on record” with their comments about the impact of the NHS deficits on their physiotherapy services. Regrettably, very few felt confident to have their comments attributable to them. This reflects badly on the atmosphere currently prevailing in the NHS where openness on the impact of the deficits is actively discouraged. The few exceptions to this came from stewards in trusts where, thanks to public campaigning, information on the deficits is already out in the public domain (eg University Hospital North Staffordshire). Below are a selection of comments received—suitably anonymised—which illustrate the reality of how the deficits are being felt “on the ground” by physiotherapists:

“There’s no strategy”
“We’re cutting services. We’ve less staff and more referrals. Our inpatients’ is running on a skeleton service. The GP’s are going for private physios because they’re fed up with the service they’re getting”
“The GP’s are looking towards private providers if our waiting lists don’t improve. We’ve lost staff through stress and vacancies are not being filled”
“It’s a bit of a disaster. There’s nowhere for juniors to move up”
“We’ve been told that if waiting times aren’t reduced there’ll be trouble. It’s all negative. The situation’s very bad. Nobody’s happy”
“Consultant referrals have gone up a lot with no extra resources and GP referrals are suffering as a result. We’re understaffed by all national guidelines”
“We have a vacancy appeals panel but vacancies are not being released, therefore waiting times are going up”
“Our waiting time target was 5 days for urgent musculoskeletal but we’re struggling with them”
“We’re not able to offer as good a service as we’d like”
“It’s affecting our professional autonomy because everything’s based on finances and not efficacy. We’re worried that if we provide a sub-standard service then PCTs will not commission us because we’re not operating to best standard—standards and patients’ recovery are definitely under threat. It’s ruining the relationship between physio and the GP surgery”
“Consultants are getting angry. Patients are frustrated. Staff are upset”
“Our situation is very bad. There’s no cause for optimism. We can’t even order Bic pens it’s that bad. I’m looking to jump ship as soon as possible”
“We’re no longer accepting pain clinic referrals”
“We’ve got longer waiting lists, more stress. We’re working on a reduced number of physios, recruitment’s not happening and retention is difficult”
“Patients are getting frustrated. Staff morale is affected. There’s no time for in-service training. Services are being reduced to the minimal amount—patients are seen in classes rather than individually, where appropriate”
“The PCT is contracted to send work to the ISTC and patient ‘choice’ is being influenced that way, which will result in a decreased income for us. I think it is a disgrace that the trust is going to lose business to a foreign-owned ITC as they are ringfenced while NHS employees are being threatened with job losses”

“We definitely feel threatened with our jobs, although there are no planned losses at present. New posts are being advertised as temporary, and temporary staff will be the first to be ‘axed’. This will give an unstable staff base to the trust with employees unable to get mortgages and feel stable”

“We’ve joined the Government ‘turn-around’ programme. We’re getting nice communications but our good will is being played upon, and its quickly being eroded”

“We have a ‘turn-around’ plan developed and are undergoing lots of ‘change management’ stuff, but its only slowly filtering through. Communications are not brilliant. We’re just keeping our heads above the water”

CONCLUSION

23. From our survey it appears clear that the Government’s agendas on choice, waiting times and health promotion are all being affected by the current financial situation in the NHS. As yet, fortunately, we can report very few redundancies amongst CSP members in the NHS, but this looks likely to change in the current financial year. An absence of current actual redundancies in physiotherapy, or staff being immediately forced out of the door, however, does not equate to a harmonious situation where there are no problems. Both our members and their patients are directly affected by the removal of vacant posts and restrictions on recruitment and the use of temporary staff. We are particularly concerned, as an organisation which is supportive of and committed to the four main goals set out in the White Paper ‘Our health, our care, our say: a new direction for community services’, about how this will impact on the employment of new physiotherapy graduates—some 2,300 of whom are due to graduate in June/July—and how in turn this will affect the ability of the NHS to meet these goals.

RECOMMENDATIONS

24. We appeal to the Health Committee to encourage an open and honest culture in the NHS where the deficits and their impact can be discussed, without fear of reprisal.

25. The CSP would like to see NHS organisations being given more realistic timescales to address the deficits.

26. The CSP calls for physiotherapy managers to be given more support in their efforts to create job opportunities for newly qualified physiotherapy graduates. The NHS is in danger of losing for good expensively trained physiotherapists. This would represent an enormous waste of public money and talent that the NHS will need in the future.

27. The CSP calls for the ‘quick-fix’ expediency of cutting training courses to be abandoned immediately. Squeezing training is a short-term gain with a long-term cost. Training for staff is vital for patient care and should be fully resourced, with training budgets ringfenced for protection. Staff development and support is key to the realisation of the Government’s goals for health care and should be respected accordingly.

28. The CSP believes that the expensive distraction of competition should be reviewed as a matter of urgency.

Phil Gray
Chief Executive, Chartered Society of Physiotherapy
5 June 2006

Evidence submitted by the Commission for Patient and Public Involvement in Health (Def 28)

INTRODUCTION

1. The Commission for Patient and Public Involvement in Health (CPPIH) was established by the NHS Reform and Healthcare Professions Act 2002 and set up in January 2003. It is an independent, non-departmental public body, sponsored by the Department of Health. In June 2004, as part of the Arms Length Body Review, it was announced that the Commission would be abolished in the Summer 2006, which was subsequently postponed until 2007.
CPPIH oversees and supports 569 statutory Patient and Public Involvement (PPI) Forums, made up of local volunteers, one for each Primary Care Trust, NHS hospitals trust, mental health trust and ambulance trust. It also gathers information and opinion from PPI Forums, in order to ensure that NHS bodies are acting upon patients' and the public's views.

It is responsible for submitting reports to and advising the Government on how the Public and Patient Involvement (PPI) system is functioning and has a remit to make sure the public is properly involved in decisions about health and health services.

2. Members of PPI Forums have a statutory role in monitoring decision-making and service delivery by local NHS bodies. They are in a strong position to comment on NHS deficits on behalf of patients and the public because of their knowledge of local structures and services and their existing relationships with trust managers. PPI Forums are active in every part of England where NHS deficits are occurring.

3. PPI Forums began raising concerns about NHS deficits in the latter part of 2005, before the scale of problems and their potential impact on service delivery had been fully recognised. As a result of this CPPIH contacted PPI forum members by email in December 2005 and March of 2006 asking them to take part in “on-line polls” to obtain a more detailed picture of emerging concerns from across England. In addition to answering a series of questions, respondents were invited to provide additional comments highlighting particular local difficulties.

4. CPPIH is encouraged that a broad range of PPI forum members responded with detailed comments on a range of issues, and we believe these surveys provide two valuable “snap shots” of emerging problems across England. We also believe that the comments, a selection of which are summarised below, provide an insight into the public’s perspective on NHS deficits, revealing a wide range of opinions about why substantial budget deficits have come about. They also highlight genuine concerns about the impact on local services affecting vulnerable members of the community, including the elderly, people with long term chronic medical conditions, and those with mental health problems.

5. They provide us with a unique insight into how the interested public at a local level have perceived the handling of the NHS deficits, and are the only channel currently available for doing so. Here we provide the views not of the Government of the day, or PR professionals, or NHS managers and staff—but of a serious financial crisis in the NHS. These are opinions from the communities that the NHS is intended to serve, and who pay for it, and whose support is essential to maintaining the consensus surrounding its values.

Size of Deficits

6. The first poll, conducted in December 2005 received 366 responses, with 63% of respondents saying that their Trust was predicting a deficit. Few at that time were able to provide details of the impact on services, with 83% reporting that they did not know whether the trust intended to cut services.

CPPIH conducted a second poll in March 2006, to which it received 237 replies. The proportion of respondents reporting their Trust faced a deficit had increased to 74%; 58% reported that their trust was planning to make staff cuts over the coming year and 62% reported plans to cut services.

7. Respondents were invited to provide details of projected deficits if they were available. Many sought to do so although in December the picture was far from clear. For example a forum member from Leicester University Hospitals PPI forum commented in December: “the projected deficit is frequently altered to take account of savings achieved and the likelihood of commissioning being adjusted by indebted PCTs to rectify their own projected losses.”

A forum member from Suffolk stated: “The projected amalgamation of the three PCTs to form “Suffolk East” has led to some confusion as to the level of debt and hence projected deficit. The extensive reductions in the service are alarming to patients in the area.” (Respondent, December survey)

An Ambulance Trust Forum Member from East Anglia raised the following concerns: “The Trust is in balance at present but under pressure from the PCT’s not withstanding 999 call demand rising annually at a 10% compound rate. Suffolk West PCT & West Suffolk Hospital are both in deficit—some £10–15 million or more. Some of this was inherited from the Suffolk Health Authority. All Forums in Suffolk are now meeting jointly to review the County wide NHS financial situation.” (Respondent, December survey)

A respondent from Yorkshire Wolds & Coast PCT Forum stated “At present another £8m. + is estimated plus £7.3 million outstanding. It was anticipated to be around £11.5 million. They must make over £1 million. savings before 31st March. This is my understanding as from last week.” (Respondent, December survey)

8. A former Forum members from West Yorkshire raised a number of serious points about achieving financial balance: “The LTHT Trust (Leeds Teaching Hospitals Trust) in West Yorkshire is projecting financial balance but it is difficult to see how this will be achieved under the current integrated performance reporting. Great progress has been made into the underlining [underlying?] reported deficit, but recovery is in the hands of the business managers at the Trust. . . . managers have experienced great difficulty in producing business plans for this last year and for 2006. . . .
“... In line with the quality sub group terms of reference there should have also been quality plans backing up these business plans, which to date have not been available. ... Having been in finance most of my working life I find the concept of doing a budget then having a deficit as large as some of the Trusts report a real concern, it all comes down to good management and accountability”. (Respondent, December survey)

9. A respondent from Central Manchester PCT Forum wrote: “It’s complicated—the finances seem to be in order and operating normally the PCT is not running at a deficit. However, due to the actions of the Central Manchester and Manchester Children’s Hospital NHS Trust, a significant amount of money had to be allocated to the CMMC to cover their deficit. As a result, Central Manchester PCT has put in place their own, voluntary, recovery plan. In the medium term, things remain uncertain. However, it is possible that a large sum of money will come its way through PBR (Payment by Results) and the acceleration of the catch-up of historically owed resources.” (Respondent, December survey)

**IMPACT OF DEFICITS**

10. A number of respondents raised similar concerns about trusts having to take on the burden of deficits from neighbouring trusts:

   A respondent from East Hants PCT Forum commented “it began at about £5 million but for some odd reason they had to take on more from other trusts and I think they are up to about £23 million” (Respondent, December survey)

   A Billericay Brentwood Wickford PCT Forum respondent added “This is an odd one as the Trust has budgeted to balance its books and strives to do that but has had imposed on it a requirement to provide £2.2 million savings to help the SHA balance its books. I think that this will be hard to achieve in the next five months without cuts.” (Respondent, December survey)

   A member of Croydon PCT Forum: “The Trust is expected to breakeven this financial year although a £2 million deficit was carried forward from last year. However a further concern is that existing deficits will be shared across sectors so Croydon services may be curtailed as a direct consequence of the financial deficits created elsewhere.” (Respondent, December survey)

11. Similar concerns featured in the March survey: “This year has seen the SHA call in money for a bail out fund for less well managed trusts and the £2.5 million called for cannot be achieved. The Chancellor’s insistence that the new merged PCTS must take forward the deficits precludes a balanced budget in most cases without reduction in services.” (PCT Forum member, March survey)

   “The PCT has been asked to contribute 3% of its income to a fund held by the SHA to plug the debts made by other trusts in London. This will amount to £11 million which the trust can ill afford to lose. It seems that the trust is being penalised for not being in debt—no question that this amount will mean cuts of some kind, either staff or services or both.” (Forum Member, Westminster, March survey)

   “The trust manages its finances well. However, due to issues with other trusts the goalposts are constantly being moved. In 2005–06 they had their budget cut by c. £700k mid year. 2006–07 year budgets have been scrapped and they are about to start the year not knowing what their budget is! SHAs should abide by the budgets set and ensure new budgets are approved 2 months before the year starts, to allow for planning.” (Respondent, March survey)

12. A respondent from Bromley Primary Care Trust Forum provided detailed comments on possible reasons for growing deficits “I am the Forum’s elected Observer on the PCT Board, and I am very much aware of the financial situation. Last March the projected deficit was 2.7 million which was largely caused by the sudden introduction of Payment by Results using the National Tariff charges, of which some new Foundation Trusts were early implementers. I learnt eventually that there was a wholesale cull of the senior management team: some Directors were not re-appointed, some were re-appointed to their job at a lower grade (eg Assistant Director), and others eventually left for jobs elsewhere. Such a ‘solution’ can be applied only once.” (Respondent, December survey)

**REASONS FOR DEFICITS**

13. Other respondents, however, reported a different understanding. Respondents cited a range of reasons for budget deficits:

   “Our trust has poor financial management. Does not know what services it is paying for in the various hospitals used in our area, May be paying for some services twice.” (Respondent, March survey)

   “Currently no-one can explain why they are in such a mess and exactly what is being proposed. The financial problems in Worcestershire are historical and currently running at £20 million.” (Respondent, March survey)

   “I think the NHS finances are not properly profiled, recorded, monitored or QA’d for Value for money, certainly not in the way Civil Service public expenditure is. I have never before heard of an organisation that asks people it is giving money to to explain what service they are paying for!” (Respondent, March survey)
“Most of the deficit has arisen because our hospital has carried out work to meet patient needs which the PCTs have not paid for due to their own financial problems.” (Respondent, March survey)

“Central NHS directives mean that my trust does not have financial control. An inherited deficit has caused major problems.” (Respondent, March survey)

“Balanced finance depends on demand, expenditure and funding. Demand from patients seems to go up year after year. Expenditure: a lot of this is outside the control of the trust; wages, government targets etc. Funding: there is little transparency in how the level of funding trusts is arrived at.” (Respondent, March survey)

“Resourcing and Allocation Budget (RAB) is, it seems to me, at the root of many Trusts problems because of the way it ratchets up indebtedness. In this area Trusts have had budgets top-sliced by 3.5% presumably increasing their indebtedness by several million pounds.” (March Survey respondent)

“Blame is being placed on central government when locally it can be shown that the overspend has been going on for many years and has not been addressed.” (March Survey respondent)

CONCERNS FOR FUTURE

14. The March survey also revealed considerable pessimism about the future, with 70% of respondents saying they did not expect the situation locally to improve.

“All trusts will struggle unless there are changes made. Those who will not suffer a financial deficit have managed well, but we all know that changes will be made in many things including the amalgamation of Trusts and it is impossible to forecast what the future holds for each trust.” (Respondent, March survey)

“With the introduction of Commissioning a patient-led NHS, choose and book, patients might see a fluctuation in services as a direct result, this is unknown territory for many even those with financial balance. Nobody really knows the fallout from choice, where money follows the patient, can existing standards be maintained or even improved upon? These are questions and answers that only with time we will know.” (Respondent, March survey)

15. Several respondents were concerned about the impact of other departmental policy initiatives on trust finances, particularly on Foundation Trusts:

“Leeds Mental Health Trust is proposing to become a foundation trust. The main threat that it sees to achieving this is that the PCT(s) in Leeds will not be able to pay for the contracted services over the coming and future financial years. For FTs the lack of confidence about cash flow is of particular concern—if major contractors cannot guarantee payment for the services they commission then vital resources will be taken up in legal challenges.” (Respondent, March survey)

“The DOH policy in introducing and expansion of Independent Treatment Centres will adversely impact on Foundation Trust’s ability to generate income from the number of patients treated. This was coupled with the DOH proposal to offer minor surgery in the Community without adequate compensation for loss of revenue to the acute trust sector will in my view entrench the foreseeable financial difficulty and subsequently adversely affect the future development of acute trust services. Having said that, improving local community services including the ability to offer minor surgical remedies can only benefit the service to patients. However this should not be done at the expense of improving services in local district hospitals.” (Respondent, March Survey)

“With PCT Commissioning and patient choice via choose and book, the planning by acute hospital trusts is very difficult. Also tariffs for services are not complete or seemingly ‘unfair’ eg same tariff for single and dual bypass heart ops. Lastly with our PCT not being amalgamated with others, yet predicted savings targets the same as those which will amalgamate and have economies of scale, plus the assumed wage geographical reductions for trusts in the south west, there is bound to be further pressure on our local PCTs finances compared to South East/and or urban areas of the UK.” (Respondent, March Survey)

SERVICES AFFECTED

16. Respondents were invited to provide details of services they believed might be affected. In December, of those that could report an impact on services, 32 said beds and wards were being closed; 9 raised concerns about loss of beds in Community Hospitals, the same number said Out of Hour services would be reduced; 6 suggested operations were being delayed; and 10 said mental health services could be cut back.

17. By March respondents were reporting a very wide range of services affected, but community services and community hospital and intermediate care services were mentioned particularly by various forums.

A Forum Member from North East Yorkshire reported reductions in the availability of “consumable items, such as the Pain Clinic cannot send out pads for TENS Machines, [Transcutaneous Electrical Nerve Stimulation] and some sizes of Acupuncture needles are not available.” (Respondent, March survey)

An Oxfordshire Forum Member reported: “The proposed dental services have not materialised due to lack of finances. There are consistent threats of closure to local Community Hospitals and community midwifery services.” (Respondent, March survey)
A Forum Member in North Devon reported: “HCT [Healthcare Trust] has 4 areas of out of hours service cuts and children’s services including paediatrics unit bed reduction from 22 to 16 and possibly more to be cut in future. oral surgery/maxillo facial out of hours services ophthalmology out of hours services ENT out of hours services clinical & support services.” (Respondent, March survey)

A forum member for University Hospitals Coventry and Warwickshire reported: “The Elective Care Unit (set up to reduce waiting times) was closed overnight and the Oncology Day Centre (which had regular patients for palliative care) was closed with a month’s notice.” (Respondent, March survey)

A member from High Peak and Dales reported an estimated £3 million deficit, saying that the following services were under threat: “MIU [Minor Injuries Unit] hours cut: Postponement of reopening of refurbished mental health ward for older people. Closure of nursing ward for older people. No vacancies being filled.” (Respondent, March survey)

18. A Sussex Forum Member reported “We in Littlehampton have been told our new Arun Community Hospital is put on hold. It has been deferred twice now and the SHA has not assured us the new hospital will ever be built. Our old one was demolished and the land is just waiting to be built on. All planning applications have been approved. We are at a loss to what will happen next. We desperately need a hospital here. The public deserve this as they are migrating to Worthing for treatment.” (Respondent, March survey)

19. Another area of concern is the impact on mental health services. For example the Hertfordshire Partnership Trust, which serves those with mental health and learning difficulties, had been asked to make savings because of deficits by the acute trusts. It was reported in April 2006 as having to reduce expenditure by £5 million, to help reduce the overall £100 million deficit in health service spending in Bedfordshire and Hertfordshire. Amongst the services likely to be affected were specialist care for children with behavioural problems, reductions in day care services, reduction in access to community mental health teams and community drug and alcohol teams and the closure of a mental health ward.

Hertfordshire Partnership Patient and Public Involvement Forum commented that service reductions may increase the burden on GPs and would run counter to the Government’s National Service Framework for Mental Health as well as to local proposals for investment in mental health services, approved in public consultation in December 2005. (Herts Advertiser, 13 March 2006)

**Lack of Information and Transparency**

20. A particular issue of concern to CPPIH is what the results of these surveys reveals about the lack of openness and transparency within many trusts and PCTs around the impact on service provision.

21. NHS Trusts, Primary Care Trusts and Strategic Health Authorities have a statutory duty, under Section 11 of the Health and Social Care Act 2001 to consult patients and the public in service planning and operation, and in developing proposals for changes. This includes consulting on:
   - ongoing service planning, not just major proposed changes;
   - not just in the consideration of a proposal, but in the development of that proposal;
   - decisions about general service delivery, not just major changes.\(^{20}\)

22. It is a regular complaint from forum members across England, that many NHS staff with responsibility for making major decisions affecting patients and the public are still resistant to providing information about service changes and the reasons for them.

23. Responses to both surveys reveal this continuing lack of transparency about decisions made and a lack of consultation. CPPIH believes the scale of service changes identified by forum members clearly fall under the remit of Section 11, yet only 40% of respondents said their PPI forum was being consulted and in March, in response to the question: “In your opinion do you feel your NHS Trust is accountable enough to its patients and local community on the issue of NHS Finances?”\(^{21}\), 33% of respondents said yes and 67% said no.

24. Yet when respondents who reported their forum had been consulted were asked whether they had found the experience useful, 53% reported that they had. A minority of forums were able to involve themselves in detailed work with their associated trust on finding solutions, in areas such as obtaining public reaction to proposed service cuts and helping develop consultation methods, as well as helping identify areas of small saving and investigating local provision of services as an alternative to providing services in hospitals.

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\(^{20}\) Section 11 (1, a, b and c); see also Policy Guidance *Strengthening Accountability—Involving Patients and the Public* February 2003.
CONCLUSIONS

25. Patient and Public Involvement Forums have been able to offer an insight into the patient and public perspective on NHS deficits and their impact on services, and on the process by which they have been dealt with. They report substantial concern about trusts’ ability to reach financial balance in the short-and medium term without reductions in services, particular as these deficits have arisen as the NHS is undergoing substantial reform, the real impact of which is unknown.

26. Lack of transparency in matters relating to NHS finances and an apparent failure of many trusts to consult on service changes has a negative impact on public confidence in the National Health Service.

27. CPPIH also has serious concerns that an admittedly very complex situation has been rendered even more difficult for patients and the public to understand by the deliberate opacity of many trusts financial decision-making processes.

RECOMMENDATIONS

28. Such a position can only be exacerbated in the future by the growing impact of Choice and the complexities surrounding the “market place” philosophy of the PBR tariff. Choice can only work well, both for communities and individuals if clear and unambiguous financial information is available about available policy and treatment options. The NHS will need to raise its game significantly in this area.

29. At the very least all trusts should, as a priority, provide clear and accurate information about the cost of services, their financial positions, the potential impact on services and how decisions are arrived at, so that the public, or at least PPI Forums, could participate in decision-making, and make choices. We recommend there should be national guidelines that all Trusts should observe, so that transparent and meaningful financial information is publicly available for scrutiny. Public willingness to participate and become engaged in local decision-making on policy and priorities will continue to be undermined if prompt action is not taken along these lines.

Sharon Grant
Chair, Commission for Patient and Public Involvement in Health
5 June 2006

Evidence submitted by the County Councils Network (Def 37)

1. INTRODUCTION

1.1 The County Councils Network (CCN) is a Special Interest Group within the Local Government Association (LGA), with all 37 English Shire Counties in membership. The County Councils Network promotes the voice of counties within the LGA and the values and interests of the English Counties. Together these authorities represent 48% of the population of England and provide services across 87% of its land area.

1.2 The CCN acknowledges that the Local Government Association (LGA) and the Association of Directors of Social Services (ADSS) are also making a joint submission to this Inquiry. The CCN supports the comments made by the LGA and the ADSS, and in particular the concerns raised by these organisations regarding the impact of NHS deficits on the provision of social care services.

1.3 This submission seeks to reflect the particular issues arising for county councils and the CCN’s concern that problems currently being faced in several county areas are likely to become more widespread unless the impact of NHS deficits on social care is understood and addressed.

2. BACKGROUND

2.1 The CCN made a response to the Government’s White Paper, Our Health, Our Care, Our Say, in which we expressed support for the broad principles outlined in the paper, in particular the acknowledgement of the leadership role played by local authorities and the proposals for a more holistic, whole-systems approach to service delivery.

2.2 However, we also outlined our concerns about funding the proposals in light of existing funding pressures, particularly the £1.77 billion funding gap identified by the ADSS and the LGA, and the context of wider demographic changes which will see people living longer, and both older people and those young people with severe physical and learning disabilities, needing care and support for longer.

2.3 County councils have a particularly strong record of engaging in partnership with health authorities. Research undertaken by the LGA and the ADSS, which has been analysed for county specific implications, shows that 75% of counties have entered into pooled budget arrangements with PCTs (Section 31), compared with the national average of 21%, with counties contributing almost double the national average
(£10.5 million). Furthermore, it is apparent that counties face particular pressures on their services when compared with other local authorities. The same research reflects that counties face significant demand and volume pressures, with care placements for older people at 57% (exceeding the national average of 38%) and care placements for people with physical disabilities at 68% (exceeding the national average of 44%). It is therefore apparent that NHS funding issues will have a particular impact on county councils.

2.4 Our response to the White Paper, developed further to comments received from county members, also outlined our concerns about the impact of NHS deficits on the delivery of social care services. We have now canvassed our member authorities to develop a more detailed perspective of the impact of these deficits on local services.

3. **Key Issues**

3.1 Some counties have indicated that they have identified potential funding difficulties arising from NHS deficits but that these have not yet been realised. These counties continue to maintain service provision and partnership arrangements but anticipate problems in the future. As a result we have received reports of a “more robust approach to partnership working”, and the preparation of contingency budgets to cover future withdrawals.

3.2 Several counties are experiencing substantial amounts in outstanding payments from health partners, which, in some areas, are being redressed by the slowing down of existing agreements. This in turn has a negative impact on front-line services.

3.3 It is therefore apparent that whilst NHS deficits might not result directly in funding withdrawals all areas, there is still an impact on counties, their services and existing partnerships.

3.4 Other county councils are experiencing the direct effects of NHS funding withdrawals. The examples we have received show withdrawals ranging from £20,000 to £1.8 million. These withdrawals are already having an impact on the provision of social care services. In Wiltshire, the county council has committed to focussing on providing or funding services to those whose needs are substantial or critical. In Hampshire, care will only be given to those with critical care needs. Counties have already identified that these changes will have an impact on the provision of domiciliary care, day services, transport, meals services and residential and nursing home placements. However, the scale of the withdrawals means that there are also likely to be significant budgetary implications for services on a county-wide basis.

3.5 Whilst withdrawals and cost-shunting are currently being experienced by a relatively small number of county councils it seems likely that this number is going to rise. In Somerset, health partners have notified the county of their intention to pay an inflationary uplift of just 2% for 2006–07 on joint funded and pooled budgets (which amounted to £15.7 million 2005–6). There is also likely to be a health review of funding within Learning Disability Services in the county, which could result in excess of £1.5 million being withdrawn. In some areas, health partners are not communicating details of financial pressures to their partners and several counties report increased distrust and further breakdowns in communications between partners.

3.6 The CCN is concerned that the withdrawals of NHS funds, and the resulting funding pressures and deterioration of relationships will have a significant impact on service users, their families and carers. Counties are already making changes as a result of funding pressures; cutting day care services, residential placements and intermediate care and increasing charges.

3.7 Furthermore, we are concerned about the impact of these pressures on existing strategic partnership working, such as that undertaken via Local Area Agreements and Local Strategic Partnerships. Some counties have indicated that they are undertaking considerations of processes of “due diligence” before signing an agreement in order to make partnership arrangements more robust. Such a process is likely to impact upon both the scope and the timescales for LAAs, and in turn impact upon the work of other local partners.

4. **Conclusion**

4.1 The CCN would urge the Government to consider the long-term implications of NHS deficits on the provision of social services. Whilst counties and their partners continue to work together to ensure the provision of services for local people, it is becoming apparent that NHS deficits are having an impact on both local partnerships and services.

4.2 We are concerned that immediate changes are being made without consideration of the longer term implications.

4.3 The issues raised in this paper affect all public bodies as well as the voluntary sector. The CCN feels strongly that all public service agencies must be able to work together to plan effectively for the medium and long term without the turbulence which such changes cause.
4.4 The CCN feels that NHS deficits are already compromising partnership arrangements and that there is potential for the withdrawals currently being experienced in some county areas to become more widespread. We are concerned that this issue is adding to existing funding pressures on social care services and feel strongly that local services should not be compromised as a result.

The CCN would be willing to give further evidence to the Health Committee in respect to this inquiry.

County Councils Network
7 June 2006

Evidence submitted by Deltex Medical (Def 32)

SUMMARY

— Reducing lengths of patient stays in hospital is key to reducing NHS costs in hospitals. At a time when the NHS is searching for greater efficiencies to reduce deficits, there are clear benefits from introducing new medical technologies which are proven to reduce lengths of hospital stay.

— The CardioQ is a British medical device, developed by Deltex Medical Group plc which monitors blood flow and has been proven to reduce patient stays in hospital after major surgery by more than two days per patient. The first NHS Trust to have implemented the CardioQ on a wide-scale has identified potential annual savings of £3 million a year and is already saving over £1 million per year. Most recently, in May 2006 the Royal Alexandra Hospital in Paisley undertook a study which resulted in a saving of over £1,000 per patient.

— However, in practice NHS managers continue to seek to avoid any new expenditure on innovative medical technologies. In many acute Trusts the budgets for new medical equipment have been slashed, regardless of the merits of individual business cases,

— Therefore, despite the Health Select Committee’s 2005 recommendation that the Department of Health improve the process of adopting new technologies, no progress has been achieved on the ground. In addition, despite being supported by independent scientific evidence and having been declared by NICE to be considered “standard clinical practice”, poor local NHS management, and overly bureaucratic procurement procedures are creating financial inefficiency and preventing the uptake of life saving technology.

1. The impact of NHS deficits on new medical technologies

1.1 It is well recognised that reducing the length of patient stays in hospital is instrumental in reducing NHS costs. The Audit Commission report on day surgery in 2001\(^\text{21}\) highlighted the link between how care is provided and financial efficiency, as provision of day care is shown to reduce hospital costs. Since this report progress in the extension of day surgery has been slow and in 2005 the Healthcare Commission concluded that “substituting day surgery for appropriate inpatient admissions is good for patient care and is welcomed by many surgeons, but it is proceeding too slowly”.\(^\text{22}\) This makes clear the need to reduce patient stays as a means of reducing hospital costs. Similarly, in 2005 in her speech to the NHS Confederation conference, Health Secretary, Rt Hon Patricia Hewitt MP underlined the need to invest in ways to reduce hospital stays when she said, “If a shorter stay in hospital gives the patient as good, or better outcomes, and it costs less, lets do it.” There is a clear financial and clinical argument for introducing new technology which has the ability to reduce patient stays in hospital. At a time when the NHS is searching for greater efficiencies to reduce deficits, it seems inconceivable that uptake of a product which has been proven to do exactly that, is proving incredibly difficult to achieve.

1.2 Deltex Medical have produced a new medical device called “CardioQ” which monitors blood flow during surgery and has been proven to reduce patient stays in hospital by over two days. The Medway Maritime NHS Trust in Kent was the first Trust to adopt the technology on a wide scale. It has reported potential savings of £3 million a year from using the technology and is already saving over £1 million per year. With an initial cost to the NHS of £7,000 to purchase a haemodynamic monitor and an additional cost of £60 to use CardioQ in a patient’s care, it is clear that when the device is saving approximately £800 per patient, the technology pays for itself. However Deltex Medical has experienced significant barriers to introducing new medical technologies in the NHS. Without reform of local management structures and national procurement procedures, the NHS will continue to be financially inefficient and patients will be denied the benefits of life saving technology.

\(^{21}\) Day surgery, a review of national findings, Audit Commission, December 2001.

Poor financial management structures

1.3 The experience of Deltex Medical highlights the failings of poor financial management structures. The process whereby doctors justify new expenditure is both complex and cumbersome, requiring detailed business cases to be made. Doctors often do not have the time or experience necessary to prepare these documents. While there are normally a plethora of rules on the required content for a business case, there is rarely any guidance on the criteria for acceptance or rejection of the business case. Most doctors do not have access to the basic management information necessary to prepare a robust business case, and, such information as they do obtain is often incomplete, out of date or inaccurate. Many doctors regard the whole process as being designed to delay and obstruct their access to new technology and their experience is usually that funding will not be available at the end of the process anyway.

Case Study

1.4 It is clear that there is a demand for CardioQ in the clinical community, however this demand is being frustrated by the actions of local management. The number of NHS patients treated using the CardioQ has increased from under 15,000 a year in 2003 to 25,000 a year today. Over the same period, we estimate that the clinical acceptance of the technology has grown significantly and that today doctors wish to use the technology on over 250,000 NHS patients a year. Doctors around the UK are actively pursuing funding for the purchase of over 600 new CardioQ monitors. However, Deltex has seen a steady drop in monitor sales in the last three years from 50 units in 2003 to 39 units in 2004 and 34 units in 2005. For example, the surgical division at Derriford Hospital in Plymouth maintains a wish-list of new technologies. This list comprises twenty items and traditionally the surgeons would expect fifteen or more of the items on it to be funded over a two to four year timeframe. By the time the CardioQ was added to the list late 2004, senior surgeons informed the company that they only expected the top one or two items on the list to be funded in the coming few years.

1.5 These difficulties are compounded by the impact of silo budgeting in Trusts. In our experience, Trust Chief Executives can see the clear financial benefit in technology such as CardioQ, however access to them is difficult as many refuse to meet “trade salespeople”. Hospital theatre management regard investment in CardioQ solely as increasing anaesthetists’ costs. This is disconnected from potentially major savings which CardioQ could bring to ward managers down the corridor who experience the financial benefits of shorter patient stays. Similarly Deltex has made numerous approaches to NHS Trust Boards who, it seems, have not used their powers to take evidence based decisions with regards to uptake of new technology. It would appear that poor local management structures and procurement procedures are preventing Trust Boards from making a decision which would result in considerable savings. There can be no doubt that funding structures at local level are hampering efficiency and require urgent reform.

Case Study

1.6 The profound inefficiency of local NHS management was experienced by Deltex Medical in the case of the Dudley Group of Hospitals NHS Trust. Here, the agenda of local management appeared to fly in the face of evidence based medicine. In October 2004, the Finance Director of The Dudley Group of Hospitals NHS Trust commissioned an audit of the effectiveness of the CardioQ in reducing lengths of stay at Russells Hall Hospital. Deltex Medical supported this audit with clinical training and support, and spent over £10,000 doing so. In July 2005 the doctors leading the audit reported on average reductions of length of stay achieved in CardioQ patients of 3.75 days per patient (a 26% reduction in length of stay). In October 2005 the Finance Director reported that he found the results, “most interesting”, however when the issue was referred to the Director of Operations Deltex spent seven months trying to elicit a response. When finally a response was received, investment in CardioQ was rejected on the grounds that the Trust had “limited resources to ensure the delivery of further reductions in length of stay.” Despite Deltex going to considerable costs to prove the effectiveness of CardioQ, it would appear that the management have rejected this clear and solid evidence base. This case is symptomatic of the attitude of the vast majority of NHS management, yet they are rarely held to account for the effect their decisions have on patient care or the financial performance of their Trust.

1.7 In addition, local NHS procurement tends to be driven by the objective of buying less equipment, and at a lower price. Reducing costs is often seen as strong management, but this is short sighted when there is evidence showing that the right investment can deliver massive savings and improve patient care.

Impact of pay awards on medical technology

1.8 The effect of the Department of Health’s underestimation of the cost of staff pay rises on individual Trust deficits has been widely reported, and the impact has also been felt by medical technology companies such as Deltex Medical. As a greater percentage of Trusts’ increased budgets has been spent on pay doctors and managers have become increasingly overly sensitive to new investments such as CardioQ despite its proven ability to create substantial cost savings. Analysis of the Plymouth Hospitals NHS Trust’s annual report reveals that it has scaled back dramatically its investment in technology in order to spend the vast
majority of its incremental income on pay. Over the last six financial years the Trust’s annual income has increased by £91.5 million. Over the same period the Trust’s annual expenditure on pay has increased by £76.0 million; ie it is spending 83% of its increased funding on pay. This has caused a major shift in the Trust’s cost base as its non-pay expenditure has increased at less than half the rate.

National procurement procedures

1.9 At a national level Deltex has spent several years liaising with organisations such as the NHS Purchasing and Supply Agency (PASA), the National Institute for Health and Clinical Excellence (NICE), the National Institute for Innovation and Improvement, and the Department of Health. Despite this we are still no further forward in achieving greater uptake of CardioQ across the NHS, even though more and more doctors want to use the technology to improve the quality of care they deliver to their patients. In the case of NICE, seven months was spent giving “careful consideration” to the evidence supporting the CardioQ before declaring in January 2006 that it did not fall within the remit of its Interventional Procedures Programme (“IPP”) because it “is considered standard clinical practice with risks and benefits that are well known”. NICE has not undertaken any review of the CardioQ under its Technology Appraisal programme which recommends on funding decisions and is unlikely to do so. CardioQ is considered a “no-brainer” by NICE because it both improves quality of care and reduces costs. NICE’s primary concern is to assess whether the improvement in care from a new technology is sufficient to justify the extra cost of it. Yet there is an astonishing lack of clarity about which body, if any, is responsible for making sure the “no-brainers” get implemented.

1.10 Similarly, in January 2006 the NHS Institute for Innovation and Improvement (NHS III) published “Delivering Quality and Value Focus Document” which included guidance for reducing lengths of stay and improving outcomes for patients undergoing surgery for fractured neck of femur. This notes that the best performing Trusts are achieving a length of stay of between 10 days (medium size hospitals) and 14 days (large hospitals). None of its recommendations refer to improving quality or value by improving intra-operative care. Yet two randomised controlled clinical trials on this group of patients using the CardioQ in NHS hospitals have been published in peer reviewed journals. The first, published in 1997, showed CardioQ patients fit for discharge after nine days and actually discharged after 12.5 days. It is alarming that the best NHS hospitals are not doing any better than they were 10 and five years ago and disheartening that the NHS III ignores innovation of this kind. At a national level, the experience feels as though we are being made to jump through hoops, being passed from one central agency to another with no tangible outcome. Such a complex and cumbersome procurement process is of no benefit to patients who could be benefiting from proven technology, and no benefit to the NHS which could be saving millions of pounds.

1.11 The Health Select Committee’s 2005 inquiry into “The Use of New Medical Technologies Within the NHS” recognised the difficulties in achieving take up. We were delighted that the Committee recommended that the Department of Health “ensure that it devotes adequate attention and resources to rectifying the currently unstructured adoption of new medical technologies”. However Deltex Medical is in no doubt that no progress has been achieved towards this target. While it is possible that the various initiatives coming out of the Health Industries Task Force (“HITF”) will make the NHS a more attractive market for suppliers of innovative medical technologies in the future, the barriers to technology adoption are becoming ever more amplified. In the current climate of financial deficit the Committee’s recommendation is more important than ever when technology exists to improve patient care, reduce hospital stays and make significant financial savings.

2. Background to Deltex Medical and CardioQ

2.1 Deltex Medical is a small innovative British Healthcare company which has developed a device, the “CardioQ” oesophageal Doppler monitor (ODM), to accurately monitor blood flow during surgery and in critical care. Reduced circulating blood volume is known as hypovolemia, which leads to insufficient oxygen being delivered to the lungs. Insufficient oxygen causes medical complications including peripheral and major organ failure which results in longer hospital stays and in some cases death. CardioQ allows the clinical team to better manage the patient during this time (haemodynamic optimisation), reducing complications and mortality.

2.2 In June 2005 the Improving Surgical Outcomes Group’s report, “Modernising Care for Patients Undergoing Major Surgery” found that 20,000 patients die unnecessarily every year in the NHS within 28 days of surgery, and recommended the use of preventative measures (such as better peri-operative care, pre-operative assessment and improved post-operative care) to avoid post operative complications.25 (This report can be made available to the Committee on request).

25 Modernising Care for Patients Undergoing Major Surgery, A report by the Improving Surgical Outcomes Group, June 2005.
2.3 Clinical evidence has shown that there are approximately 1 million NHS patients each year who would derive a clear clinical benefit from haemodynamic optimisation. If lengths of hospital stay for these patients were reduced by two days each, the NHS would free up about 5,500 beds, with a saving of at least £350 million a year. Were managers to embrace the CardioQ technology and work with their clinical colleagues to implement it effectively they allow two to three more patients per week to survive major surgery. NICE has declared CardioQ to be “standard clinical practice”, yet it is used in less than 5% of cases where patients and NHS finances could benefit.

2.4 Most recently, in May 2006 the Royal Alexandra hospital in Paisley used CardioQ in a study of thirty patients who underwent major colorectal surgery. The result was a 20% reduction in the average length of post operative hospital bed stay and a saving of over £1,000 per patient.

2.5 In 2004 the Medway Maritime NHS Trust conducted an audit of the impact of using CardioQ technology in approximately 200 operations over a period of four months. It revealed that CardioQ reduced the average length of patient stay after surgery by over three days for the broad range of moderate and major risk surgery where it was used. This equated to an approximate saving of £800 per patient, and a realised saving of £1 million a year for the Trust in its first phase adoption. Chief Executive of the Trust Andy Horne underlined the effectiveness of CardioQ commenting that “We have used the CardioQ in around 200 operations over the last four months and had very good results. It has improved the quality of care for patients as they are healthier when they leave theatre, need less post-operative care and get home quicker.”

3. Recommendations

3.1 NHS healthcare regulators such as the Healthcare Commission, Audit Commission and Monitor, should review financial management structures and business case assessment procedures as part of their regular reviews of NHS Trusts.

3.2 Reform of procurement procedures as recommended by the Health Select Committee in 2005 must be implemented without further delay to remedy the current lack of structure and transparency.

3.3 The current bias towards price considerations in NHS procurement should be redressed by considering the financial savings which could be made through procurement rather than focusing on the initial cost alone.

Deltex Medical

June 2006

Evidence submitted by Diabetes UK (Def 30)

Diabetes UK is one of Europe’s largest patient organisations. Our mission is to improve the lives of people with diabetes and to work towards a future without diabetes through care, research and campaigning. With a membership of over 170,000, including over 6,000 health care professionals, Diabetes UK is an active and representative voice of people living with diabetes in the UK.

1. INTRODUCTION

1.1 Diabetes UK welcomes the opportunity to submit evidence to this enquiry. We would like to use this submission to highlight our concerns about the possible consequences of the deficit and the possible reasons for the financial problems being experienced. Further, examples of some of the problems highlight the impact of the NHS deficit on local diabetes service provision. Not an exhaustive list, this provides an indication of the nature and extent of concerns.

2. THE REASONS FOR THE DEFICITS

2.1 The deficits have occurred due to a combination of factors including historic issues, implementation of Department of Health policy, new technologies and medicines, changes in demand, and pay reforms. What appears to have impacted most on the NHS’s ability to develop better diabetes services in accordance with the Diabetes National Service Framework is increased local competition for scarce resources. This has been brought about by the simultaneous implementation of the raft of reforms and initiatives as well as increased demand for existing and new services.

2.2 The amount of the NHS’s overall deficit when compared to its total budget is practically insignificant. It seems very short sighted to put the delivery of health services (and therefore individuals’ health) at risk due to the requirement to balance budgets year on year when it would be relatively straightforward (by the use of eg debentures) to allow Trusts to balance their budgets over a longer period of time to fit in with three year planning cycles. The provision of effective services for people with diabetes relies on consistent investment in primary and secondary preventative care over years. Diabetes services are therefore at particular risk within a culture of short-termism.
3. THE CONSEQUENCES OF THE DEFICITS

3.1 The main feedback that Diabetes UK is getting from our members, healthcare professionals and people with diabetes alike is that they are incredibly concerned about the impact of the deficit. They are concerned about the effect on the care that people with diabetes receive, the effect on healthcare professional’s ability to do their jobs and job cuts. Diabetes UK continues to hear worrying reports from around the country about failures to deliver on services such as retinal screening and education. The situation appears to be worsening in light of the “cash crisis”, with some Primary Care Trusts now using this as an excuse to ignore both patient need and government priorities.

3.2 The current feeling of unease is creating problems with commissioning services, ensuring that ringfenced capital funds are released and maintaining or initiating specific elements of diabetes programmes such as retinal screening. Even programmes marked by government targets are affected, and creating an unwillingness to invest in services at a time when considerable progress has been made. We are getting feedback that diabetes services are particularly vulnerable because of the nature of diabetes as a long-term condition, people with diabetes receive specialist care at intervals over a number of years. Service cuts are leaving people at risk of developing complications over time.

3.3 The evidence that we have received cuts across many areas of diabetes care. Some examples are detailed below.

4. THE EFFECT ON CARE—LOCAL EXAMPLES

4.1 Retinopathy screening programmes

4.1.1 Many healthcare professionals and campaigners are flagging up retinopathy screening programmes being at particular risk due to the deficit. The government have stipulated that 80% of people with diabetes should be offered screening by March 2006 rising to 100% by the end of 2007. 70% of people with diabetes should have received screening by June 2006. £27 million has been ringfenced for digital cameras and software. However these measures do not appear to be giving the service increased prioritisation at a local level.

4.1.2 The latest Department of Health figures show that targets for offering retinopathy screening to people with diabetes have almost been achieved. Results show that 78.4% of people with diabetes have been offered screening in England. Diabetes UK welcomes these results but are concerned that, while some PCTs have reached and even surpassing the target, over a third of PCTs are not reaching 80% and in many areas are failing. These are dramatically below target.

4.1.3 The latest Department of Health figures show that 65% of people with diabetes received screening between April 2005 and March 2006. However this figure masks the fact that many PCTs are reporting a deterioration in service and many are not on course to meet the target of 70% by June 2006.

4.2 Examples of where the cuts have had an impact have been reported to Diabetes UK.

4.2.1 In May, a North East London Health District cancelled the £96,000 plan by the PCT to implement a new retinal screening model of service. The effect is that the centrally set retinopathy screening targets will not be met.

4.2.2 In London, Havering PCT did not carry out any retinopathy screening between November 2005 and March 2006 but has now reinstated an “improved service”.

4.2.3 Surrey and Sussex Strategic Health Authority says it is expecting an £83 million deficit. The SHA delayed releasing the capital for retinal cameras to most of the PCTs. PCTs were required to write stating that revenue had been ringfenced in the Local Delivery Plan to receive the money. Because of these delays the PCTs will not reach their retinal screening targets.

4.2.4 Hampshire and Isle of Wight SHA are also in deficit and most of the PCTs in that area will not reach the retinopathy screening target. The programmes in place are not meeting National Screening Committee guidelines, reportedly due to financial constraints.

4.3 Job cuts and redundancies

4.3.1 Along with concern about the risk of diabetes programmes becoming a lower priority there have also been a great deal of concern regarding staff resources. Reports point to many diabetes staff including nurses and consultant posts being frozen across many specialties. This is equivalent to a cut but is broadly invisible.

4.3.2 Reports suggest that diabetes nurses are not being replaced by an acute NHS trust because of cuts in funding from the local PCT. The James Paget Healthcare NHS Trust in Norfolk has had to reduce staff from three whole time equivalents to 2.4 whole time equivalents when they were promised and expansion in cover.

4.3.3 It has recently been announced that, in line with many other hospitals in London and throughout the country, there was a massive over-spend at Queen Mary’s Hospital, Sidcup. Management in response were proposing drastic cuts to services and will be consulting over the loss of 190 jobs. Rumours ranged from threats of job losses through to complete closure of the hospital. Queen Mary’s Hospital is a centre of...
Health Committee: Evidence

excellence and provides extensive services in the area for people with diabetes. The proposed cuts would reduce the hospital diabetes service by 50%, having a great impact on patient education and clinic appointments. The reduction in staffing included the loss of the in-patient specialist nurse, and the post of the paediatric specialist nurse being cut to a half time post.

4.4 Paediatric Diabetes services

4.4.1 Diabetes services for children are still not being prioritised at a national or local level, which has been reflected in many of the comments received by Diabetes UK. For some time there have been reports of low levels of investment, poor staffing, absent audit facilities and inadequate accommodation for paediatric diabetes services. This situation is seemingly being compounded by the financial problems.

4.4.2 In a North East London Health District a contract of the visiting consultant paediatric diabetologist was cancelled on the basis that the acute hospital trust has appointed a consultant paediatrician with diabetes interest. However, the original plan was for a substantial “crossover” period for the new consultant to receive training and support. The new consultant will not be able to provide the same level of clinical commitment to children with diabetes and young adults. This is a retrograde step for the care of young people with diabetes and occurred as a result of financial cuts.

4.4.3 Further reports in Hertfordshire suggest that parents who take their children to annual review have been told that they no longer check children’s feet. They are then referred back to the GP.

4.4.4 In response to a letter about a lack of Paediatric Diabetes Specialist Nurses (PDSN), Milton Keynes PCT has accepted the need to develop paediatric diabetes services but has said that it is unable to fund an expansion of service during 2006–07. In 2007–08 they hope to invest further to improve local services. Currently they have one part time PDSN to 140 children. The Royal College of Nursing recommends one full time PDSN per 70 children.

4.5 Psychological support

4.5.1 All people with diabetes need access to psychological and emotional support so they can manage their condition effectively and reduce the risk of complications. People with diabetes and healthcare professionals alike highlight the lack of emotional and psychological support, particularly at diagnosis.

4.5.2 In Peterborough the paediatric team, without resource for in house psychological support, refer children to specialist psychological support. They have now been told that there is no longer any budget available for this service. Therefore, the children are referred back to the hospital.

5. Conclusion

5.1 Diabetes UK believes that the year on year deficit firefighting that most NHS Trusts are forced to engage in is having a detrimental impact on diabetes service provision. This submission highlights just some examples of the variations in service being experienced across the country, which were supposed to be addressed by the implementation of the National Service Framework for Diabetes. Indeed, where targets have been introduced, for example for retinal screening programmes, there is still great variation in the quality and reach of services provided.

Claire Francis
Public Affairs Officer, Diabetes UK
6 June 2006

Evidence submitted by the Finance & Leasing Association (Def 09)

1. This is the Finance & Leasing Association’s (FLA) response to the Select Committee on Health’s enquiry into NHS deficits.

2. We would like to bring three points to the Committee’s attention in this context:

(i) The increasing propensity of NHS Trusts to pay their creditors late.

(ii) The failure of the Department of Health to deliver long promised proposed legislation on the arrangements for winding up NHS Trusts.

(iii) The impact on the NHS finances of tax changes currently going through Parliament.

The FLA and the NHS

3. FLA is the principal representative of the asset, consumer and motor finance sector in the UK. FLA members achieved £84.7 billion of new business in 2005. Of this £26.8 billion was provided to the business sector and UK public services, representing over 30% of all fixed capital investment in the UK in 2005 (excluding real property). The remaining £57.9 billion was provided to the consumer sector and FLA
members represented 25.6% of all unsecured lending in the UK. In the above total is £18.6 billion of finance provided to the motor sector. FLA members financed at least 50% of all new car registrations in the UK in 2005.

4. The NHS Purchasing and Supplies Agency estimates that the NHS spends in the region of £500 million a year on operating leases, covering a diverse range of equipment from scanners, pathology analysers and ambulances/vehicles to catering equipment and photocopiers. (Operating leases cover part of the equipment’s economic life.)

5. The FLA has a Forum, comprising Members active in the NHS market. It currently includes 26 businesses providing finance as well as associate members providing support services, principally in the fields of law, software and consultancy. The Forum seeks to explain asset finance to the NHS and to represent Members’ views on policy and legal issues impacting on the NHS finance market.

6. As a condition of membership, FLA Members have to adhere to a Business Code of Practice, available from www.fla.org.uk. It has a section specifically on the NHS and other public services. The Code’s main theme is that the terms of the finance must be transparent to the client.

NHS DEFICITS

7. The FLA welcomes the Committee’s Enquiry. Our Members have reported to us a number of concerns, detailed below, that flow primarily from these deficits, we believe.

8. We mention one instance to illustrate the problems that are looming if these deficits are not tackled effectively. A Member recently received a letter from a Trust demanding a 10% reduction in “all future invoices”. This letter appeared to ask unilaterally for a reduction in payments against existing contracts. This is clearly unacceptable as a business practice and indicates the desperate financial circumstances of at least one NHS Trust. It is the only Trust we have heard of that has gone to these lengths, but a growing pattern of financial shortcomings suggests that the NHS has a systemic problem which must be solved urgently.

PAYING LATE

9. A number of Members have reported to the FLA that some NHS Trusts are paying their creditors late, as a policy aimed at alleviating short-term financial pressures, not through administrative shortcomings.

10. We were sufficiently concerned to approach Monitor, the Independent Regulator for Foundation Hospital Trusts. We were pleased to get a reassuring reply that Monitor did not consider it acceptable practice to stretch creditors unreasonably or beyond contractual terms, which we have advised Members to draw on if such Trusts pay late.

11. Monitor cannot be responsible for individual Trusts’ payment performance. The Trusts themselves must do so. There are current cases causing difficulties, albeit a minority. Monitor’s Board meeting of 27 April 2006, for example, reported that “Monitor continued to have concerns as to the Gateshead Foundation Hospital Trust’s liquidity given that it continued to stretch its creditors and was not adhering to best practice standards in this respect.”

12. Traditional Trusts are also paying late. The evidence is only anecdotal at present, but sufficient Trusts appear to be using late payment to make it a concern to FLA Members. We believe that the Department of Health should take steps to send the same message to traditional Trusts as Monitor has sent to Foundation Hospital Trusts, and ensure that it is adhered to.

13. Late payment causes obvious commercial damage. It is bad enough for large businesses (which FLA Members in this market are, either bank/finance house subsidiaries or the financial arm of manufacturers). We suspect that certain Trusts are applying a “delayed payment strategy” to all or most of their creditors. The effects would be particularly damaging, perhaps fatal, for SMEs.

14. Late payment would also damage NHS Trusts if adopted as a strategy. Late-payment strategies cost more as late payment interest is incurred and potential failure to pay promptly is built into future pricing. Ultimately, some funders may walk away from the sector, reducing choice and competitiveness, if the risks of lending to both traditional Trusts and FHTs is thought to be too great. Funders already do this to firms in the private sector that prove to be poor payers.

15. It is perhaps symptomatic of this trend that some Trusts, our Members tell us, are reluctant to pay by direct debit, causing unnecessary costs for funders and themselves. We would like the Department to encourage all Trusts to adopt this as a practice.
WINDING UP FOUNDATION HOSPITAL TRUSTS (FHTs)

16. When FHTs were set up, under the Health and Social Care (Community Health and Standards) Act 2003, it was provided that they could be wound up, unlike traditional NHS Trusts. This made their creditworthiness unclear, so the FLA met the Department of Health in early 2004 to express our concerns. In April 2004 the Department consulted on the secondary legislation required to explain, in detail, what would happen if a FHT was wound up. They proposed a model loosely based on insolvency legislation applicable to the private sector. The FLA and others responded by the deadline of June 2004.

17. The FLA explained why the model was unsatisfactory from our perspective. In particular, it transferred liabilities from traditional Trusts, covered by the 1996 Residual Liabilities Act, which guaranteed repayment when a Trust was re-reorganised, to FHTs, where the Act did not apply; and it did not provide clarity on what would happen to the assets and liabilities of a FHT if it were wound up.

18. Since then, there has been no movement towards the needed legislation. Over the years this has caused considerable difficulties for asset finance providers, since it has created considerable uncertainty about the creditworthiness of FHTs. These concerns are not theoretical. A few FHTs have experienced considerable financial difficulties. Monitor has put in place an excellent financial control regime, but it cannot guarantee there will be no windings-up. The legislation is needed and the Department of Health should bring it forward soon.

NEW TAX ARRANGEMENTS FOR NHS LEASING

19. The current Finance Bill includes a radical re-shaping of the taxation of leasing. One consequence will be that for leasing transactions lasting over five years it may be the lessee that has to claim capital allowances on investment in equipment. Lessees that are ineligible for allowances will not get any benefit, since in these circumstances the lessor too will be unable to claim. This applies to the NHS. It seems a curious time to make it more difficult for the NHS to access asset finance, given its financial benefits, including for NHS cash flow. We have pointed this out to HMRC but they have insisted that changing this would threaten the structure of their approach. We doubt this and would like it re-visited in the 2007 Finance Act.

Finance & Leasing Association
31 May 2006

Evidence submitted by the Healthcare Commission (Def 45)

SUMMARY OF KEY POINTS

— Under the star ratings system of assessing the performance of NHS organisations, their financial performance was hidden in the trust’s overall rating.
— From what we can examine, there are few clear links between deficit and the overall performance against targets under star ratings. We believe this is because the current financial deficits are not solely caused by poor management.
— We have created a new system of assessing the performance of NHS organisation—the annual health check. This will offer a rating in two parts, which will look separately at the quality of care and use of resources, the latter including financial management. We hope that this will allow much greater transparency and give proper weight to financial performance.
— We consider this is important because we believe that, over time, a good quality of care and good financial management are closely linked.

INTRODUCTION

1. The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales.

1.1 In England, we are responsible for assessing and reporting on the performance of NHS and independent healthcare organisations to ensure they are providing a high standard of care. We also encourage providers continually to improve their services and the way in which they work.

1.2 We believe that trusts that are managed well should be able to achieve both a secure financial balance and services that are of a high quality. Conversely, trusts that are poorly managed may struggle to hit targets for both finances and quality of care.

1.3 The Healthcare Commission is responsible for giving NHS trusts in England an annual performance rating. We have developed the annual health check, which replaces the former “star” ratings, with the first results due to be published on 12 October 2006. The annual health check aims to give a broader and richer picture of performance.
1.4 In this submission we have examined what we currently know about NHS deficits and their performance from the old star ratings system, and we have set out how we intend to monitor the financial performance and quality of care under our new system (the annual health check).

CURRENT PICTURE

2. We have made some observations looking at what we know from the performance ratings of NHS trusts in 2004–05 and from information on the Department of Health’s website detailing forecast deficits at month six of 2005–06. We found it useful to separate PCTs from other NHS trusts, as the reasons for their financial performance can be very different, as one group primarily commissions services while the other provides services.

RELATIONSHIP BETWEEN DEFICITS AND STAR RATINGS (NON-PCT TRUSTS)

2.1 The star ratings system looked at how well NHS trusts performed against key targets in areas such as waiting times and cleanliness. Under the star ratings system, the overall rating included an assessment of financial balance. This must be remembered when comparing the deficits trusts have with their star rating. Poor financial performance may have been a significant factor in their poor star rating. We must not count poor financial performance twice.

Figure 1

HOSPITAL STAR RATINGS 2004–05 AND DEFICITS

2.2 Figure 1 shows that the higher the star rating of a hospital trust, the higher the proportion of trusts with no deficit. However, figure 1 also shows that a large proportion of trusts with a two star rating projected deficits at month six in 2005–06, which shows that a deficit is not directly correlated with a low star rating.

2.3 As noted above, the weakness of looking at star ratings and deficits is that financial performance will influence the star rating of a trust, so we do not have independent measures of quality and finance here.

2.4 Using an adjusted rating, it is possible to come closer to a measure of quality, which does not include the financial aspect of performance.

2.5 Figure 2 shows the relationship between the adjusted scores and the projected deficit.
2.6 This comparison makes clear that a large proportion of hospital trusts reporting a deficit in 2005–06 had a relatively high score on other aspects of their performance in 2004–05. Therefore, a lower score on the adjusted rating is not a good predictor of a deficit.

### The Relationship between Deficits and Targets for Waiting Lists

2.7 Targets for waiting times provide a separate basis for assessing the quality of services in a trust. We have looked at the proportion of trusts not meeting the targets for waiting times, and deficits. However, the proportion of provider trusts meeting their targets for waiting times is relatively high and so there is no strong correlation between performance for waiting lists and forecast deficits.

### Underlying Cost Structure

2.8 Under payment by results, NHS providers will receive a fixed payment for each type of care they provide. Payments are linked to specific types of healthcare and patient groups and based on the average cost of providing each type of care. It is possible in the future that hospitals that cost more will be more likely to incur a deficit. However, payment by results has so far only been applied to part of the total caseload of providers (primarily admitted patient care).

2.9 It is possible that providers with higher underlying costs may be more likely to incur a deficit. However, we have examined reference costs, which measure the cost per patient of each type of care provided, at each trust. There is no clear relationship, suggesting that higher costs do not lead directly to a deficit. This could be because hospitals that cost more are likely to have these higher costs reflected in agreements on services with their local PCTs. While they may be more at risk of deficits if payment by results affects all their caseload in future, currently there does not appear to be a strong link between cost per case and deficits.

2.10 Some deficits may be from structural causes—underlying problems in the organisation or the local health economy, which are not easily fixed by short-term management action. For example, a number of the providers with large deficits operate several hospitals of small to medium size, which may be in smaller towns without a natural flow of communications. These providers are also less likely to benefit from market forces, which compensate providers in areas where the local labour market results in above average wages (particularly London and other big cities). Increased performance of larger city centre hospitals, stimulated by pressure to meet targets and, to a lesser extent, by the new payment by results regime, is likely to have presented challenges to these smaller providers, which could be difficult to resolve without significant and unpopular service changes.

### The Relationship between PCT Deficits and Funding Growth

2.11 Because of changes in the funding formula for PCTs, different PCTs have received differing levels of growth over the last three years. Close to one in three of those PCTs with the lowest levels of growth are projecting a deficit.

2.12 It may seem obvious that a PCT with a higher rate of growth in its funding is less likely to incur a deficit. This situation becomes more likely if deficits are due to factors external to the PCT. For example, if pay and prices rise by a given percentage across the NHS, those PCTs with growth above this level are much more likely not to incur a deficit.
2.13 The relationship is less clear where growth of activity is a major cause of a deficit as growth in activity may occur at different rates in different areas.

2.14 If weak management is the cause of deficits, we might expect to see more deficits in PCTs with high rates of growth, as these would not be immune from poor management. Indeed, these PCTs could be at risk of behaving with less financial prudence because of their higher growth in resources. A link between deficits and funding growth could therefore suggest that it is external pressures on resources, rather than an internal source such as weak financial management, that is driving the deficits.

**Moving Forward—the Annual Health Check**

3. In October, the Healthcare Commission will be giving NHS trusts the first performance ratings using our new system, the annual health check.

3.1 The annual health check is a new information-led and risk-based approach to assessing and reporting on the performance of NHS organisations. Our annual health check is designed to answer two questions:

— Are healthcare organisations getting the basics right?

— Are healthcare organisations making and sustaining progress?

3.2 We are committed to delivering an annual assessment that provides meaningful information for patients, the public and those who commission and provide services. We have therefore decided that in 2005–06 we will publish performance ratings across two elements: use of resources and quality of services. We recognise that good financial management is absolutely necessary for the provision of good quality care and these elements will therefore be closely linked. However, by assessing and reporting on the two elements, we believe the ratings will provide more meaningful information about the quality of services while maintaining a strong emphasis on the use of resources.

3.3 The Commission will score trusts for each of these areas on a four-point scale that ranges from “excellent” to “weak”. We believe that this will lead to a deeper understanding of the all round performance of NHS trusts. Throughout the year we will be closely monitoring the quality of care provided by trusts with the biggest financial deficits.

3.4 The part of the rating looking at use of resources will provide a more rigorous and complete picture of financial performance. We will assess trusts on a range of financial measures including financial planning and value for money, not just whether the trust has broken even (as with star ratings). This new way of reporting will ensure that financial management is assessed more thoroughly and is not hidden within the overall rating.

3.5 The rules for assessing financial management have been significantly strengthened. In the star ratings in 2004–05, a non-foundation trust was scored as “significantly under-achieved” (the lowest rating) if it was more than 1% of turnover or £1 million overspent. In the 2005–06 annual health check, a trust will be scored as “weak” (the lowest rating) if it fails to achieve the statutory duty to break even. There will not be any threshold of allowed overspending. We recognise that good financial management is absolutely necessary and we will reflect this in the strong emphasis on assessment under the use of resources.

3.6 A key element of our approach to regulation is to make use of existing information and not to duplicate the work of other regulators. Therefore, our assessments of the use of resources will be derived from other regulators. Monitor will provide the assessment of NHS foundation trusts, based on its financial ratings. The Audit Commission will provide this assessment for other trusts and PCTs, based on findings from the local evaluation assessments by auditors as part of its statutory external audits.

3.7 In 2006–07, to reflect the continued importance of financial standing within the NHS, we will continue to take a tough approach to this area of our assessment. We will also consider how we can provide comparative information on relevant matters relating to the use and management of the workforce alongside the financial rating. This will not affect the rating provided by other regulators.

3.8 The annual health check will also provide clear information on the quality of services being provided. Compliance with core standards is crucial for patients, but we also want to promote further improvements in health and healthcare by stretching the highest performers.

3.9 For 2006–07 we intend to assess NHS progress in relation to some of the developmental standards, measuring improvement in the areas of safety, clinical and cost effectiveness, patient focus and public health. These standards will enable improvement to be assessed within trusts and across the NHS. We also plan to conduct focused reviews in priority areas such as diabetes, substance misuse, mental health, race and equality and maternity services.
3.10 We believe this approach supports a comprehensive assessment of NHS organisations, which recognises the importance of both the quality of services and sound financial management in delivering sustainable high quality care for patients. It will enable us to comment in the future on both the quality of services and financial management, and any links that may be apparent between the two elements.

Alexa Knight
Healthcare Commission
6 June 2006

Evidence submitted by Patient and Public Involvement Forum, Hull and East Yorks Hospital Trust (Def 17)

HULL AND EAST YORKSHIRE HOSPITALS TRUST

Background to the author of this submission: the Clinical Radiology Patient Liaison Group was set up six years ago under the patronage of the Royal College of Radiologists and is now a Trust-adopted patient-group, monitoring and supporting the work of all modalities of medical imaging within HEYHT.

The Patient and Public Involvement Forums were set under Parliamentary legislation on December 2003, one Forum to every healthcare Trust. The PPI Forum has statutory powers to inspect and monitor, and its work-plan is shaped specifically by local concerns and issues as these arise through Forum’s contacts with the public, with local organisations and with patients and carers’ groups. Forum can respond to these contacts within a matter of days and be in the Trust to assess the validity of any concerns. Forum is made up of an independent team of local people, all users of the Trust’s services, and has a well developed understanding of the system and its constraints. The Forum regularly visits and inspects the Trust, identifying good practice and highlighting concerns. It sends copies of its Visits’ Reports to the Trust for response and action. PPI Forum for HEYHT provided a Commentary for the Healthcare Commission’s Healthcheck Assessment of April, 2006. The Forum complements and underpins the work of the Healthcare Commission, which relies on Trusts’ self-assessment and which actually visits only about 20% of Trusts.

1. DECIFIT

£13 million deficit, end of 2005–06
Income for 2005–06 = £343 million
Budget set = £329 million
Savings to be made in 2006–07 in baseline budgets (include efficiency gain, maintaining cost pressures, and eliminating underlying deficit in 2006–07) = £18 million
TOTAL to find in 2006–07 = £31

2. REASONS FOR DEFICITS:

2.1 Factors from the Dept. of Health.

2.1.1 There has been constant change and instability in the fiscal landscape, for example, “balance in-year” now seems to have become “monthly income must equal monthly expenditure by the year-end”. These changes to rules and time-scales, and all the successive government imperatives absorb an enormous amount of expensive managerial/clinical time and detract from focus on the core-business of nursing and caring. There is too much imposed emphasis on protocols/data-gathering/auditing/regulation. This draws management-attention and expertise away from the patient-interface and creates, rather than the desired single, seamless activity, two worlds, one looking up and outwards to Whitehall, the other actually trying to deliver patient-care. There remains uncertainty within investment/planning due to government changes, and dogma.

2.1.2 The artificial “push” towards Independent Sector provision has fragmented the service. The different systems do not “speak to each other” administratively or clinically. The incentives available to the private sector leave a non-level playing field. Further, the Independent Sector cherry-picks, only accepts the “routines” because the ethos of the private provider is commercial and driven by profit. There remains a lack of transparency in the IS due to the shield of “commercial confidentiality” and worse, and more worrying from the patients’ viewpoint, an absence of audit/ follow-up. The NHS picks up the pieces and inherits the complications.

2.1.3 Political dogma before clinical priorities and patient-need causes a dangerous distortion. The government imperatives skew the service. Patients are not “units” but individuals. Hospitals are not supermarkets. “One size fits all” policies are totally inappropriate and allow no recognition of local conditions. For example, the cancer-targets treat all cancers as the same yet the course of breast cancer and of prostate cancer is very different. Of men over 60, one in three may have prostate cancer yet only 2% of men die from it. Aggressive intervention causes unnecessary anxiety, suffering and often impotence. Many
of the “two-week wait” referrals turn out to be inappropriate, comprising only about 30% of cancer cases actually confirmed at the Trust. The targets in general propel care at such a rate that often true patient-consultation is absent, the clinician and his patient have little chance to consider options and implications and develop understanding and mutual trust. There is too much control from the centre.

2.2 Local factors

2.2.1 HEYHT is a large complex organisation with 7,000 staff (6,500 Full Time Equivalents) on two main sites. It provides acute and elective care for a city with high social deprivation and a high incidence of smoking, alcohol-intake, and obesity. The ensuing chronic health problems bring huge pressures on the Trust’s cancer, cardiac, renal, and diabetes services. There are ever rising numbers of acute care/non-elective patients and a significant proportion are the elderly with long-term co-morbidities.

2.2.2 The Accident and Emergency Department treats nearly twice the numbers it was built to manage and this is fuelled by the fact that Hull Royal Infirmary is surrounded by the city’s area of greatest social deprivation so the locals understandably all use A and E as “walk-in centre”. It is their nearest port of call.

2.2.3 These factors lead to relentless demand for bed spaces and there is inadequate step-down care in the community. The Trust has on average the equivalent of two-wards-full of elderly patients awaiting discharge. Beds are “blocked from the back door”. Red alert status often prevails.

2.2.4 All this has caused inevitable over-trade on SLAs (Service Level Agreements). Some commissioning PCTs, conspicuously the more rural ones, are in overspend and cannot pay for the care some of their patients have received. These commissioners are restricted in their future investment in HEYHT.

2.2.5 HEYHT has on one site a massive PFI building programme (cardiac, cancer care) for which no funding is yet agreed for pre-recruitment. On the other hand, it has aged building-stock on another site with the unavoidable incidence of expensive, unforeseen repairs. There are the inevitably poor functional and clinical adjacencies of older buildings.

2.2.6 There are costs beyond the Trust’s control. For example, energy prices went through the roof in the last financial year, and the cost of drugs and of blood products similarly went up dramatically.

2.2.7 Consultants’ contracts, being now pinned to PAs (Programmed Activities), have capped clinicians’ primary impulse to care and restricted them to less. Agenda for Change cost the Trust in cash and in significant management-hours. Further, A. for C. wiped out the established and understood structural progression through grades and destroyed the incentives to role extension. EWTD (European Working Time Directive) has limited the flexibility of staff, which in the areas of national skills’ shortages like Radiology has been particularly difficult to accommodate.

2.2.8 The endemic skills’ shortages in key areas like radiology, palliative care and microbiology force reliance on overtime-cover with its higher costs.

2.2.9 This Trust is a tertiary centre and a trauma centre and has some high unit costs as a result. It is also a teaching hospital and has education and training and supervision costs.

2.2.10 In the middle of all this, the Trust was required to undertake the diagnostic exercise of modelling for Foundation Trust status. There was no funding given for this and in view of the other issues with which the Trust was contending, it seemed singularly ill-timed as a requirement.

2.2.11 HEYHT undertakes much innovative Interventional Radiology work, recently, for example the first thoracic fenestrated graft of any kind in the UK and the first in the world performed inside a pre-existing thoracic stent graft. The outcome was excellent. This work is high cost, (currently PBR exempt), yet the benefits to patients are inestimable. The PBR (Payments By Results) formula in general, based on “average price”, could take some lessons from this for in many areas of care it is particularly unforgiving. A better formula would be “best practice” or “clinical-need” based.

2.2.12 The reconfiguration of the SHAs, though it caused no apparent hiatus in support, did not help as established relationships were being broken up. Similarly, the reconfigurations of PCTs caused unavoidable but unwelcome distractions from service issues.

3. Turnaround Team

3.1 The team is a Trust-appointed team from PriceWaterhouseCooper, not a team sent in by the Department of Health. The team is currently at work in the Trust. It is believed it will cost £300,000. The assumption that Trust staff do not already consider the best and most economical ways to treat is something of an insult. Clinicians constantly strive to do the best for their patients and find much of this exercise bureaucratic nonsense. Departments feel that the Turnaround Team is picking staff’s brains and submitting ideas thus gleaned in its report and recommendations.
4. **Effect on Care**

4.1 There is the tendency towards overcrowding on some wards and day rooms are often in use as bedspaces. There are pockets of poor infection-control, exacerbated by the lack of isolation units and by patient-movements. The constant high bed-occupancy rate does not allow this to be addressed. Privacy and dignity issues remain as the Trust is unable to replace/upgrade its mixed wards, and Nightingale wards. Some ward facilities are not refurbished and the Ward Environment Funds have been discontinued. “Charitable funds” of contributions from grateful relatives are now relied upon. Decant-facilities are often impossible to provide and some discharge-decisions are delayed due to poor MTD (Multi-Disciplinary Team) facilities.

4.2 This places huge burdens on the staff yet there has been a vacancy freeze in place as a result of the SHA’s ruling, and reliance on bank/agency staff has had to stop. Approval is being sought for “service critical” vacancies. The medical secretaries are under threat as HR actively considers outsourcing this function in an effort to save money. This would break clinicians’ vital relationships with patients and may put patient-confidentiality at risk. The personal and human touch will go if medical secretaries go. Clinicians’ work will be made more difficult. Staff shortages amongst administrative and clerical staff are already disrupting and delaying clinics. Stress levels are rising amongst staff, especially nursing staff, in the face of ever greater dependence on their already over-stretched goodwill.

4.3 Financial stringency has meant the Trust has been unable to address the shortage of MDT rooms, clinicians’ PPD (Personal and Professional Development) is at risk, and some mandatory training has already lapsed.

4.4 Some patient-wait facilities in HRI are inappropriate and inadequate, being trafficked by both in-patients and out-patients. The car-parking costs have been increased to yield more income, at the cost of the greater stress of patients and their relatives.

4.5 Non-target waiting lists have increased. Elective care has been delayed and operations cancelled. The thrombolysis targets have not been met, some cancer-care targets are similarly worsening. Radiotherapy waits are too long.

4.6 With baseline budgets severely limited, referrals are being “managed back” to budgets, the replacement of kit delayed/deferred (screening equipment, u/s, etc) and other refurbishment on hold.

4.7 There is monthly revision and restriction of the Trust’s Formulary with costs at the top of the discussion-agenda. Lab-testing is at full stretch and were the service to be asked to test for all likely MRSA colonisation-cases, it could not cope.

4.8 Staff are in receipt of e-mails asking, “What test or treatment is a ‘luxury’ and what can we stop?”

4.9 There is a lack of support now available for patient-groups, which serve as the vital independent patient-voice/patients-champion. The Trust’s PPI (patient and public involvement) Strategy is currently under review.

4.8 Some patient-wait facilities in HRI are inappropriate and inadequate, being trafficked by both in-patients and out-patients. The car-parking costs have been increased to yield more income, at the cost of the greater stress of patients and their relatives.

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5. **Number of Job Losses**

The SHA requires HEYHT to shed 300 staff. It is hoped that this can be achieved by natural wastage.

6. **Effect of “Top-Slicing”**

There exists some resentment amongst Trusts which do balance, that their reserves have in the past been clawed back by SHAs to bail out Trusts not in balance. The experience of some Foundation Trusts has been that their being in balance has led their commissioning-PCTs to be tougher with horse-trading.

7. **Recommendations**

7.1 The Dept. of Health should actually listen and respond to the local voice of the users of healthcare and defer to the knowledge of the clinicians and staff delivering the service. Token “consultation exercises” do not legitimise the current direction of so-called “reforms”. Every healthcare community is individual and the NHS, particularly the secondary sector responsible for acute and emergency care, should be allowed to shape the provision appropriate to the community it serves and have the local flexibility to continue to do this.

7.2 The Patient and Public Involvement Forums should be further supported as they constitute the only fully independent, statutorily empowered patient-voice and are ideally placed to promote best practice in standards of patient care and safeguard and enhance the patient experience.

7.3 The mania for “modelling from the middle” and for the over-control of the service and those who use it should be abandoned, as it is a philosophy propelled by defensive politics not by patients’ needs.
8. Finally

While it is acknowledged that it is impossible to substantiate a direct causal connection between the scenario here described, and the shortage of funding and the Government’s interference, this evidence is provided in absolute good faith and to the best of my knowledge. Many of the staff, at all levels, feel understandably inhibited from submitting evidence of their own, and it should be noted that evidence provided by real patients, on behalf of patients as a whole, is all too rare in the alleged “patient-led NHS.”

I would be prepared to give oral evidence if required.

Ruth Marsden,
Chair, Clinical Radiology Patient Liaison Group, and Chair, Patient and Public Involvement Forum for HEYHT.
4 June 2006

Evidence submitted by the Improving Surgical Outcomes Group (Def 41)

1. Introduction

1.1 The ISOG is an independent medical group comprising surgeons, anaesthetists, critical care consultants and others involved in operative management and care. The group is concerned with improving patient outcomes and modernising care for patients undergoing major surgery.

2. Summary

2.1 Overwhelming scientific evidence shows that haemodynamic optimisation of patients undergoing moderate and major risk surgery reduces the number and severity of post-operative complications. As a consequence, as patients feel better and need less post-operative care, they can be discharged sooner. The clinical benefit therefore translates into economic benefit as the cost of the patient’s hospital stay is reduced. In 2004 it was shown that the benefits shown in the clinical studies, of better patient outcomes at less cost, could be delivered in the NHS at Trust level. This raises the possibility of every Trust being able to save substantial amounts of money.

2.2 The effect on care arising from the Trust deficits means that Trusts are slow to introduce new technologies designed and proven to save money as they traditionally resist up front spend even if savings can subsequently be made.

2.3 This submission will examine only the term of reference concerning the consequences of the deficits and the economic benefits to Trusts of adopting Haemodynamic Optimisation for the benefit of patients and for saving money which could have an enormous impact on deficits.

3. The Consequences of the Deficits: The Effect on Care

3.1 The economic benefits of the introduction and use of haemodynamic optimisation arise because the technique not only saves lives but also saves money. Government initiatives like “spend to save” need to be more proactive to allow the faster introduction of procedures that are proven to save money for the NHS and help to reduce deficits.

3.2 The clinical studies suggest typical reductions in length of stay for haemodynamically optimised moderate and major risk surgical patients of around four days and audits of the real world impact have reported reductions of up to three days per patient. Even if these reductions were only in the lowest cost wards in UK hospitals at around £200 per day, this saving still equates to £600 to £800 per patient. It costs £50 to £60 to optimise each patient.

3.3 Based on the body of clinical evidence which has accumulated, mostly from UK hospitals, over the last 10 years there are about 1,000,000 NHS patients a year who would derive a clear clinical benefit from haemodynamic optimisation. If lengths of hospital stay for these patients were only reduced by two days each, the UK NHS would free up nearly 5,500 beds—the equivalent of 11 hospitals of 500 beds each. The saving would be, at the lowest estimate, £330 million a year rising to over £1 billion. This would represent a magnitude of cost-saving that could allow huge reductions in the deficit of an average NHS Trust.

3.4 The resources freed up by haemodynamic optimisation would be redeployed to enable the other two steps ISOG recommendations at minimal additional cost.

3.5 The benefits of haemodynamic optimisation are now well accepted by the majority of UK anaesthetists and those involved in intensive care. However, we estimate that no more than 40,000 NHS patients were monitored with appropriate equipment to allow doctors to haemodynamically optimise them in 2004.
3.6 At the rates of technology adoption typical in the NHS it will be many years until the remaining 960,000 patients receive the treatment evidence based medicine and basic economic sense demand they receive today. As a result, thousands of patients will continue to die unnecessarily each year, many more will carry on suffering the pain and misery of avoidable post-surgical complications and NHS hospitals will continue to spend hundreds of millions of pounds treating compromised patients who need not have been so ill in the first place. The status quo will potentially lead to even greater deficits.

3.7 Our report entitled Modernising Care for Patients Undergoing Major Surgery outlines a number of ways in which real savings can be made by NHS Trusts which will have an impact on deficits.

3.8 Examples demonstrating better use of surgical/anaesthetic resources include improving surgical outcomes by intra-operative haemodynamic optimisation and other techniques.

3.9 These interventions reduce both the number and severity of post-operative complications.

3.10 A study conducted at York District Hospital on the use of improved intraoperative care involving haemodynamic optimisation and other interventions, combined with the planned transfer of patients to ICU, resulted in a reduction of the mortality rate to 3% compared with 18% in the control group.

3.11 The study also demonstrated a reduction in the patients’ length of hospital stay—in terms of total bed days as well as ICU bed days—without increasing costs.

3.12 A Department of Health funded study at Worthing Hospital assessing “goal directed” fluid administration during bowel surgery (using oesophageal Doppler probes) showed a significant reduction in post-operative morbidity, faster return of gut motility and shorter length of stay.

3.13 Recent work from St Georges Hospital using goal directed fluid therapy in high risk surgical patients in intensive care after surgery reduced post-operative infections by 50% and cut length of stay by almost 40%.

3.14 Improvements in pre-operative assessment and preparation, peri-operative care and post-operative support have provided an important reduction in the mortality rate as well as decreasing the number and severity of complications suffered by patients following surgery, which has in turn provided savings in terms of ICU/HDU bed days per patient.

3.15 In addition to reducing the mortality rate, the study conducted at York demonstrated that haemodynamic optimisation reduced the number of ICU or HDU bed days used by 40% compared with routine care (median 3.3 days vs. 5.5 days), and total bed days per patient were reduced by 41% (median 13 days vs. 22 days).

3.16 The capital and running costs for providing improved pre-operative, peri-operative and post-operative support are marginal in comparison with the potential savings:

3.17 Pre-operative surgical risk assessment of patients undergoing major surgery can be measured by use of Cardio-pulmonary exercise testing (CPX), which is cheaper and more effective at predicting individualized pre-operative risk than many of the tests that are currently conducted to assess surgical risk (such as resting echocardiography) which are poor at predicting actual risk.

3.18 Consistent implementation across the NHS of existing treatments known to be effective at preventing post-operative complications (such as measures to prevent the formation of deep vein thrombosis) would also reduce unnecessary post-operative morbidity. Evidence on this particular issue has recently been given to the Health Select Committee.

3.19 For haemodynamic optimisation, the potential savings in terms of reduced hospital stays have been estimated for an average NHS trust to be in the order of over £2 million, based on reduction in stays of 22–31% and taking into account capital outlay of £60,000 and running costs of £150,000.

3.20 Overall, the package of improvements described would be cost effective. In addition, the introduction and use of haemodynamic optimisation into the NHS could realise savings for the NHS in the region of £1 billion which would have an enormous impact on the current and potential deficits in the NHS.

3.21 The ISOG would be prepared to offer oral evidence if requested to do so by the Committee.

4. Recommendation

4.1 Government initiatives like “spend to save” need to be more proactive to allow the faster introduction of procedures that are proven to save money for the NHS and help to reduce deficits.
Evidence submitted by Kensington and Chelsea PCT (Def 57)

This memorandum has been produced by Kensington and Chelsea PCT (KCPCT) in response to the inquiry being conducted by the Health Select Committee into NHS Deficits.

The following individuals have been requested to attend the evidence session on 22 June and will therefore be available to answer any questions the committee may have on this submission, or any other aspect of their inquiry:

Andrew Kenworthy Chief Executive
Martyn Everett Director of Recovery

In order to give the committee some background into KCPCT, attached to this memorandum is an overview of the size and scope of our operations and a brief financial history. It also gives a summary of the key findings in PricewaterhouseCoopers Public Interest Report issued in April 2006, a full copy of which is enclosed.24

Also enclosed is a copy of the Turnaround Plan 2006–09 which was presented to, and approved by, the Strategic Health Authority on 30 May 2006.24 It is due to be presented to the KCPCT Board for final approval on 20 June. The plan sets out in more detail the financial position of the trust and the savings initiatives that have been identified to bring the Trust back into financial balance.

For ease of reference, a bullet point summary has been included which sets out brief answers to some of the issues specifically listed in the committee’s terms of reference.

BACKGROUND AND HISTORICAL PERFORMANCE

Introduction

— Kensington and Chelsea PCT was formed on 1 April 2002 to serve a population of c190,000, covering the Royal Borough of Kensington and Chelsea. The PCT was formed from four predecessor NHS organisations.
— The PCT has 80 GPs within 44 practices.
— KCPCT has a large estates portfolio including:
  — St Charles Hospital site;
  — two nursing homes;
  — learning disabilities centre;
  — day hospital; and
  — numerous health care centres/GP surgeries.
— St Charles hospital was built in 1881 and was originally a hospital for the sick and poor but has been in use as an NHS hospital since 1948. Central and North West London Mental Health Trust occupy approximately one third of the site. The remainder provides a range of facilities for inpatient, rehabilitation and community services, including four wards, Minor Injuries Unit, palliative care centre, pharmacy and head office. Some 70% of inpatient care is for non KCPCT residents. The site also houses a number of services for other NHS organisations, including NHS Direct.
— The PCT provides the following health services to the local community in Kensington and Chelsea:
  — Community Nursing ie district nursing, specialist nursing, school nurses & health visitors;
  — Therapy Services including: physiotherapy, speech & language therapy, podiatry, occupational therapy, dietetics & nutrition and osteopathy;
  — Children’s Services including: children’s community nursing teams, child health surveillance;
  — Primary care/General Practitioner (GP) services from 44 General Practices and NHS Dentistry from 22 practices;
  — Learning Disability Services including: community learning disability team, adult residential unit (planned short break unit, emergency unit, crisis unit);
  — Older People’s Services including: 61 rehabilitation beds (of which only 18 are used by KCPCT patients), 73 continuing care beds and community care services;
  — Palliative Care—caring for people with advanced life threatening illnesses, at the 17-bed Pembridge Palliative Care Centre (of which KCPCT use only three) and providing specialist nurses in the community;
  — Minor Injuries Unit—15,615 attendances in 2005–06, of which 7,689 related to KCPCT residents;

24 Not printed here.
— Neuro-Rehabilitation Services—providing care and therapy for patients who have had a head injury or stroke; and
— GP Co-op providing out of hours general practice care.

— Key acute and mental health providers are:
— Chelsea & Westminster Hospital (£31.2 million SLA 2006/07);
— St Mary’s Hospital, Paddington (£21.9 million SLA 2006/07);
— Hammersmith Hospital (£14.7 million SLA 2006/07); and
— CNWL Mental Health (£31.2 million SLA 2006/07).

**Historical financial position**

— The PCT has underperformed financially since its inception and has breached its Revenue Resources Limit (RRL) in each of the last three years:

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<tr>
<td>RRL under/(over) spend</td>
<td>£0.7m</td>
<td>£(8.7)m</td>
<td>£(11.6)m</td>
<td>£(7.2)m</td>
</tr>
<tr>
<td>Under/(over) spend as % of RRL</td>
<td>0.3%</td>
<td>(3.7)%</td>
<td>(4.3)%</td>
<td>(2.8)%</td>
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— 2003–04 audited accounts showed an overspend of £1.6 million. However, a prior period adjustment of £7.1 million was made to the accounts during the 2004–05 audit. This related to invoices that had not been recorded correctly in the accounts, either because they had not been recorded on the PCT’s ledger or because they were in dispute between the PCT and the other health bodies.

— Of the total overspend c80% has been due to overspends against commissioning budgets.

— According to PricewaterhouseCoopers Public Interest Report, there were three principal reasons for underperformance:
  — significant failure in systems of corporate governance, particularly financial:
    — inappropriate commissioning budgets were set;
    — poor and incorrect budget monitoring so preventative measures could not be taken in time;
    — operational activity data and financial management information was not linked, which could have identified risks to budgets and adverse trends in actual expenditure;
    — staff were not deployed according to the level of commissioning expenditure risk;
    — poor co-operation between the Commissioning and Finance departments;
  — high levels of estate holdings and underutilised infrastructure; and
  — failure to recover the full cost of providing estate services to other local health bodies.

In addition the cost of providing a number of community services on behalf of other health bodies was also not fully recovered.

**Actions undertaken to address underperformance in 2005–06**

— As a result, management have taken a number of steps to address the consistent financial underperformance:
  — Interim chair appointed in July 2005;
  — Andrew Kenworthy appointed Chief Executive in September 2005;
  — David Avis appointed interim Financial Director in April 2005;
  — The interim chair has reviewed governance, with the following objectives:
    — undertake a board level review of current governance arrangement, perceptions and attitudes;
    — review the PCT’s corporate objectives and ensure these are risk assessed;
    — develop mechanisms to support delivery of objectives and ensure appropriate reporting to the Board;
    — develop an effective assurance framework;
  — The Chief Executive has reviewed management arrangements and has made the following changes:
— commissioning and finance department combined and strengthened, with improved data validation;
— a new role of Director of Performance Management and Primary Care has been created;
— The Chief Executive is working with managers to embed the following principles:
— ensure that the financial impact of decisions is understood by all staff (“finance is everyone’s business”);
— make decisions, see them through and performance manage them;
— emphasis on detail and challenge;
— continue to concentrate on relationship management with stakeholders;
— achieve full cost recovery on provider services;
— The interim Financial Director has improved routine financial controls, restructured the finance department and strengthened the finance team. He has also improved the financial reporting;
— External consultants appointed to review demand management procedures and initiatives; and
— Martyn Everett appointed to lead the turnaround process in April 2006, supported by Deloitte. A Chartered Accountant with initial experience with PriceWaterhouseCoopers, more recently in industry, as Deputy Chief Executive of an international group, dealing with the challenges confronting the UK manufacturing sector, particularly business restructuring and turnarounds.

SUMMARY

Size of the deficit
— Brought forward deficit at 1 April 2006 of £26 million.
— In year deficit in 2005–06 of £7.2 million, which was broadly inline with the control total set by the SHA.
— Base budget for 2006–07 showed a deficit of £10.1 million, after 3% topslice of £7.6 million, but before savings initiatives.

Savings initiatives
— Full year effect of the savings initiatives identified, £14.9 million.
— In year effect of savings, due to the timing of implementation, £9.9 million.
— One off costs arising from the initiatives, £0.4 million.
— Further savings of some £5 million–£7 million per annum are possible from rationalising the estate. The options are still being evaluated and would be subject to consultation and financial support from the SHA, to fund the associated one off costs.

Turnaround team
— Work commenced mid April 2006.
— Led by an independent turnaround director, full time until mid July and part time until the end of October.
— Assisted, until mid June, by a team of two from Deloitte’s, supported by specialist consultants in a number of areas.
— KCPCT senior managers seconded full time to the team, comprising, associate director bedded services/pharmacy, head of clinical governance, finance special projects and head of nursing practice development.
— Total estimated external cost of £0.4 million.
— KCPCT fully agrees with the findings of the recovery team. It believes the recovery plan is robust, achievable and sets a clear strategic direction over the next three years.
Reasons for the deficit

— Main cause of the deficit was poor management and a lack of financial controls, prior to the appointment of the current senior management team during 2005. This is evidenced by the enclosed Public Interest Report which is summarised in Appendix 1 and resulted in the resignations of the previous Chair, Chief Executive and Finance director.

Consequences of the deficit

— In the short term a number of the savings will be difficult but will not affect our core services. In the longer term it is our belief that this is an opportunity to improve patient care, and allow the trust to generate resources which can be reinvested into primary and community services for the future.

— Staff reductions arising from the plan are as follows:

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<th>Type</th>
<th>Numbers</th>
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<tr>
<td>Redundancies</td>
<td>73</td>
</tr>
<tr>
<td>Cancellation of vacant posts</td>
<td>31</td>
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<td>104</td>
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— KCPCT received a 3% reduction in growth monies for 2006–07. This was to create a London wide fund which aims to help the NHS in London to achieve balance in 2006–07. The plan assumes that this topslice of £7.6 million is not returned until at least 2009–10, but that there are no further topslices in either 2007–08 or 2008–09.

Period over which balance should be achieved

— Recurrent monthly surplus forecast from 1 October 2006.
— In year balance achieved in 2006–07.
— Cumulative deficit fully repaid in 2008–09.

Martyn Everett and Andrew Kenworthy
Kensington and Chelsea PCT
June 2006

Evidence submitted by the Overview and Scrutiny Committee on Health, Kensington and Chelsea (Def 14)

I am writing as Chairman of the Overview and Scrutiny Committee on Health in the Royal Borough of Kensington and Chelsea in response to your request for information on the current NHS deficits. I will be addressing more specifically the serious consequences which may arise from the likely attempts by the Department of Health to correct the financial problems of our local Primary Care Trust.

Many people must be astonished that after a period of unparalleled increase in funds into the NHS we are now faced with deficits on such a scale. Record funds seem to have led in some areas to record cuts and closures. All of this points directly to poor management. Clearly this has to be addressed and the present position is unacceptable. My purpose in writing is to express my fear that the solutions demanded today will not address the key issues which created the problems in the first place and will not help to create the sustaining and effective health service which we all seek.

The Kensington and Chelsea Primary Care Trust (KCPCT) is estimating an accumulated deficit at the end of March 2006 of around £28 million and their budget for the year 2006–07 indicated a further deficit of £9.4 million after a range of cuts. (KCPCT Board paper 9 May 2006) The Trust was aiming to come back into balance on a monthly basis by September 2007.

The new management of KCPCT is facing an uphill battle to correct the problems which it inherited when it took office in the second half of last year and this letter should not be seen as a personal attack on them. They did not create the problem, which has been further exacerbated by the 3% “top slicing” from its budget, the logic of which has never been explained to us.

The effect of being compelled to have no deficit for 2006–07 will have serious consequences and is the antithesis of good management practice. At the time of writing the full list of cuts which the PCT will seek to impose are not known but would be available for discussion at the hearings of the Committee later.

It is said that the NHS is moving from the discipline of targets to the discipline of the market. The effect of sudden and arbitrary cuts will compel the diversion of expenditures elsewhere and by reducing choice be directly contrary to what the NHS says it is seeking.
By demanding a very tight financial timetable KCPCT will be forced into a series of knee jerk painful financial decisions, which will be decided with little reference to the long term needs of the community. Ease of enforcement could be the determinant rather than community need. This is the very antithesis of good management and the supposed philosophy of the market in the delivery of services to the public.

Well run NHS Trusts which are in balance could be penalised by the failings of this PCT. Certain cross border Trusts may find that they can provide services to the residents of one borough but not to those who live across the border.

One possibility for KCPCT may be to concentrate on the provision of statutory services, although many of the so called “discretionary” services are as important in some localities as the statutory ones. Indeed the Drug Action Team in this Borough, which faces possible cuts, has been encouraged by the Department of Health itself as necessary for the well being of the community.

Long established partnerships carefully built up over the years with local authorities and voluntary organisations could be destroyed, as well as the credibility of the NHS.

At a time of financial crisis, as now in this Borough, what is needed is calm and considered analysis of what went wrong and a financial recovery programme which establishes a regime that will not repeat the failings of the past and which reflects the genuine needs of the community. Demanding that KCPCT has no deficit in the year to end March 2007, while current plans of the PCT are for breaking even in September 2007 is a slash and burn approach to management which should have no place in today’s world. Services destroyed today for short-term considerations cannot be switched on again in 12–18 months time, when the position has stabilised. They could be lost for a long time, possibly forever.

The nonsense of this short term approach is more apparent when the PCT moves to financial stability, perhaps even surplus. This is no way to provide a sustaining service designed to meet the long term health needs of the country.

There is an underlying problem of weak management in parts of the NHS, particularly at the centre, but short term panic cuts, arbitrary by their very nature, will not solve this.

The painful, and costly, solution must be to take time to rebuild management, analyse the problems (eg why does KCPCT pay £1 million a year to the costs of running Broadmoor when no KC resident is within the institution?) and to create a new culture of seeking to control costs logically and rationally. Money is not well used in the NHS but harsh decisions taken today to balance the books this year, rather than by September 2007, will be destructive of good services for our community which may well not become fully apparent for two/three years.

This letter has been written in general terms, for the full details of the cuts being forced on KCPCT are not known, but if the accounting dictats are to be met then I fear the consequences could be severe.

I am however far more concerned at the Department of Health’s approach to a serious problem which will not address the underlying issue, is contrary to good management practice and which may well have adverse long term consequences. The “quick fix” solution rarely works.

Cllr Christopher Buckmaster,
Chairman of the Overview and Scrutiny Committee for Health, Kensington and Chelsea.

2 June 2006

Evidence submitted by the King’s Fund (Def 49)

INTRODUCTION

This paper is a response by the King’s Fund to the Health Select Committee NHS deficits inquiry. The King’s Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding others. We are a major resource to people working in health and social care, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

1. The size of the deficits and the savings which each trust has to make in 2006–07

Final (unaudited) accounts 2005–06

The 2005–6 unaudited English NHS accounts (released on 7 June 2006) reveal a gross deficit of £1.277 billion, a gross surplus of £765 million and a resultant net deficit of £512 million. These figures exclude Foundation Trusts which recently reported equivalent figures of £53.8 million, £29.8 million and a net deficit of £24 million.
Overall, these figures represent not only a deterioration on the outturn position for 2004–05, but a worsening of the gross deficit position compared with the six month end of year forecast by NHS organisations.

Although the net deficit of £512 million is an improvement on the month six forecast of £623 million, this is almost entirely due to much larger underspends than forecast by Strategic Health Authorities—primarily on the NHS staff training budget (workforce development confederation) and not the result of improvements in trust and primary care trust finances (see figure 1).

Further, while 133 NHS organisations forecast a deficit end of year position, the outturn indicates that this has increased to 174.

A more detailed organisation-by-organisation analysis of the accounts released on 7 June is required, but a first cut, comparing the six month forecast end of year position with the final outturn suggests the following:

Primary care trusts:
- Of the 70 (out of 303) PCTs forecasting at month six an end of year deficit, 38 finally reported a worsening of their deficit and 32 an improvement. Of the improving group, half reported surpluses and half remained in deficit.
- Of the 198 PCTs originally forecasting balanced books, 49 finally reported deficits (totalling £195.5 million), 139, surpluses (totalling £65 million) and 10 remained in balance.
- Overall, the gross PCT deficit rose from £348 million to £391 million, and PCTs forecasting a surplus (of £47 million) finally reported a total deficit of £84.5 million.

Trusts:
- Of the 61 (out of 235) trusts forecasting at month six an end of year deficit, 25 finally reported a worsening of their deficit and 36 an improvement. Of the latter, 20 finally reported a surplus (or balanced books) and 16 remained in deficit.
- Of the 145 trusts originally forecasting balanced books, 27 reported a deficit (totalling £148.2 million), 110 reported a surplus (totalling £69.6 million) and 11 remained in balance.
- Overall, the gross trust deficit fell by £35.8 million, but trusts forecasting a surplus of £34.5 million finally reported a deficit totalling £46.4 million.
Strategic Health Authorities:

— Of the three (out of 28) SHAs forecasting a deficit, all finally reported a surplus.
— Of the seven SHAs forecasting balanced books, all, again, finally reported a surplus.
— Overall, the forecast gross SHA deficit of £50.6 million was finally reported as a surplus of £19.8 million. And the forecast net surplus of £193.2 million rose to £524 million in the final accounts.

Despite the intense pressure on the NHS since the publication of the month six forecast end of year position in December 2005, the overall picture revealed by the final (unaudited) accounts is not overly encouraging. While there have been improvements in many organisations financial situation, half of those forecasting a deficit in December saw their position worsen. And the overall improvement in the net deficit was largely achieved by the large increase in surpluses reported by SHAs in the final accounts, while the net deficit position of trusts and PCTs worsened overall.

Savings required by NHS organisations in 2006–07 as a result of 2005–06 net deficit

It is difficult to be precise the level of savings that the NHS will make in 2006–07 as a result of the carry forward of the 2005–06 deficit as this hinges on the application of the resource accounting and budgeting (RAB) framework principles and decisions about the period over which recovery plans are agreed.

In principle, NHS Trusts ending 2005–06 with a deficit are wholly responsible for recovering their financial position. Again in principle, the period over which they do this can extend exceptionally to four years, under a recovery plan agreed with their SHA. Under RAB, organisations in deficit in 2005–06 will have their allocations in 2006–07 reduced by the amount of the deficit in order that the Department of Health remains within its Departmental Expenditure Limit (DEL). This is because the Department of Health allows organisations to retain surpluses and the whole system must be in balance. In effect, through this application of RAB, one year’s deficit is immediately recovered in the next year, leaving deficit organisations in the position of fulfilling their contractual duties with reduced income.

However, RAB also requires that a deficit incurred in 2005–06 is posted on a Trusts’ balance sheet as a cumulative deficit which also needs to be recovered over the following two years. As the NAO have noted however25, in effect this application of RAB by the Department of Health (that is, cascading down the basic RAB principle to SHAs and then to trusts) means that once financial balance has been lost the effect of this “double deficit” (reduced income plus a cumulative deficit which needs to be recovered) makes it doubly difficult for an organisation to recover financial balance in subsequent years.

However, as the NAO also point out, how RAB has actually been applied within the NHS is unclear, although there appear to be inconsistencies between SHAs.

It is also the case that while the RAB income-reducing principle is also applied to PCTs with a deficit, unlike trusts the deficit does not have to appear on their balance sheet as well. In effect, a deficit PCT “pays back” its deficit immediately through the simple expedient of having its allocation reduced the following year.

The actual strategies adopted by SHAs to deal with the 2005–06 deficit in 2006–07 appear to adopt a more system-wide approach to fulfilling the RAB principle with, for example, requirements for organisations with surpluses to give these up to their SHAs in order to help deficit organisations with their financial recovery—a sort of up-front brokerage. Deficit organisations can then draw on this money over three years—but are required to pay it back. Some SHAs have gone further, topslicing all organisations regardless of their financial position in order to create such a cash buffer.

2. The reasons for the deficits, including:

— whether the causes are systemic or local (eg the role of poor local management and poor central management, the effect of pay awards and Government policy decisions);

There is no single cause of deficits, nor one cause that stands out as more important than others. Based on our scrutiny of board papers and Public Interest Reports issued by the Audit Commission we have identified three types of cause: local management problems; local health economy problems and the impact of national policies and decisions.

Local management problems: These include failings unique to individual institutions, such as (rarely) impropriety in accounting techniques or understaffed finance departments. There are also more generic management failings that are common to many organisations that have experienced financial problems: poor quality financial data and reporting techniques, a failure by senior management to assign the same importance to financial competence as to clinical matters, and (most importantly) a long standing assumption that overspends (and cash shortages) could be sorted out at the end of the financial year through short term fixes, either using capital to revenue transfers (now no longer allowed); brokerage from other NHS institutions and savings from “non-recurrent” sources of money (eg underspent IT projects).

Local health economy problems: these causes include historical deficits (a minority of PCTs appear to have inherited old Health Authority deficits) but also patterns of neighbouring PCTs and Hospital trusts all experiencing deficits. This appears to have led to disputes about payment over work done and unsigned service level agreements. In addition, some areas do appear to experience difficulties because services need to be reconfigured-either there is duplication across several sites or an excess of provision.

National policies: All trusts have been subject to central government targets. In some cases, meeting these targets has led Trusts to spend in excess of their income, which appears to have been justified on the grounds that ensuring patient access is a higher priority than the duty to achieve financial balance. Although this practice has been criticised by the current government, official documents from the Department of Health in the past have struck a similar note, for instance guidance issued in 1999 made it clear that a trust’s break-even period might be extended beyond three years if the actions needed to cut a deficit “might seriously threaten the achievement of national performance targets” or lead to “unacceptable service consequences”26.

All trusts have also been subject to known cost pressures, including higher pay for GPs, consultants and the costs of implementing Agenda for Change, implementing NICE guidance, clinical negligence and so on. Some Trusts do identify the cost of meeting higher deals as a contributory factor but it is not clear why some trusts would feel the impact on a bigger scale than others.

Similarly, all trusts are subject to the same accounting regime, namely the Resource and Accounting Budget regime (RAB), which, in theory, automatically adjusts a Trust’s income up or down according to the previous year’s over or underspend. However, some Hospital Trusts have complained that RAB has created a “double deficit” (see above) as their income is reduced at the same time as a deficit is posted on their balance sheet. Only a minority of deficit-hit trusts mention RAB as a problem, however, which might be explained by SHA’s interpreting the regime in different ways, according to the NAO.

What does seem clear is that the big system reforms of patient choice and payment by results are unlikely to be a contributing cause of the deficits, as choice has only been rolled out since January 2006 and Payment by Results has only applied to the bulk of hospital activity since April 2006.

While not a direct cause, system reform could be thought of as an indirect cause: the Government has predicted (and indeed deliberately engineered) a much more risky and potentially turbulent financial environment for trusts in order to generate more responsive and efficient services. This has led to an important change of message from the centre: financial competence has now become the top priority for the NHS and surpluses should be generated routinely in the future, in order to facilitate the new system reforms.

However commendable this new attitude to the stewardship of public money, it is clear that the current deficits have been accruing over several years (and, it must be assumed, with some cognisance by the centre) and are unlikely to be amenable to instant remedy.

— the findings of the “turn-around” teams, whether these findings are right and whether the turn-around teams have provided value for money; and

The latest government document reports that 98 organisations are receiving “turnaround” support, coordinated by a National Programme Office27. There is no information in the public domain about its current findings, or a full list of the organisations involved. There is no information about the cost of the support.

An initial assessment of financial turnaround was published in January 2006, based on an analysis carried out in late 2005 by KPMG of 62 PCTs and Trusts forecasting significant deficits28. According to that assessment, KPMG identified poor management and poor information as key factors, however the full KPMG report has not been published, so it is difficult to comment on their findings.

On 25 January the Department of Health announced that “teams of financial specialists” would be sent into 18 organisations deemed to require urgent intervention. The full effects of these teams have yet to be assessed, however comparing the month six forecast financial situation with the final outturn, of the 18 trusts in question: eight saw their deficit increase and 10 improved. Of the latter, six still have deficits, and four are now in surplus.

— the relationship between the funding formula, the allocation of funds to trusts and the size of their deficits or surpluses

As mentioned above, there are no simple patterns behind the deficits. Although some have suggested that there is a geographical pattern to deficits which is in turn linked to the NHS allocation formulae, the Department of Health29 have found no relationship between the size of deficits and spending per head, or the distance from target (for PCTs) or the growth in allocations.

The map below similarly suggests that for PCT deficits there is little obvious geographical pattern.

26 Department of Health Health Service Circular HSC 1999/146.
29 Department of Health Health Service Circular HSC 1999/146.
Conclusions

The deficit incurred by the NHS in England last year was serious, but not catastrophic; similar overspending has been dealt with in the past. However, the current financial environment now leaves NHS organisations with less room for financial manoeuvre and the demands placed on the NHS, for example, to meet centrally-set targets, are much tougher. While system reforms such as patient choice and payment by results have, in the view of the King’s Fund, contributed little so far to the 2005–06 financial position, there is no doubt that these reforms make the current and future financial environment more uncertain for NHS organisations and will demand much tighter financial control than previously.
As the King’s Fund and others have already noted, the causes of the deficit problem are multiple and vary from organisation to organisation, in part a result of national decisions and policies, and in part the particularly financial and management history of local organisations.

The solution to future financial stability must lie in much greater transparency in accounting procedures (in particular, a consistent application of RAB and clarity about planned financial support); system-wide support and technical help to head off potentially serious financial problems; and a balanced approach to the incentives on organisations to balance their books.

Importantly, looking to the future, the NHS needs to prepare itself for changes in the financial environment heralded by system reforms such as payment by results and patient choice so that it does not fight the next war as if it were the same as the last.

King’s Fund
June 2006

Evidence submitted by KPMG (Def 56)

1. NATIONAL REVIEW ON BEHALF OF THE DEPARTMENT OF HEALTH (PROJECT SANDS)

On 1 December 2005, the Secretary of State made a public statement revealing that at the half way stage (ie six months to September 2005) the NHS had a deficit of £620 million. She also announced that turnaround teams would be sent into those SHAs, NHS Hospital Trusts and Primary Care Trusts with the biggest deficits to assess their ability to achieve financial balance.

Following a tender process, KPMG undertook a review of 62 entities and two SHAs and reported back to the DH on 23 December 2005. We carried out a review of a further 36 entities during January and February 2006 and reported on 16 February 2006.

Our findings can be summarised as follows:

— Following a review of our findings with each SHA, 25 entities were categorised as requiring significant external assistance to achieve financial balance.

— Financial planning by the NHS commenced too late during 2005–06 and should be advanced for 2006–07.

— Management capacity generally in the NHS needed to be improved. In particular:
  — SHAs lacked executive experience in change management.
  — Hospital trusts needed support, especially in developing improvement plans and with financial management.
  — PCTs had too many layers of management and needed support in developing turnaround plans.

— The quality of financial information was generally poor. In particular:
  — The Income and Expenditure and cash impacts of operational changes were not well analysed.
  — Trusts generally lacked benefits tracking processes to help monitor their improvement plans.
  — The level of brokerage confused the underlying trading position of the entities.
  — There was a lack of transparency in how entities forecast their financial outturns.

— The NHS needed improved leadership and control. In particular:
  — SHAs needed to play a greater role in capacity planning and service reconfiguration in their local health economy, and help resolve local conflicts between providers and commissioners.
  — Entities should be required to provide timely and deliverable turnaround plans which could be extensively monitored by the SHAs.
  — Entities should not be limited to take an in-year view of turnaround plans and some savings would take more than one year to effect.

2. BACKGROUND ON TRUSTS PROVIDING EVIDENCE TO THE HEALTH COMMITTEE FROM THE NATIONAL REVIEW

With regard to the four trusts the Health Committee is hearing evidence from later in this process (West Hertfordshire Hospitals Health Trust, University Hospital of North Staffordshire NHS Trust, South Tees Hospitals NHS Trust and Kensington & Chelsea PCT), all of these trusts were part of the National Review carried out by KPMG referred to above.

Each of these trusts had large deficits forecast for 2005–06 ranging from £18 million to £30 million. With the exception of North Staffordshire, a large proportion of these deficits (approximately 50%) related to brought forward deficits accounted under the RAB adjustment.
Our review focused on a number of key areas for a turnaround:

— Current and forecast Income and Expenditure.
— Robustness and deliverability of any cost reduction or financial recovery plan.
— Current and forecast liquidity position.
— Achievability of recurrent financial balance.
— Clinical and operational performance.

From our review and in consultation with the local Strategic Health Authority, we prioritised the trusts in terms of urgency on the part of the Department of Health to intervene as well as the ability of the management team to achieve financial balance. University Hospital of North Staffordshire NHS Trust was categorised as needing urgent action, two of the trusts were assessed to need support to aid the turnaround (West Hertfordshire Hospitals Health Trust and Kensington & Chelsea PCT) and one needed careful monitoring (South Tees Hospitals NHS Trust).

3. KPMG INVOLVEMENT IN NHS TURNAROUND SINCE PROJECT SANDS

We set out below the NHS entities we have assisted with their turnaround plans since completing Project Sands:

<table>
<thead>
<tr>
<th>Hospital Trusts</th>
<th>KPMG Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLH Foundation Trust</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Surrey and Sussex Healthcare Trust</td>
<td>Completed</td>
</tr>
<tr>
<td>Queen Mary’s Hospital Trust, Sidcup</td>
<td>Completed</td>
</tr>
<tr>
<td>Royal West Sussex Healthcare Trust</td>
<td>Completed</td>
</tr>
<tr>
<td>Whipps Cross University Hospital Trust</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Lewisham Hospital Trust</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Queen Elizabeth Kings Lynn Hospital Trust</td>
<td>Completed</td>
</tr>
<tr>
<td>Blackpool Fylde and Wyre Trust</td>
<td>Completed</td>
</tr>
<tr>
<td>Wolverhampton Trust</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Trusts</th>
<th>KPMG Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selby and York PCT</td>
<td>Completed</td>
</tr>
<tr>
<td>Cheshire West PCT</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Cambridge City and South Cambridgeshire PCT</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Kennet and North Wiltshire PCT</td>
<td>Completed</td>
</tr>
<tr>
<td>West Wiltshire PCT</td>
<td>Completed</td>
</tr>
</tbody>
</table>

4. OVERVIEW OF KPMG APPROACH TO NHS TURNAROUND

Our approach to NHS turnaround has a number of features:

— All the KPMG teams are blended teams of restructuring professionals, who have extensive experience of turnaround in the private sector, and health specialists, who are clinically experienced in complex Trust areas such as theatres, nursing establishments, procurement, clinical support services and service redesign.

— We see our role as supporting management, helping them to make the right decisions based on all available information.

— We provide hands-on support, working jointly with the Trust’s own project team. This joint team, led typically by someone from the Trust, develops opportunities for cost improvement. By working in a joint team, we are able to encourage skills transfer so that our processes for financial recovery plans become embedded in the Trust’s day to day management.

— Our style is to understand the Trust’s current performance and plans for improvement so that we jointly agree a set of robust and deliverable plans.

— We provide objective benchmarking of the Trust’s operational performance. We compare length of stay, reference costs, day case rates and theatre utilisations against a carefully chosen peer group of UK NHS Trusts. This benchmarking is essential in identifying the key areas of operational inefficiency and obtaining clinical buy-in.

— Our scope of work usually requires us to identify only those opportunities which are within management’s control to improve. Service reconfiguration or capacity reduction across the local health economy is usually an area reserved for the SHA to address.
— An essential part of our approach is to ensure ownership and accountability of each project by an identified individual within the Trust. We facilitate clinical engagement and buy-in by working alongside the Directorates. At every major stage, our findings are shared with, discussed and agreed by appropriate clinical leaders.

— We also help the Trust to put in place an appropriate governance structure which ensures that the joint team is structured and controlled by clinical, operational and finance managers and board directors, who are ultimately accountable to the Trust for the turnaround plan.

5. The Need for Turnaround Specialists

— Organisations that are incurring financial deficits require a different style of management compared with stable, growing and profitable organisations. This is readily accepted in the private sector where individuals and teams are often drafted into troubled companies to help effect stabilisation and turnaround.

— Stopping losses requires a management team to have clear short and medium goals; to be clear in their expectations of others; to be pragmatic, decisive and consistent; to communicate clearly and continuously with key stakeholders and to develop and implement a plan rapidly. Leadership of a turnaround demands a more directive style than the cooperative approach that typically works in healthy situations.

— A turnaround plan must be clear, well articulated and fully accepted by those responsible for its implementation. The ideas underpinning a plan are generally most successful if they are generated internally. The role of the turnaround specialist is to set stretch targets, challenge preconceived ways of working, offer new approaches and thereby draw out from an organisation the best, most practical initiatives.

— Evaluating options requires robust and reliable financial and other information. In environments where reporting systems have been designed for purposes other than financial stability, the turnaround specialist must rapidly determine what must be improved and what can be relied on. Thereafter they will help put in place essential improvements to reduce risk.

— Implementing a plan demands widespread support, alignment of objectives within the organisation, detailed and responsive monitoring and obvious acceptance of leadership and responsibility.

— The elapsed time for the development and implementation of all of the above is typically 4 to 16 weeks for the planning and 6 to 24 months for the implementation. Throughout this period it is essential that management maintain their rigorous pursuit of the operational objectives of the organisation.

— Hospitals and PCTs are complex organisations dealing with a large number of individuals, regulatory bodies and other organisations. It is rare that they will have either the skills in-house or the spare capacity to be able to effect a turnaround and maintain operational focus.

Philip Davidson
Partner, KPMG
June 2006
2. BACKGROUND

2.1 In November 2005 the LGA, ADSS, NHS Confederation and other partners developed a paper *The future of health and adult social care: a partnership approach for well-being*. This approach stresses the vital role of local partnership work and seeks to better join-up social care and health, making these services more responsive and adaptable to local needs. It aims to ensure that the planning, commissioning and delivery of health and social care is firmly embedded within the well-being agenda. It is based on local authorities and PCTs working in partnership to deliver the strategic vision for their areas, based on local consultation and needs, supported by integrated commissioning and quality assurance processes, joint workforce planning and development and an effective shared performance management framework. A copy of the paper is attached.\(^*\)

2.2 The LGA and ADSS therefore strongly welcomed the Department of Health (DH) White Paper *Our Health, our care, our say* providing a potentially unifying vision for integrated health and adult social care. It fully recognised local authorities’ local leadership role for health and well-being, advocating partnership working in localities between councils and Primary Care Trusts (PCTs), building on local area agreements as a key mechanism for joint planning and delivery.

3. NHS DEFICITS

3.1 To take forward the partnership approach it is important that the right environment is created for partnerships between local authorities and PCTs to flourish. A stable financial environment is one of those elements, though not necessarily easy to achieve. Health and social care are two sides of the same coin. Under invest in one and you over stretch the other.

3.2 An LGA/ADSS report, based on a survey of local authority social services departments showed the worrying pressures on local authorities themselves for the next financial year. The survey revealed that pressures amount to a £1.76 billion black hole in funding for social services. There are a number of reasons for the severe funding pressures that social services departments across the country are facing including: the requirements of an aging population; increased life expectancy of young adults with severe physical and learning disabilities due to medical advances; increased needs of carers; costs of contracts with the independent and voluntary sector outstripping inflation; implementation of Every Child Matters is uncovering more children in need of care; and councils are reporting an increased demand for foster care.

3.3 In compiling this response the ADSS also undertook a survey of its members to assess the consequences of NHS deficits on social care provision in particular seeking information on whether there had been significant withdrawal of funding by the NHS from pooled budgets or jointly funded services; notification of intention to withdraw funding, or late/outstanding payments.

3.4 The survey found that in some areas the effects of NHS deficits are impacting on pooled and joint funding arrangements, delays in implementing planned development, or councils are experiencing a reduced inflationary uplift in PCT funding. There are some well publicised areas where the local authority is facing significant problems from the impact and therefore experiencing real difficulties which need to be resolved though, at present, there is no consistent pattern of this type of impact across the country.

3.5 It is a testament to the relationships developed between local authorities and PCTs that in many areas across the country they are working together to deal with any budget difficulties and minimise the effects on frontline services.

3.6 However there are concerns amongst local authorities that health partners may transfer costs through less direct routes than withdrawal of funding for example the transfer of continuing care clients to local authority social services. The perceived risks may affect the confidence of local authorities to enter into agreements with PCTs, for example into Section 31 agreements and local area agreements, founded on the high profile nature of the NHS deficits. It will impact not just on social services but on the overall strategic partnership arrangements for health and well-being including, for example, initiatives on public health. At a recent briefing meeting held by the LGA for authorities developing LAAs in the third phase the authorities believed they could deliver better health and well-being outcomes for local people from the LAA and discussed many of the ways they could do this with PCTs. However in discussing barriers they felt could hinder progress NHS deficits was one of the key concerns, including where councils were in areas where there were no deficits but the PCT was merging with a PCT in deficit.

3.7 It is important for both local government and PCTs that they are able to enter into agreements which are robust and provide security for all parties including for example around notice of withdrawals or changes to funding, arrangements for overspends, etc. As one authority indicated in preparing their new Section 31 Agreements they had undertaken due diligence work by which the authority would not enter into any partnership arrangements unless the parties make available sufficient funding to sustain the partnership.

3.8 Being able to join up the totality of public services at the local level and redesign services around the user is one of the aims of the LGA’s recent publication *Closer to people and places: a new vision for local government* which sets out a number of key reforms over what powers local people and councils should get

\(^*\) Not printed here.
from Whitehall to: improve public services; widen both access and choice for local people; make better use of the public’s taxes; and create attractive, vibrant, safe and friendly places where people are proud to live.

A copy of the summary of the paper is attached.

4. Conclusion

4.1 Local authorities and PCTs will continue to develop their partnerships to deliver improved health and well-being outcomes for local communities and deliver the vision of the White Paper, Our Health, our care, our say. In doing so they are working within constrained financial environments and are currently working together to minimise, as far as possible, the impact of NHS deficits. However it is important to continue to monitor the nature of the impact and be aware of the effect this has in the wider delivery of health, social care and well-being.

Maria Reader
Local Government Association
6 June 2006

Evidence submitted by Macmillan Cancer Support (Def 43)

Introduction

1.1 Macmillan Cancer Support has invested approximately £230 million in cancer services over the past five years in England. Macmillan currently funds or supports 3,349 health and social care posts in England. We operate a “pump-priming” funding model under which we fund a new post—typically for three years—on the condition that the NHS “picks up” long-term funding thereafter.

1.2 We are extremely concerned that some of our posts are currently under threat as a result of the combined effects of local financial deficits and NHS financial and structural reform.

2. Macmillan’s Audit of Posts at Risk

2.1 Since January 2006 Macmillan has been conducting a monthly ongoing audit through our Service Development Teams of all Macmillan posts and services “at risk”. “At risk” is the term we use to identify those posts where there is a threat of the post being made redundant, being frozen, not being picked up for long-term funding by the NHS, not being filled following a vacancy, or being significantly changed.

2.2 Our service teams reported the following problems on 31 May 2006:

— In order to reduce financial deficits NHS Trusts are cutting what they see as expensive specialist cancer services. Posts are being frozen and postholders are facing redundancy.
— PCTs and hospital trusts are reneging on written agreements, negatively affecting posts and services that Macmillan has supported financially.
— PCT managers are reluctant to sustain funding commitments when their future is uncertain.
— Specialist nurses are being asked to undertake generalist duties to compensate for the overall shortage of nurses.
— PCT re-organisation is disrupting long-established relationships with commissioners.
— Agenda for Change is resulting in specialist nurse and other posts being downgraded with staff demoralised and/or moving jobs as a result.

3. Which Posts are Affected?

3.1 The figures from our 31 May 2006 audit show that:

— 204 Macmillan posts are currently “at risk”. Of these, 24 posts are at risk of redundancy, a further 33 posts have been frozen, and funding for 14 posts is at risk due to PCTs reneging on their commitment with Macmillan to pick-up funding.

— The main reasons for the reported problems are:
  — NHS financial deficits—118 posts (58%); and
  — Agenda for Change grading disputes/problems—58 posts (28%); and
  — PCT structural reforms—30 posts (15%).
— Four out of five posts at risk (83%) are Macmillan nursing posts (169 posts). Nurses comprise 73% of all Macmillan postholders.
— Other posts at risk are doctors (two), allied health professionals (10), information posts (12), social care posts (nine) and user involvement posts (two).
— In 49% of the posts at risk (100 posts), a change is currently happening or has happened already. A change is “very likely” or “likely” to happen in 25% of posts (50 posts), and “possible” in 27% of posts (55 posts).
— Nearly four out of five posts (160) currently “at risk” are in Macmillan’s London, Anglia and South East Region (LASER). The problems are most acute in North and West London, Kent and West Anglia.

4. Why Do Macmillan Posts Matter?

4.1 There is always a clear “case of need” developed and agreed in partnership with NHS clinicians, patients and carers before any Macmillan post is funded. Macmillan has invested between £12.1 and £14.1 million (at current market value) of publicly donated money in the posts currently “at risk” as a consequence of NHS financial deficits.

4.2 While cost-cutting measures to reduce specialist cancer care services may help trusts to balance their books in the short-term, they will also undermine the key Government policy objectives of delivering the NHS Cancer Plan targets, reducing health inequalities, improving the patient’s experience and quality of life, and facilitating greater patient involvement and choice.

4.3 There is a substantial body of evidence that demonstrates the difference that specialist services make for cancer patients and their families (see appendix for more detail). Benefits include improved coordination of care, symptom control, information and emotional support, and a stronger “voice and choice” for cancer patients.

4.4 More specifically, the NHS in England: the operating framework for 2006–07 planning guidance sets out “must-do” targets that all NHS trusts are required to deliver. These include implementation of the NICE Improving Outcomes Guidance (IOG). Cutting Macmillan posts will directly compromise trusts’ ability to meet these targets.

4.5 It is too early to assess the full impact on patient care as Macmillan service teams are still negotiating with our NHS partners over the future of specialist posts. A number of threatened posts have been saved as a result of these negotiations. These saved posts have not been included in the figures.

4.6 However, we remain extremely concerned that patient care will suffer. The threat to patient care is most evident where the problem is redundancy, the post being frozen or loss of pick-up funding. We are being told that specialist teams are being stretched to capacity to cover the workload as vacant posts are frozen and the district nursing team depleted.

4.7 The impact of specialist nurses being asked to work shifts on general wards also has an impact on the quality of care. In one case a specialist palliative care nurse has been told to work one shift a week on a ward. This means she has less time to spend with each palliative care patient and less time to attend to patients’ psychosocial needs. In another case a lung cancer nurse has reported that patients are being readmitted to die in hospital rather than their preferred wish to be at home because of the lack of specialist support in the community.

4.8 By reneging on agreements to fund Macmillan posts, NHS trusts may also undermine the relationship built over many years between Macmillan and the public. There is a risk that public donations to Macmillan may be negatively affected and this will, in turn, significantly affect our relationship with the NHS in the future. It is therefore imperative to both the future of cancer services and the future of our organisation that Macmillan posts are protected.

5. Recommendations

5.1 We have been in discussions with our NHS partners at a local level and have expressed our concerns to both Ministers and senior Department of Health officials. We would ask that the Committee recommends that NHS trusts should honour existing funding agreements with Macmillan and pick-up funding for services we are currently developing.

Duleep Alhiajah
Macmillan Cancer Support

6 June 2006
APPENDIX

MACMILLAN POSTHOLDERS

<table>
<thead>
<tr>
<th>Post</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist cancer and palliative care nurses</td>
<td>Specialist cancer nurses play a crucial role in improving health outcomes and the patient experience, coordinating care and providing psychosocial support and patient-centred care for cancer patients. They improve outcomes by delivering high quality and effective symptom/pain control and enabling greater choice in end-of-life care.</td>
</tr>
<tr>
<td>Information posts</td>
<td>Macmillan information professionals play a vital role in supporting patient choice, facilitating self-management of symptoms, improving the patient experience, and helping patients to access health and social care services.</td>
</tr>
<tr>
<td>User involvement posts</td>
<td>User involvement facilitators enable people affected by cancer to directly influence the design and delivery of cancer services. Cancer partnership groups have brought about improvements in information, communication of bad news, transportation, parking, waiting times and the design of new buildings.</td>
</tr>
<tr>
<td>GP facilitators</td>
<td>GP facilitators improve cancer care within the primary care sector. GPs have a vital role to play in the early detection of cancer, co-ordination of cancer care and palliative care.</td>
</tr>
<tr>
<td>Psychological support services</td>
<td>The NICE supportive and palliative care guidance recommends that specialist psychological support is available for patients with the most severe needs. We have developed specialist services where no service existed before, eg the Pan-Birmingham cancer network had no specialist service for a population of over one million people.</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>Allied health professionals (AHPs), such as physiotherapists, occupational therapists, dieticians and specialist radiographers, contribute significantly to the support for patients in both specialist palliative care and in treatment plans by making sure that all aspects of care are supported and enabling patients to exercise control over their treatment and disease.</td>
</tr>
<tr>
<td>Social care posts</td>
<td>Macmillan social care posts/services, which include social workers, carer schemes and benefit advisers, meet the practical and psychosocial needs of people affected by cancer and, as such, are crucial to the implementation of the NICE Supportive and Palliative Care Guidance.</td>
</tr>
</tbody>
</table>

Evidence submitted by Monitor (Def 46)

SUMMARY

1. NHS foundation trusts are delivering a solid financial performance. Unaudited figures show that the NHS foundation trusts achieved a net £8 million deficit for 2005–06, around 0.1% of turnover. This is the figure before exceptional items which provides a better basis for comparison with the rest of the NHS. This is based on information supplied to Monitor from the 32 NHS foundation trusts which were in existence during 2005–06.

2. Monitor’s rigorous assessment process ensures that only organisations which are able to demonstrate financial viability and strong management are authorised as NHS foundation trusts.

3. The regulatory framework which is applied to NHS foundation trusts builds on the rigour of the assessment process. Where an organisation is performing well it is subject to a proportionately low level of regulatory scrutiny, with the foundation trust being relied upon to report openly and accurately on its own performance.

4. Where an organisation is performing poorly, the regulatory regime identifies this promptly and ensures that the foundation trust responds appropriately. This may take place by a collaborative approach between Monitor and the NHS foundation trust or, as was the case with Bradford Teaching Hospitals in 2004, it may require use of Monitor’s formal intervention powers.

5. The effectiveness of Monitor’s regulatory regime can be seen in the effective turnaround of the three NHS foundation trusts which incurred the largest deficits in 2004–05. Peterborough and Stamford, Royal Devon and Exeter, and Bradford incurred an aggregate deficit of £23 million in 2004–05. Following Monitor’s involvement this has reduced to a net deficit of £3 million for 2005–06 (based on unaudited figures).
6. Monitor is committed to maintaining the high level of financial performance within the NHS foundation trust sector. It has developed processes which will ensure that the standards of assessment and regulation remain high, even as the number of NHS foundation trusts increases steadily over the coming three years.

**OVERVIEW OF MONITOR AND NHS FOUNDATION TRUSTS**

7. Monitor’s statutory name is the Independent Regulator of NHS Foundation Trusts. Monitor was established in January 2004 under the Health and Social Care (Community Health and Standards) Act 2003. Monitor’s statutory responsibilities include the authorisation and regulation of NHS foundation trusts. Monitor is independent of the Department of Health. It is accountable to Parliament.

8. NHS foundation trusts are autonomous organisations. They are no longer subject to direction by the Secretary of State for Health, although they must continue to work within the framework of national targets and standards established by the Secretary of State. Their primary purpose must remain the provision of services to the NHS.

9. The Board of Directors of each NHS foundation trust is responsible for strategy and performance. They are accountable to local members through the Board of Governors, to their commissioners (such as primary care trusts) through contracts and to Monitor, through the Terms of Authorisation which are issued to each NHS foundation trust.

10. The first 10 NHS foundation trusts were authorised on 1 April 2004. There are now 40 NHS foundation trusts, of which the most recent group was authorised on 1 June 2006. A list of the NHS foundation trusts is included at Appendix A. The forty NHS foundation trusts have annualised total income of £8.2 billion (based on unaudited 2005–06 figures). £7.9 billion of this is from 37 acute trusts, representing around 22% of acute trust activity in England. The remaining £300 million is from the three mental health trusts which were authorised as NHS foundation trusts on 1 May 2006.

11. The number of NHS foundation trusts is expected to increase steadily over the next three years, given the Government’s wish to allow all NHS trusts the opportunity to apply for foundation trust status. Monitor is currently anticipating that there will be between 125 and 175 NHS foundation trusts by April 2009.

12. The number of NHS foundation trusts, and the fact that this number is set to increase steadily over the next three years, means that an understanding of their financial environment and performance is essential in order to assess the current and future financial position of the NHS.

**NHS FOUNDATION TRUSTS’ FINANCIAL PERFORMANCE 2005–06**

13. Monitor has published unaudited financial information for the financial performance of NHS foundation trusts for 2005–06. This is based on information supplied to Monitor as part of NHS foundation trusts quarterly returns. The audited accounts of individual NHS foundation trusts for 2005–06 will be laid before Parliament during July; Monitor prepares consolidated accounts for NHS foundation trusts and these are expected to be laid before Parliament in October.

14. The unaudited figures show that before exceptional items the 32 NHS foundation trusts recorded an aggregate deficit of £8 million for 2005–06. This represents around 0.1% of their £6.8 billion total income. The deficit before exceptional items provides the best basis for comparison with other NHS organisations (see Appendix B for an explanation of exceptional items).

After exceptional items the NHS foundation trust sector incurred a deficit of £24 million for 2005–06, marginally behind the £20 million full-year deficit forecast in Annual Plans prepared at the beginning of the financial year.

NHS foundation trusts have reported £28 million of provisions against potential bad debts with primary care trusts (PCTs). While these figures are subject to audit, it suggests that nine NHS foundation trusts have significant concerns about whether their commissioning PCTs will make payment for work which has been carried out. PCTs commission services from NHS foundation trusts on the basis of legally-binding contracts.

University College London Hospitals NHS Foundation Trust (UCLH) incurred a deficit of £36m. Excluding the performance of UCLH, the remaining 31 NHS foundation trusts generated a £12m surplus (see paragraph 17).

Further information can be found in Monitor’s preliminary report on 2005–06.*

* Not printed here.
15. In 2004–05 the three NHS foundation trusts with the greatest deficits were Bradford (£7.9 million), Peterborough and Stamford (£7.7 million), and Royal Devon and Exeter (£7.3 million). In each case concerted action was taken to address the deficit leading to a marked improvement in performance during 2005–06. The unaudited figures for 2005–06 show that Bradford had a deficit of £2.8 million, Peterborough and Stamford a deficit of £1.0 million and Royal Devon and Exeter a surplus of £0.6 million.

16. These effective turnarounds shared a number of common factors:

- Early identification of issues—Monitor’s light touch but risk focussed compliance framework gives early indication of financial underperformance. This facilitates prompt diagnosis of the size and nature of the problems and promotes rapid remedial action.
- Transparency—there is greater transparency in NHS foundation trust financial statements; in particular their accounts are free from the distorting impact of financial support and prior year deficit adjustments. Enhanced transparency, allows for improved financial planning, control and turnaround.
- Commercial discipline—NHS foundation trusts have greater independence. This brings greater responsibility and accountability. This accountability and associated sanctions for failure inject commercial disciplines into culture of NHS foundation trusts which again helps to ensure strong financial management and successful turnaround of deficits.
- Intelligent use of professional advisors—early detection of issues and greater commercial discipline promote the optimal use of professional advisors to assist in the identification and implementation of turnaround plans.
- Independence from political process—The culture of NHS foundation trusts is generally one of non reliance on direct subsidies and non interference by Government bodies, which expedites successful turnaround because it reduces influencing activities.
- Independent regulator—Monitor’s blend of role and powers means that it is viewed as an “honest broker”, facilitating a trust’s successful recovery with Monitor’s own focused team.
- Focusing on clinical efficiency—in developing a response, it is essential to focus on the organisation’s core costs and the processes which determine those costs; particularly under the payment by results system financial performance is dependent on an organisation developing effective programmes to improve clinical efficiency and increase productivity.

17. The approach which Monitor adopted successfully with the three worst-performing FTs in 2004–05 is also being applied to UCLH. The Trust began to suffer adverse performance in the first quarter of 2005–06. The significant underperformance in 2005–06 has been due to activity levels which were significantly below plan, higher than anticipated facilities management costs arising from the move to the new PFI-funded hospital and underachievement of cost improvement plans. The Trust has been subject to monthly monitoring during the year as it develops a recovery plan. The plan has now been agreed and provides for UCLH to return to financial break-even in 2007–08. It will remain subject to close scrutiny by Monitor and remains under consideration for formal intervention if necessary.

DEVELOPING FINANCIALLY STRONG NHS FOUNDATION TRUST APPLICANTS

18. The positive effects of NHS foundation trust status have been observed by Monitor not just in improved performance by existing NHS foundation trusts but also in greater rigour from organisations applying for NHS foundation trust status. With the early applicants Monitor identified a number of recurring issues which gave rise to concern. These included cases where financial plans were subject to frequent change; cost improvement plans which were highly aspirational and lacked detail; and Boards which lacked sufficient financial or commercial expertise within the non-executive directors. The level of concern at these issues, while not entirely eliminated, has been significantly reduced as more recent applicants appear to have a better appreciation of the demands of FT status.

19. A notable recent example of an organisation which has demonstrated greater financial accountability through the application process is East Somerset NHS Trust. It originally applied for authorisation in Autumn 2004. At the time its programme included a £30 million capital investment to replace a number of existing buildings on the Trust’s main site with a new single building. Monitor questioned the affordability of the scheme and the application was deferred while the Trust undertook further review of its forward plans.

20. When the Trust reapplied to Monitor in Spring 2006 it had considerably revised its plans. Following the deferral of its application the Trust undertook a thorough review of its planning assumptions and the scope for achieving cost improvements. Working with external advisers it identified considerable scope for efficiency within internal processes which would allow length of stay to be reduced and achieve improvements in operating theatre and bed use. When the Trust reapplied to Monitor in Spring 2006, the proposed £30 million capital investment had been dropped. The Trust outlined how it could achieve its desired improvements in services through greater efficiency and improve the existing buildings through more modest incremental expenditure. The Trust and its main commissioner expect to be one of the first health economies in the country to achieve the 18 week treatment target. It is significant that during the period from
Autumn 2004 to Spring 2006 the Board at the Trust was strengthened with a number of new appointments with greater commercial experience. The application was approved and the Trust was authorised as Yeovil District Hospital NHS Foundation Trust from 1 June 2006.

21. Monitor has also gained valuable insights into the financial challenges facing the NHS through its involvement with the Department of Health and SHAs in the Whole Health Community Diagnostic Programme. The programme provides individual trusts with a clear indication of the issues they need to address to be able to apply successfully for NHS foundation trust status. A consistent theme is the need for trusts to understand the link between their costs and activity so that they can operate successfully under a tariff system. The actions identified also often include ensuring that cost improvement plans are robust and appropriately supported and undertaking actions to improve productivity and efficiency. The diagnosis also identifies actions for SHAs, particularly where service reconfiguration needs to be considered or where there are strategic financial issues for commissioners as well as providers.

22. Implementing the action plans for each trust will take some time particularly where significant work is required to achieve a financially robust position and to strengthen appropriately their Board and organisational capacity and capability. Monitor estimates that it will take more than two years for the majority of the remaining acute NHS trusts to reach a position where they could credibly apply for NHS foundation trust status. It is important that “turnaround” work does not focus on short term fixes to achieve financial balance at year end. The Whole Health Community Diagnostic Programme provides a planned basis for ensuring that all acute trusts are financially viable within a time frame which reflects their local circumstances.

CONCLUSION

23. While a number of NHS foundation trusts have generated surpluses in 2005–06, Monitor believes that it is essential that the size of the surpluses, and the number of NHS foundation trusts generating them, needs to increase. NHS foundation trusts need to generate reasonable surpluses in order to fund the renewal of their assets. While NHS foundation trusts can borrow from commercial organisations in order to fund investment, it is probable that it will be more efficient to fund small scale investment programmes through funds which the organisation has generated itself. In addition, a commercial lender is unlikely to look favourably on a borrower who cannot demonstrate a track record of strong cash flow and surpluses.

24. The accounting and regulatory framework which applies to NHS foundation trusts promotes transparency and encourages rigour. NHS foundation trusts are delivering a relatively strong financial performance. Where problems are identified, the regulatory framework ensures that they are addressed promptly with appropriate and achievable plans. At the heart of the system are the Boards of Directors of each NHS foundation trust. By making them solely accountable for the performance of their organisation, and giving them the freedoms to lead their organisations within a clear framework of rules, they will be well placed to respond to the financial pressures which the NHS will continue to face in the future.

William Moyes
Executive Chairman, Monitor
6 June 2006

APPENDIX A

NHS FOUNDATION TRUSTS (AS AT 1 JUNE 2006)

Barnsley Hospital NHS Foundation Trust
Basildon and Thurrock University Hospitals NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Derby Hospitals NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Frimley Park Hospital NHS Foundation Trust
Gateshead Health NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Guy’s and St. Thomas” NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Heart of England NHS Foundation Trust
APPENDIX B

THE REGULATORY FRAMEWORK FOR NHS FOUNDATION TRUSTS

1. Monitor’s first task after its establishment was to develop a method to assess applicants for NHS foundation trust status. The process which has been developed tests whether the applicant is able to operate as an autonomous organisation. The key questions which are asked at assessment are whether the applicant NHS trust will be legally constituted, financially viable and well governed. These are essential conditions to be met for an NHS foundation trust to be able to survive and prosper.

2. The assessment of financial viability involves a review of the applicant trust’s historic financial position and future projections. In its assessment process Monitor removes brokerage and one-off items, such as capital to revenue transfers, from the analysis of past years’ performance. This is done to show the true underlying position of the organisation’s past performance.

3. The applicant NHS trust must submit a financial plan forecasting its financial position for the next five years. Monitor scrutinises the plan closely, for example by testing the assumptions about future income against the expectations of PCTs, cross-checking assumptions on cost inflation against the data from other applicants, and examining the applicant’s track record in achieving cost savings. The review of the key assumptions underlying the projections will include sensitivity and scenario analysis to evaluate the key risks faced by the applicants. Our experience suggests that this is a greater level of scrutiny of financial planning than the trust will ever have experienced before. It ensures that only trusts which meet the demanding criteria are authorised. It also serves as an effective preparation for Boards who must operate in a more commercial and demanding environment post-authorisation.

4. Monitor continues its rigorous approach in the regulatory framework for NHS foundation trusts when authorised. The emphasis is on ensuring thorough financial planning and then transparency in monitoring financial performance.

5. NHS foundation trusts are required to submit annual plans to Monitor. These are reviewed and a risk rating assigned to each NHS foundation trust to indicate the risk of it breaching its terms of authorisation in three areas: finance, governance and mandatory services. The financial risk rating is ranked from 5 to 1, with 5 representing the lowest financial risk. The rating assesses a trust’s financial position against four criteria: achievement against plan, underlying performance, financial efficiency and liquidity. Each NHS foundation trust then submits a quarterly report on performance against plan. The information in the report
is based on what the Board of Directors would usually receive on a monthly basis, to minimise the information burden on the organisation. The plan allows Monitor to track performance on a quarterly basis and to take appropriate action where performance starts to differ adversely from plan.

6. Transparency is also applied to the public reporting of NHS foundation trusts. Monitor has set out an accounting regime for NHS foundation trusts which is akin to that used in the private sector, reflecting UK GAAP (generally accepted accounting practice), rather than the resource accounting approach used elsewhere in the NHS. This results in greater transparency and allows greater comparability with the commercial sector.

7. One effect of this is that NHS trusts are required to include impairments in the profit and loss account. Impairments occur where an asset, such as a building, is revalued and the revised valuation differs from that currently shown on the balance sheet. Under the accounting rules for NHS foundation trusts the impairment is shown as an exceptional item and is included in the profit and loss account; it therefore hits the “bottom line” of the accounts. For an NHS trust an impairment appears on the balance sheet but not in the profit and loss account. It is for this reason that Monitor quotes the performance of NHS foundation trusts before exceptional items, as this provides a better basis for comparison with the rest of the NHS.

Evidence submitted by the NHS Confederation (Def 36)

INTRODUCTION

1. The NHS Confederation welcomes the Committee’s inquiry into NHS deficits and the opportunity to present evidence.

2. The NHS Confederation is a membership body that represents over 92% of all statutory NHS organisations across the UK. Our role is to provide a voice for the management of the NHS and represent the interests of NHS organisations. We are independent of the UK Government although we work closely with the Department of Health and the devolved administrations.

WHETHER THE CAUSES ARE SYSTEMIC OR LOCAL (EG THE ROLE OF POOR LOCAL MANAGEMENT AND POOR CENTRAL MANAGEMENT, THE EFFECT OF PAY AWARDS AND GOVERNMENT POLICY DECISIONS)

3. There seem to be three main causes of deficits:

   (i) organisations in areas that have longstanding, unresolved structural problems for example, where reconfigurations of hospital services to deal with over capacity are required to create financially sustainable systems;

   (ii) pressure from national policies such as targets and workforce reforms which have had an adverse effect on particular organisations partly because of the allocation formula and the short time given for the changes notably the consultant contract and the GMS contract;

   (iii) some loss of management control, particularly in those areas where targets have been aggressively chased.

4. Whilst there is an element of management failure in some cases there are also a number of underlying problems that may have caused or exacerbated this failure. These should be examined rather than simply taking the easy route of blaming individuals. The scale of the current challenges makes it clear that there are systemic as well as individual failings.

5. There has been a long history of a lack of financial transparency in the NHS. Organisations have been expected to break even on the last day of March and in some areas there has been a culture of achieving this through short term measures many of which were not sustainable and would require corrective action at a future date. These mechanisms, such as capital to revenue transfers have gradually been removed by the DH and Treasury but the action to increase transparency exposes the underlying issues.

6. In the past, many budgets were balanced by savings programmes or allowances for risk that were not supported by viable management plans. This reflects a number of issues. The short term approach to financial management adopted in public services is not compatible with the scale and complexity of the service redesign required to make major savings. This requires significant buy-in by clinicians. Organisations therefore had an incentive to find short term fixes rather than deal with fundamental issues. Targets, the performance management culture and financial regime have all exacerbated this. A particular difficulty has been the nervousness about major service reconfigurations. In some local systems organisations have developed strategies that have led to the financial problem simply being passed around the health system, with PCTs trying to reduce their spend on the acute sector and the acute hospitals attempting to increase their income from PCTs.
7. One feature of the NHS system in recent years has been a down playing of the role of the statutory board in favour of performance management mechanisms. Boards have found themselves weakened because of the strength of the line from the SHA to the chief executive of the organisation. This is not conducive to good governance and may have led to the Boards of some organisations taking their eye off some performance issues because of ambiguity about accountability.

8. There is a particular issue with hospitals that have recently made very significant capital investment, particularly through Private Finance Initiative (PFI) schemes. The tariff is set on the basis of the current capital stock in the NHS—a significant amount of which is close to valueless because of its age and which has significantly cheaper running costs than a new hospital built to modern standards. This reflects a long term reluctance to invest in modern facilities, unlike the rest of Europe. It is shocking that a significant proportion of care in many communities is still delivered in buildings designed and built in the 19th century. PFI hospitals have the added disadvantage of a higher charge for their capital than allowed by the tariff. There is some very modest tapering finance provided by the Department but members report that this is wholly inadequate and requires a significant review.

THE FINDINGS OF THE “TURN-AROUND” TEAMS—WHETHER THESE FINDINGS ARE RIGHT AND WHETHER THE TURN-AROUND TEAMS HAVE PROVIDED VALUE FOR MONEY

9. Those of our members that had turnaround teams generally found that they were helpful but, in general, did not identify any particular causes of the problems that were not already understood. Most of these members felt that the rigor they have brought to the process and the discipline they have imposed has been very helpful. A minority of respondents were much more negative about the appropriateness and knowledge of the individuals appointed to the teams.

10. We have not looked at the experience of the appointment of turnaround directors as systematically but it appears that the response to these is more mixed. A particular issue has emerged in Primary Care Trusts that are not in balance. Whilst there is a fairly well understood set of responses for dealing with hospitals in deficit it is much less clear how to deal with a commissioning organisation in financial trouble. There are few short term measures that can be used to reduce demand and in any case this may simply pass the financial problem on to local hospitals. There is no failure regime for either provider or commissioning organisations.

11. The cost of the turnaround directors and consultants appointed at the behest of the Department is often very significant and some organisations have been informally told to put aside over £1 million for this purpose. Whilst the intervention of these individuals is generally regarded as very helpful a number of members did have significant concerns about whether this represented value for money. Some organisations have appointed senior people from within the NHS who are finding that having the time to focus on these issues is producing significant results. These individuals have the advantage of understanding the NHS and of being significantly cheaper. This highlights that one of the key pressures is an overstretched management cadre which is trying to deliver change of enormous proportions and that delivery would be enhanced by creating time and space for proper analysis of issues, planning for change and, most importantly implementation. There is still a sense that implementation takes less time than policy formulation yet all research evidence indicates that the opposite is true.

THE RELATIONSHIP BETWEEN THE FUNDING FORMULA, THE ALLOCATION OF FUNDS TO TRUSTS AND THE SIZE OF THEIR DEFICITS OR SURPLUSES

12. There are some important questions about whether the current resource allocation formula has contributed to the problem. The focus of deficits in areas that have relatively affluent but elderly populations (as shown by the work recently commissioned by Suffolk PCT) suggest that the current formula which contains a significant element for health inequalities—fails to recognise that populations in these areas may make high levels of demand for services as they age when compared with areas with relatively young but deprived populations. This requires some investigation although it is confounded by the effect of high levels of supply in many of these areas. Research demonstrates that the biggest determinant and predictor of the use of resources is the availability of supply and that in areas with high levels of supply usage increases. Whilst this factor may have contributed to financial problems in some areas it seems unlikely that it is a prime cause of their difficulties. We have long called for a separation of the funding stream for health improvement from that for health services to ensure adequate investment in tackling health issues in communities with higher levels of deprivation.

THE CONSEQUENCES OF THE DEFICITS—THE EFFECT ON CARE

13. The approach to making savings has been to target areas which have the least effect on patients and to focus on improving the efficiency of care. There has been significant emphasis on streamlining administrative services, sharpening up laundry services and sharing back office functions but further areas for efficiency are very dependent on the availability of modern technology and offer a diminishing return especially as there is likely to be some increase in transaction costs as tariff mechanisms are introduced. The
majority of resources are tied up in the delivery of services for patients and increased efficiency requires a focus on clinical pathways and service redesign. Hospitals cannot easily reduce deficits by reducing the work they do because payment by results will remove that money from their budget, thus potentially compounding the problems unless significant efficiency gains can be delivered. This is in contrast to previous times of financial pressures when reducing activity in the short term generated true financial savings.

14. An important change in the system with the introduction of a more market-based approach is that it is the responsibility of trusts to create a financially viable organisation providing high quality care and of commissioners to ensure that population needs are met. In the past trusts have tried to deal with financial problems by increasing income. The direction of policy and the fact that there is a fixed sum of money in the national system means that this strategy is no longer viable there must be winners and losers in a capped system if patient and commissioner choice is exercised. It also appears that growth does not necessarily create financial economies of scale. To become financially sustainable some hospitals might need to retrench significantly so that fixed costs are reduced and income and expenditure balanced. In some cases this may mean not offering the full range of services. There may, in addition, be clinical and other reasons why this is appropriate. Where this happens it is the responsibility of the PCT to ensure that patients can access care from other providers.

THE CONSEQUENCES OF THE DEFICITS—THE NUMBER OF JOB LOSSES

15. NHS Employers has undertaken a survey to investigate this, 150 responses were received. Current deficits or the avoidance of future deficits are the main cause of job losses in the hospital sector although there is evidence that service reconfiguration is beginning to produce benefits which is allowing posts to be released whilst services are enhanced. For PCTs Commissioning a Patient Led NHS has led to some of the loss in posts. In organisations with deficits a number of additional reasons were cited such as merger, loss of work to private sector providers, and in a few cases the anticipated effects of Payment by Results. Pay issues such as Agenda for Change and the Consultants contract were only cited as contributory in a handful of cases.

16. Our enquiries suggest that the very large majority of announcements of job losses do not represent equivalent numbers of redundancies and even where true redundancies are planned only a small proportion will be compulsory. In our survey only 25 (33%) of the organisations listed as in deficit had declared true redundancies. The posts lost are often filled by bank and agency staff or the reductions can be achieved through the turnover of staff.

THE CONSEQUENCES OF THE DEFICITS—THE EFFECTS OF “TOP-SLICING”, IN THE CURRENT AND FUTURE YEARS

17. Many of our members were perturbed by the timing of the announcement of the top slice particularly the fact that very little notice was given of the need to make significant changes in commissioning plans so close to the beginning of the financial year.

18. We recognise that the top slice was necessary to create strategic reserves and to correct the problems caused by the late change in policy on the Purchasing Parity Adjustment which removed the protection that PCTs had from the effect of moving from local prices to the national tariff.

19. Some areas have had experience of top slicing approaches in previous years. The lesson of this is that a top slice can be an effective tool if accompanied by a strategy for major change and where it is developed as a strategy supported by the whole community. It is not clear whether such strategies are yet in place in all areas. Without such a strategy the top slice could become a slush fund used to bail out failing organisations and thus perpetuating the lack of transparency which is at the heart of the current problems. It is demoralising to clinicians and staff who have worked hard to achieve savings to then be asked to deliver more to provide support other organisations which have not always been managed as stringently. Incentives must genuinely reward success and help systems in difficulty to deliver rather than reward failure. Whilst there is a willingness to behave collectively in the NHS there are limits to this.

20. The principle that the statutory role of boards should be honoured is important in this context. Money top sliced from any organisation should be returned to it within an agreed period. We support the charging of an interest rate on such money provided that this is set at a fair rate.

THE PERIOD OVER WHICH BALANCE SHOULD BE ACHIEVED

21. It is important to distinguish between annual income and expenditure deficits and historic deficits that may be a problem for organisations that are otherwise in financial balance.

22. The burden of historic deficits and the impact of the Resource Accounting and Budgeting (RAB) regime in which allocations to providers are reduced by the amount of previous years deficits means that even organisations that have income and expenditure in balance may still have an unachievable level of savings to make to balance current expenditure as well as pay back historic deficits. The RAB regime has created significant problems and requires urgent review. The issues are highlighted in the public interest report into Woolwich hospital.
23. Once an organisation has achieved a sustainable income and expenditure balance such historic deficits should be converted into long term debt (which will attract interest but where payment dates can be determined by the trust). For the most challenged communities this may require the same timescale as required for PFI schemes.

OTHER COMMENTS

24. One of the consequences of a policy regime which is deliberately intended to create instability and “constructive discomfort” (the phrase used by Simon Stevens—the Prime Minister’s previous Health Policy Advisor) is that many organisations will from time to time run surpluses and deficits and will need to make adjustments accordingly. These need to be considered over a longer period than a year. We therefore support the roll out of the FT financial regime to all provider trusts provided that the commensurate flexibilities are designed into the commissioning framework.

25. The NHS Confederation’s foundation trust members believe there are major benefits of operating within a more rigorous financial regime. Foundation trusts have improved their performance from 2004–05 and delivered results very close to plan. The three foundation trusts that generated the greatest deficits last year have also successfully turned around their finances by implementing tough recovery plans.

26. The key issue is for the system to become equally as concerned with ensuring that the correct strategy and governance arrangements are in place as establishing the exact financial position of organisations at any one time.

NHS Confederation

6 June 2006

Evidence submitted by North East London Strategic Health Authority (Def 26)

This evidence focuses on the impact of weaknesses in central government policy and its implementation, of financial management and control at a local level and of expenditure on local health services.

1. INTRODUCTION

1.1 North East London Strategic Health Authority is one of five Strategic Health Authorities (SHAs) in the capital, serving a population of approximately 1.5 million. It was established in April 2002 as the local headquarters of the NHS, covering the London Boroughs of Barking & Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest and the Corporation of London.

1.2 The SHA manages the performance of seven Primary Care Trusts (PCTs), four acute hospital trusts and two mental health trusts. A fifth trust—Homerton University Hospital Trust—became a Foundation Trust in April 2004 (in the first wave of Foundation Trusts).

1.3 North East London is an area of considerable and unparalleled diversity—in ethnicity, religion and culture—with a long history of being home to refugees and asylum seekers. It has some of the poorest levels of health and the worst health inequalities in the country against a backdrop of historic and persistent social and economic deprivation.

1.4 As the committee will be aware, the NHS is currently undergoing a radical reorganisation, as a result of which there will be a single SHA for London from 1 July 2006. North East London Strategic Health Authority will, therefore, cease to exist as from this date. The evidence below is given as a contribution to the debate, from the perspective of an organisation which has delivered financial balance across the local NHS for each of the four years of its existence, coupled with year on year improvement in performance and quality of care for local people, despite receiving the lowest per capita funding in the country (see 4.1).

Unlike the rest of England, no change is currently planned in the configuration of the capital’s 31 PCTs, which remain co-terminous with local authorities.

1.5 While this evidence is submitted by North East London Strategic Health Authority, the capital’s particular needs and challenges are common to the London NHS as a whole and it is in this context that this evidence should be considered.
More than just the capital, London—as one of very few world cities—faces a unique combination of high needs and high costs. It is this combination of factors, such as the relative youth, significant mobility, high health need and exceptional extent and range of the diversity of its growing population, which makes London different.

1.6 With its population set to increase by over 800,000 by 2016, London is growing faster than any other city in the UK. It is currently anticipated, for example, that 33% of all new housing in the capital will be built in North East London during this period. At the same time, the current allocation of resources does not fully take into account the complex needs of a significant proportion of this diverse and very mobile population. In Newham, ethnic minorities constitute over 60% of the population. Tower Hamlets and Hackney are amongst the 10 most deprived boroughs in England and, overall, life expectancy is worse—seven years worse in Canning Town than in Westminster, for example.

The incidence of TB in London is four times that in the rest of England and there are three and a half times as many cases of HIV. Infant mortality rates are high, as is morbidity from high levels of coronary heart disease and diabetes. The costs and pressures on local health services are perhaps best illustrated by mental health needs in the capital. One in four of the UK’s adult drug users lives in London; at twice the national rate, compulsory admissions on the basis of mental illness result in longer lengths of stay and, therefore, increased costs.

2. CENTRAL GOVERNMENT: POLICY, PLANNING AND MANAGEMENT

2.1 London’s particular challenges are exacerbated by the tension created by competing policies, planned in isolation and poorly implemented, producing perverse incentives and excess volatility in the system.

2.2 Planning cycle

The NHS operates a three-year planning cycle whereby PCTs receive funding allocations covering a period of three years. While this is intended to enable effective forward planning, this is, in fact, persistently thwarted by the late availability of vital information. Examples in 2005–06 include:

- the late issue of tariffs and information on the generic uplift to cover, for example, inflation on goods and services, pay awards and hospital drugs costs;
- the late negotiation of pay settlements;
- unfunded policy initiatives introduced in year for which there is no budget (for example, choice of scans); and
- the procurement of additional and unnecessary capacity.

2.3 Changes to the financial regime

Changes to the financial regime are poorly planned and executed, often resulting in contradictory outcomes. The clearest current illustration of this is Payment by Results, which has been subject to considerable, inflexible central control:

- the 2006–07 tariff was introduced late (on 31 January 2006), was found to be incorrect and had to be withdrawn (on 22 February 2006) and was finally re-issued (on 17 March 2006)—a fortnight before the end of the financial year;
- the Payment by Results regime provides incentives to deliver greater secondary care activity at the very time when the focus is on reducing this activity—as per the White Paper “Our Health, Our Care, Our Say” (on care outside hospitals), the management of long-term conditions etc.;

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31 Prime Minister’s Strategy Unit July 2004 Final Report—The London Project (page 102).
— changes in policy execution have been introduced with insufficient notice to ensure effective financial planning—for example, the change in transition arrangements, resulting in the policy no longer being cost neutral to PCTs; and
— the use of the full cost tariff fails to recognise the variation in fixed costs between individual NHS organisations, which are a product of historic investment decisions. All fixed costs take time to adjust; some can only be changed through major service reconfiguration, decisions all too often constrained by political considerations.

2.4 Practice-based commissioning

In order to ensure financial balance, practice-based commissioning should have been implemented before, or at least, in parallel with Payment by Results to provide a necessary counterweight in the form of effective demand management. More generally, it is clearly difficult to present GP practices with the necessary incentives to take on practice-based commissioning when the level of resources is declining. Moreover, evidence on the costs of shifting services to primary care is not yet available, even at a national level.

2.5 Information systems

Regime change is being introduced at a pace faster than the delivery of the supporting information systems by the National Programme for IT.

The Department of Health has confirmed that the programme will be delivered two years late33; there is no indication that the programme is adapting to meet evolving priorities. There is, for example, nothing in the current programme to support effective practice-based commissioning.

2.6 Education, Research and Development

Teaching hospitals are being destabilised by major policy change in the allocation of funds for Research and Development and the service increment for teaching, at a time of significant regime change.

Short-term responses to financial challenges have the potential to damage long-term goals, such as training the workforce of the future.

2.7 Management of central budgets

The late issue of central budgets constitutes a recurrent problem for the NHS in ensuring effective financial and strategic planning. This is exacerbated by:
— the poor costing of policy initiatives—such as Connecting for Health and primary care contracts—leading to a shortfall in central budgets, with a knock-on effect on the level of resources and/or cash available to the health service; and
— attempts to use central budgets to manage NHS overspend, creating further random, unplanned deficits through the short-term funding of plans, with poor assessment of the impact. An illustration of this is the current proposal to lump central budgets together and distribute them to SHAs on a capitation basis, rather than according to local need.

For the London NHS, which teaches by far the highest proportion of all the UK’s medical and other healthcare trainees, the allocation of the MPET (multi-professional education and training) budget on a population basis would have a profound, adverse effect on workforce and training for the whole NHS.

2.8 Pay modernisation

New national pay and conditions, such as the consultants’ contract and Agenda for Change, were based on inadequate cost data, resulting in shortfalls in funding which are having to be picked up from within existing service allocations. The absence of a clearly defined and consistently applied process to realise the benefits of these significant increases in pay has resulted in there being little leverage on staff to deliver change.

2.9 Service delivery targets

Central direction has failed to achieve the right balance between the delivery of service targets and financial balance. This has been compounded by the poor quantification of the potential costs of delivering service targets, such as the maximum four-hour wait in A&E, and accompanied by timescales for delivery which preclude the necessary time for intelligent service redesign. This has resulted in expensive, short-term and unsustainable solutions in order to meet targets. Given the disproportionate pressure on A&E services, often a result of repeat attendances by people with complex needs (see 1.6), this has had a particular impact on London.

3. THE ALLOCATION OF RESOURCES

3.1 The Department of Health purports to promote equity in the allocation of resources to the NHS. Changes to some elements of the resource allocation formula (which remain poorly evidenced and insensitive to local factors) have offset expected gains from population growth and movement towards target. A prime example is the market forces factor, which is clearly pivotal to London, where the cost of living and the relative attraction on non-NHS employers is substantially higher than any other city in the country. It is difficult to demonstrate that the latest study on market forces is any more robust than previous studies. An approach which uses pay rates in Hackney to represent local market factors, ignoring the effect of the adjacent City of London, is clearly not credible.

3.2 No protection is given to those PCTs which have been allocated extra growth to meet local need. The current directive to top-slice PCT growth monies to meet deficits in better funded parts of the NHS clearly disadvantages those areas of greatest need. For example, in North East London, PCTs received a supplement to their allocation for 2006–07 to reflect population increase as a result of growth area housing developments. This supplement, while welcome, represented only 1.1% of their total allocation for 2006–07, much of which has, in effect, been clawed back by the 3% top-slice applied across London.

4. THE IMPACT ON NORTH EAST LONDON

4.1 Over the past three years (2003 to 2006), the NHS in North East London has received the lowest per capita funding in the country. Despite movement towards our fair share target over this period, the gap between what should have been received—as per the funding formula—and the actual allocation is the widest in the country. That is, North East London has received 4% (£85 million) less than indicated by the formula (see Appendix).

4.2 The Department of Health has accepted the principle of supplementary funding for growth areas—that is, for growth over and above that experienced in other parts of the country and as a direct consequence of government policy—but this represented only 0.2% of PCTs’ annual revenue allocation in 2005–06. This additional funding has largely gone into redressing the backlog of local service shortfall and inadequate infrastructure, themselves a consequence of distance from capitation. It has allowed North East London to go some way in catching up with other parts of the country in terms of the quality of health services, but has enabled little development to meet the needs of the growing and diverse population (see 1.6).

4.3 In the current financial climate, the progress envisaged in addressing specific local health needs—such as the implementation of Choosing Health—appears particularly vulnerable. In North East London, the chlamydia screening programme has been an early casualty of the London-wide top-slice, with £1.7 million (of the £1.8 million originally designated for the programme) being diverted to support the financial recovery of other parts of the NHS in London. Funding will be also be substantially reduced for key developments such as stop smoking programmes, sexual health clinics and the development of school nursing and the specialist public health workforce.

5. Conclusion

5.1 Despite some recognition of the need for ad hoc supplementary funding, the allocation of resources to the NHS remains insufficiently responsive to the specific needs of particular areas. As demonstrated above, this has allowed the gap between the best and worst funded health systems to grow, perpetuating unacceptable social injustice.

5.2 Effective financial and strategic planning in the NHS is increasingly hampered by inconsistent and incoherent policy making and implementation.

This evidence is submitted by the Board of North East London Strategic Health Authority. Both the Chairman, Baroness Murphy of Aldgate and the Chief Executive, Carolyn Regan, would be willing to give oral evidence.

Carolyn Regan  
Chief Executive, NE London SHA.  
6 June 2006

Appendix

<table>
<thead>
<tr>
<th>SHA</th>
<th>Distance from target</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West London</td>
<td>7.7%</td>
</tr>
<tr>
<td>South West London</td>
<td>7.7%</td>
</tr>
<tr>
<td>North Central London</td>
<td>4.3%</td>
</tr>
<tr>
<td>South East London</td>
<td>4.1%</td>
</tr>
<tr>
<td>Surrey &amp; Sussex</td>
<td>3.7%</td>
</tr>
<tr>
<td>North &amp; East Yorkshire &amp; Northern Lincolnshire</td>
<td>1.8%</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>1.3%</td>
</tr>
<tr>
<td>South West Peninsula</td>
<td>0.9%</td>
</tr>
<tr>
<td>Hampshire &amp; Isle of Wight</td>
<td>0.8%</td>
</tr>
<tr>
<td>Avon, Gloucestershire &amp; Wiltshire</td>
<td>0.4%</td>
</tr>
<tr>
<td>West Yorkshire</td>
<td>0.3%</td>
</tr>
<tr>
<td>Bedfordshire &amp; Hertfordshire</td>
<td>−0.1%</td>
</tr>
<tr>
<td>Dorset &amp; Somerset</td>
<td>−0.4%</td>
</tr>
<tr>
<td>Northumberland, Tyne &amp; Wear</td>
<td>−0.6%</td>
</tr>
<tr>
<td>Norfolk, Suffolk &amp; Cambridgeshire</td>
<td>−0.6%</td>
</tr>
<tr>
<td>Kent &amp; Medway</td>
<td>−0.9%</td>
</tr>
<tr>
<td>Cumbria &amp; Lancashire</td>
<td>−0.9%</td>
</tr>
<tr>
<td>South Yorkshire</td>
<td>−1.3%</td>
</tr>
<tr>
<td>Leicestershire, Northamptonshire &amp; Rutland</td>
<td>−1.6%</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>−1.7%</td>
</tr>
<tr>
<td>Trent</td>
<td>−1.7%</td>
</tr>
<tr>
<td>Shropshire &amp; Staffordshire</td>
<td>−1.7%</td>
</tr>
<tr>
<td>West Midlands South</td>
<td>−1.8%</td>
</tr>
<tr>
<td>Essex</td>
<td>−2.6%</td>
</tr>
<tr>
<td>Cheshire &amp; Merseyside</td>
<td>−2.6%</td>
</tr>
<tr>
<td>Co Durham &amp; Tees Valley</td>
<td>−3.1%</td>
</tr>
<tr>
<td>Birmingham &amp; the Black Country</td>
<td>−3.4%</td>
</tr>
<tr>
<td>North East London</td>
<td>−4.0%</td>
</tr>
</tbody>
</table>

Department of Health

Evidence submitted by University Hospital for North Staffordshire (Def 58)

Trust Profile

The University Hospital North Staffordshire NHS Trust is a large acute Trust based in the West Midlands. The Trust provides a full range of district hospital services to the local North Staffordshire population of around 470,000, and specialised acute services to a population of some 3 million across the local and wider communities of Staffordshire, Shropshire, Cheshire and Derbyshire.
Organisational Characteristic

| Acute Total Beds (incl Maternity) as of June 06 | 1,184 |
| Sites operated | 1. Royal Infirmary Hospital  
2. City General Hospital  
3. Outpatients Department and Pathology Laboratory |
| Services provided | Accident and Emergency services.  
Intensive care, Critical care, Neonatal and Paediatric intensive care.  
Full range of district services plus Cardiothoracic surgery; Neurosciences; specialist Cancer and Renal services. |
| Staff as at 30 April 2006 | 6,167.48 full time equivalent |
| Trust Total Income 2005–06 and deficit | £296.9 million with a deficit of £14.98 million |
| Total Deficit to be recovered through the Service and Financial Recovery Plan | £21.9 million 2006–07 |
| Star Rating prior to new Health Care Commission rating | Two Star Rating |
| Teaching Status since 2002–03 | Keele University |

Local Health Community

<table>
<thead>
<tr>
<th>Organisation</th>
<th>2005–06 outturn £000</th>
<th>2006–07 Cost Saving to be delivered £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Stoke PCT</td>
<td>10,758</td>
<td>16,632</td>
</tr>
<tr>
<td>South Stoke PCT</td>
<td>-87</td>
<td>8,330</td>
</tr>
<tr>
<td>Staffordshire Moorlands PCT</td>
<td>4,893</td>
<td>8,196</td>
</tr>
<tr>
<td>Newcastle under Lyme PCT</td>
<td>1,584</td>
<td>7,374</td>
</tr>
<tr>
<td>Combined Healthcare NHS Trust (mental health and elderly)</td>
<td>-505</td>
<td>4,464</td>
</tr>
<tr>
<td>Staffordshire Ambulance NHS Trust</td>
<td>0</td>
<td>449</td>
</tr>
<tr>
<td>UHNS</td>
<td>14,980</td>
<td>21,900</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31,623</td>
<td>67,345</td>
</tr>
</tbody>
</table>

Background, Cause and Extent of the Trust Financial Problem

The Trust for a number of years has successfully achieved the vast majority of its clinical targets, maintained a two star rating and achieved financial breakeven.

However, the underlying financial position of the Trust had been deteriorating since at least 2003–04. The breakeven position had been supported by short term non-recurrent savings and additional income from activity to ensure delivery of the waiting times target.

Historically the majority of past efficiencies had been found from the Trust’s non-pay budgets whilst the workforce had continued to grow.

The productivity at the Trust had worsened during this period of staff growth.
During 2005–06 additional pressures added to the difference between income and expenditure. These included:

— reduced income from commissioners not matched by reductions in costs; and
— costs of implementation of national initiatives (including the New Consultant Contract, Working Time Directive for Junior Doctors and Agenda for Change) which were not contained within available resources.

The Public Interest Report issued by the Audit Commission\(^\text{35}\) concluded that the problems in 2004–05 were compounded by:

— The Trust budget setting process was inadequate and contained material errors.
— The Trust continued to implement internally funded developments during this period without a firm basis for assuming additional income.
— The lack of adequate challenge and scrutiny of the financial assumptions by the Board.
— The lack of evidence of detailed planning to deliver savings and to monitor delivery of the financial plan.
— The Trust had weak corporate governance and control.

### 2005–06 Financial Position

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Recurrent £M</th>
<th>Non-recurrent £M</th>
<th>Net £M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004–05</td>
<td>Opening Underlying Deficit</td>
<td>16.0</td>
<td></td>
<td>16.0</td>
</tr>
<tr>
<td></td>
<td>Savings Achieved</td>
<td>(6.5)</td>
<td>(9.5)</td>
<td>(16.0)</td>
</tr>
<tr>
<td></td>
<td><strong>2004–05 Year End Position</strong></td>
<td><strong>9.5</strong></td>
<td><strong>(9.5)</strong></td>
<td><strong>Nil</strong></td>
</tr>
<tr>
<td>2005–06</td>
<td>Opening Underlying Deficit</td>
<td>9.5</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR Tariff Efficiency</td>
<td>4.0</td>
<td></td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>PbR Transitional Relief (75%)</td>
<td></td>
<td>(3.5)</td>
<td>(3.5)</td>
</tr>
<tr>
<td></td>
<td>Market Forces Factor Adjustment</td>
<td></td>
<td>(3.0)</td>
<td>(3.0)</td>
</tr>
<tr>
<td></td>
<td>Shortfall in Income Recovery Due to High Reference Costs (equal to 100% transitional relief)</td>
<td>4.7</td>
<td></td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Loss of contracted income</td>
<td>4.5</td>
<td></td>
<td>4.5</td>
</tr>
</tbody>
</table>

\(^\text{35}\) A copy of the Public Interest report is available from the Audit Commission or from Shropshire and Staffordshire SHA.
### Turnaround and Recovery

The Trust, supported by Ernst and Young, produced an initial Service and Financial Recovery Plan during January and February 2006. This focused on the improving the Trusts productivity and eliminating inefficiencies.

The schemes were grouped into four principle categories:

- **Improving Service Productivity**
  - Reducing the Trusts length of stay to the average for that specialty.
  - Increasing the day case procedures to 80%.
  - Improving Theatre productivity and utilisation.
  - Eliminating unnecessary outpatient follow-ups.
  - Reducing inefficiencies of split site working for emergency care.
  - Ensuring best practice service efficiencies are realised through delivering the 10 High Impact Changes.

- **Workforce Redesign to improve Productivity:**
  - Matching consultant job plans to agreed activity as part of planning capacity.
  - Move as much out of hours work to normal working hours as possible.
  - Standardise working practices to more effectively match patient and service needs eg shift start and finish times.
  - Reduce the need for agency staffing to save costs.
  - Reduce clinical staff time spent on non-direct patient care activities and move these to support or administrative staff.
  - Aligning staffing and skill mix within teams to better meet patient and service needs.
  - Introduce more flexible working to ensure a match between workforce and demand for services.
  - Exploit the opportunities presented by new technology eg Electronic Patient Record; outsourced transcription services to manage peak demand; e recruitment.
  - Reduced management costs.

- **Redesign Back Office Functions and reduce costs:**
  - Explore the opportunity for shared service savings.
  - Reduce the costs of Procurement.

- **Increasing Income:**
  - Ensure that all activity is coded correctly and counted.
  - Identify opportunities to increase income by delivering additional activity at marginal cost.

The Trust commenced immediate action and implemented:

- A stop on all non-essential non pay and capital expenditure.
- Limited to the minimum levels spend on bank and agency staff, and overtime spend, reducing expenditure by £787,000 in the second half of 2005-06.

### Table: Excess costs of national initiatives and internally funded developments

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Recurrent £M</th>
<th>Non-recurrent £M</th>
<th>Net £M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>Excess costs of national initiatives (Agenda for Change; Consultant Contract; Working Time Directive for Junior Doctors; increased CNST premium) Includes Agenda for Change Project Costs</td>
<td>4.2</td>
<td>0.8</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>Internally funded developments</td>
<td>1.2</td>
<td>2.8</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>Trust Contribution to impairments</td>
<td>(6.0)</td>
<td>(6.0)</td>
<td>(12.0)</td>
</tr>
<tr>
<td></td>
<td>Cost Improvement Plan</td>
<td>(6.0)</td>
<td>(6.0)</td>
<td>(12.0)</td>
</tr>
<tr>
<td></td>
<td>Non-recurring savings and income</td>
<td>(4.3)</td>
<td>(4.3)</td>
<td>(8.6)</td>
</tr>
<tr>
<td></td>
<td><strong>2005-06 Year End Position</strong></td>
<td><strong>22.1</strong></td>
<td><strong>(7.1)</strong></td>
<td><strong>15.0</strong></td>
</tr>
</tbody>
</table>
— Instigated robust management of vacancies created by staff turnover, and only appointing to vacant posts where clinical services would otherwise be compromised. The Trust have already achieved savings of 173 FTE posts through vacancy management between October 2005 and April 2006.

**DEPARTMENT OF HEALTH APPOINTED TURNAROUND TEAM**

The Department of Health commissioned KPMG to review all Trusts with a deficit during December 2005. The report on UHNS identified the Trust as one of the 18 requiring further intervention and support.

Deloitte’s were appointed as the Trust Turnaround Team in March 2006. They helped support in various areas:

— Identified additional substantial savings to be made on the Trusts procurement, increasing the initial target from £1 million to £2.4 million.
— Set up a method to capture staff ideas for productivity improvements and savings.
— Validated the savings to be made from the four clinical turnaround schemes in the Service and Financial Recovery Plan.

Overall the Trusts view is that the Team have provided some added value, particularly by creating the opportunity for greater savings on procurement, and doubling the original target.

**THE PCTs FUNDING FORMULA**

The four local PCTs distance from the target allocations remain below target — £798,000 in 2006–07 and, — £721,000 in 2007–08.

<table>
<thead>
<tr>
<th>PCT Distance from Target Allocation</th>
<th>PCT Distance from Target Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffordshire Moorlands PCT over target by £1,199K</td>
<td>Staffordshire Moorlands PCT over target by £590K</td>
</tr>
<tr>
<td>South Stoke PCT under target by £3,015K</td>
<td>South Stoke PCT under target by £2,060K</td>
</tr>
<tr>
<td>North Stoke PCT over target by £348K</td>
<td>North Stoke PCT over target by £291K</td>
</tr>
<tr>
<td>Newcastle under Lyme PCT over target by £670K</td>
<td>Newcastle under Lyme PCT over target by £488K</td>
</tr>
</tbody>
</table>

The national average recurrent growth in allocation for 2006–07 is 9.2%, and for 2007–08 9.4%. North Stoke PCT and South Stoke PCT will soon reconfigure to become one PCT for the population of the City of Stoke on Trent. This PCT is expected to receive significant growth in funding over the next two years.

Staffordshire Moorlands PCT and Newcastle under Lyme PCT are already above their target allocations, the distance above target will reduce next year.
FINANCIAL POSITION MOVING FORWARD

The table below illustrates the Trusts planned financial position for 2006/07 and beyond, taking into account the anticipated savings from the recovery plan.

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Recurrent £M</th>
<th>Non-recurrent £M</th>
<th>Net £M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006–07</td>
<td>Opening Underlying Deficit</td>
<td>22.1</td>
<td>22.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR Tariff Efficiency</td>
<td>5.9</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR National Tariff Adjustments</td>
<td>5.9</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR Transitional Relief (50% but incorporates additional services)</td>
<td>(5.2)</td>
<td>(5.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gain from Market Forces Factor</td>
<td>(4.1)</td>
<td>(4.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lost Income Due to Commissioner Downsizing</td>
<td>17.6</td>
<td>17.6</td>
<td></td>
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<tr>
<td></td>
<td>Variable Cost Savings as a result of Commissioner Downsizing</td>
<td>(6.1)</td>
<td>(6.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings from Recovery Plan</td>
<td>(21.9)</td>
<td>(21.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation Costs of Recovery Plan</td>
<td>1.1</td>
<td>7.3</td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>Cost pressures (inc Agenda for Change, impairments etc)</td>
<td>0.7</td>
<td>0.3</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Non-recurrent Measures (various)</td>
<td>(6.1)</td>
<td>(6.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RAB adjustment from 2005–06</td>
<td>15.0</td>
<td>15.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bank Support for RAB</td>
<td>(15.0)</td>
<td>(15.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interest Payable on Bank Support for RAB</td>
<td>0.6</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West Midlands Bank Support (incl redundancy costs support)</td>
<td>(19.0)</td>
<td>(19.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interest Payable on West Midlands Bank Support</td>
<td>0.9</td>
<td>0.9</td>
<td></td>
</tr>
</tbody>
</table>

2006–07 Year End Position 21.2 (21.2) Nil
<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Recurrent £M</th>
<th>Non-recurrent £M</th>
<th>Net £M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007–08</td>
<td>Opening Underlying Deficit</td>
<td>21.25</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR Tariff Efficiency (assumed 1.5%)</td>
<td>3.5</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR Transitional Relief</td>
<td>(2.6)</td>
<td>(2.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings from Recovery Plan</td>
<td>(21.9)</td>
<td>(21.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation Costs of Recovery Plan</td>
<td>1.0</td>
<td>2.2</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Interest Payable on Bank Support</td>
<td>1.5</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Semi-fixed Cost Removal as a Result of Commissioner 2006–07 downsizing</td>
<td>(6.1)</td>
<td>(6.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Bank Support</td>
<td>(2.2)</td>
<td>(2.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loan Repayment</td>
<td>3.0</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>2007–08 Year End Position</strong></td>
<td><strong>(2.3)</strong></td>
<td><strong>1.9</strong></td>
<td><strong>(0.4)</strong></td>
</tr>
</tbody>
</table>

**CONSEQUENCES OF THE DEFICITS: STANDARD OF CARE AND JOB LOSSES**

The main aim of the recovery plan is to continue to deliver the same levels and quality of activity but using fewer resources than currently. If the Trust provides health care in accordance with other NHS acute hospitals, some patient services will certainly change but patient safety will not be compromised.

As the Trust reduces lengths of stay, and as a consequence the number of beds, fewer staff will be required. These changes have been planned using proven activity and workforce models. For nursing, the recommendations of the Audit Commission ward Staffing Audit 2004 will be taken into account, in particular the need to maintain core levels of very experienced staff.

It is clear that the Trust need to catch up with other Trusts on productivity and deliver redesigned services to achieve best use of hospital resources. Examples of some of the ways that the Trust plans to change service delivery are set out below.

- At the moment hundreds of patients come into hospital as an emergency each year with a relapse of an ongoing condition such as chronic bronchitis and emphysema. The plan is to change the way we care for these patients so they have more help to cope with their condition at home, many of them will not reach the relapse stage and so will not need to be rushed into hospital. The Trust will therefore not need as many beds, or staff to manage these beds.

- Another area where there are inefficiencies compared to other hospitals of a similar size is on the number of operations we do as day cases, where the patients come in, have their operation and go home again on the same day.

- One of the areas where the Trust are not as good as similar hospitals around the country is on the length of time patients stay in hospital. The Trust will reduce the length of stay to the national average which, again, will mean we need fewer beds.

- Reducing patients’ length of stay is not about sending people home before they are fit, but there are a number of patients in our hospital who simply no longer need the type of care we provide.

- The Trust are working with community healthcare providers and Social Care to make sure community services are in place for these patients.

- The Trust are also changing some ways of working to be more efficient during the time that patients are with us. For instance, improving the patients’ journey by faster access to diagnostic testing so that patients are not lying in bed simply waiting for tests.

**THE JOB LOSSES IN THE SERVICE AND FINANCIAL RECOVERY PLAN (SFRP)**

The Trust have confirmed that the reductions will be achieved through a number of methods namely, management of vacancies and agency usage followed by voluntary redundancies, and finally compulsory redundancies.
The latest forecast of numbers of full time equivalents expected in each category is shown below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Planned Reduction (FTE)</th>
<th>Current Position (SFRP Identified) (FTE)</th>
<th>Deficit against Planned (FTE)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants*</td>
<td>15.0</td>
<td>0.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Other Medical Staff</td>
<td>11.03</td>
<td>7.52</td>
<td>3.51</td>
</tr>
<tr>
<td>Nursing and Midwifery (Qual)</td>
<td>371.13</td>
<td>240.99</td>
<td>130.14</td>
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<tr>
<td>Other Clinical Staff</td>
<td>322.30</td>
<td>75.40</td>
<td>246.90</td>
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<tr>
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<td>60.00</td>
<td>42.47</td>
<td>17.53</td>
</tr>
<tr>
<td>Clerical and Admin and Managers</td>
<td>242.93</td>
<td>111.32</td>
<td>131.61</td>
</tr>
<tr>
<td>**Totals</td>
<td>1,022.38</td>
<td>477.70</td>
<td>544.68</td>
</tr>
</tbody>
</table>

*The SFRP for this staff group will be delivered via a reduction in Programmed Activities (PA’s) rather than the removal of posts.

**Plans to deliver the remaining workforce changes are to be finalised by the end of June 2006.

Vacancy management is an ongoing element of the Trusts workforce strategy. The Trust are about to undertake a second round of asking for voluntary redundancies before making further decisions on compulsory redundancies.

A comparison of the workforce post delivery of the Service and Financial Recovery Plan has been modelled and compared with the workforce modelled for the Fit for the Future PFI project, this is illustrated below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Planned Staff in Post position (post-SFRP)</th>
<th>Planned FfiF Staff In Post position (2012–14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants*</td>
<td>194.29</td>
<td>235.41</td>
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<tr>
<td>Other Medical Staff</td>
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<td>382.54</td>
</tr>
<tr>
<td>Nursing and Midwifery (Qual)</td>
<td>1,567.71</td>
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<td>Other Clinical Staff</td>
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</tr>
<tr>
<td>Non-clinical Support, Estates</td>
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<td>673.15</td>
</tr>
<tr>
<td>Clerical and Admin and Managers</td>
<td>954.66</td>
<td>921.82</td>
</tr>
<tr>
<td>**Totals</td>
<td>5,213.43</td>
<td>5,271.58</td>
</tr>
</tbody>
</table>

**Achievement of Financial Balance**

The Trust plan is to achieve a small surplus of £2.3 million by the end of the financial year 2007–08, and to achieve target run rate (monthly income matching expenditure) six months before this.

University Hospital of North Staffordshire

June 2006

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Evidence submitted by the Parkinson’s Disease Society (Def 44)

1. **Introduction**

1.1 The Parkinson’s Disease Society (PDS) welcomes the opportunity to comment on the effects that NHS Trusts’ financial deficits are having on the number of job losses and their impact on the quality of patient care.

1.2 The PDS is pleased that the Committee has agreed to conduct an inquiry on this issue as we are concerned that NHS Trusts will sacrifice the post of the Parkinson’s Disease Nurse Specialist (PDNS), who have a key role in treating and caring for people with Parkinson’s, in order to reduce the level of the deficit they are experiencing.

1.3 It is important to note that access to a PD specialist nursing services is one of the five key recommendations in the draft NICE Guideline for Parkinson’s disease, which is to be published on 28 June 2006. The Guideline also states that the PDNS is key to maintaining people with Pd within the community for the maximum time possible.
2. THE CONSEQUENCES OF NHS DEFICITS: NUMBER OF JOB LOSSES

2.1 The PDS is deeply concerned about the impact that NHS deficits are having on job losses and patient care—an impact that is already being felt by PDNS' in many areas and therefore is felt by their patients.

2.2 In Greater London one PDNS has handed in her notice because she had been told she must work on the ward three days a week and look after her Parkinson’s disease patients as and when the ward allowed. Across the UK the PDS has been told that many nurses are discussing with their managers how to maintain their role as specialist nurses rather than being required to adopt a role as a generalist nurse on the ward for a number of days during the week.

2.3 With regard to recruitment issues the post of nurse specialist is no longer as attractive to the nursing workforce. For example in recruitment there are currently only one or two applicants per post if any yet Community Matron posts, which are considered more secure, are yielding numerous applications.

2.4 There are other posts that the Society has recently funded where Trusts/PCTs are unable to recruit in the present financial climate for example in Greater London and the South East, the PDS has agreed to extend funding for two posts for a further period rather than lose the service in these areas.

2.5 The PDS has also been informed that PDNS' working in the new South East SHA have been told their jobs are under threat because they are the “nice to have posts” rather than being essential posts[c1]. As part of Agenda for Change PDNS posts have been generally graded at a higher levels (six to seven and in some cases eight). This banding reflects the expertise and role of the nurse specialist. Financial recovery plans in Trusts are targeting nurses on higher levels of banding as managers seek to drive down workforce labour costs.

2.6 When post holders leave their posts these posts are being frozen. An example from the South West illustrates this problem. A PDNS left her post because she could not be reassured her job would be retained. The post since this time has been re-advertised but the Trust failed to recruit and the post has now been frozen due to financial deficits.

2.7 This has resulted in several areas of nurse specialists having to defend their jobs. PDNS are being required to compile business cases to substantiate their salary band. This has led to those nurses concerned feeling vulnerable and under threat.

2.8 Most disappointingly the PDS has now learnt of the first redundancy of a specialist nurse post in the South East to which we gave three years “pump priming” funding. This post will be made redundant as of September this year, when the “pump priming” funding runs out. The PDS is extremely concerned that this Trust does not become the first of a series who feel they are unable to continue to provide a vital support for people with Parkinson’s in their area in order to provide a short term solution to their financial deficits.

2.9 The PDS is also deeply disappointed that this redundancy comes despite a letter of intent being signed by the Trust at the outset agreeing to take on funding of the post once the PDS’ initial “pump priming” has run out.

2.10 The PDS has provided £5 million of funding over the last fifteen years to develop the PDNS service across the UK, working with NHS Trusts and SHAs to develop agreements to jointly provide a PDNS. As part of these agreements the PDS provides funding for the initial two years of a PDNS’ employment with the Trust or SHA after which their employment is taken on by the Trust or SHA. These agreements are set out in a “Letter of Intent” which acts as a legal partnership between the PDS and the NHS organisation.

2.11 The PDS is concerned that the Government’s and NHS’ desire to work more closely and encourage greater involvement of the voluntary sector in providing a greater level of services for patients will be endangered if such funding agreements for services are not honoured.

2.12 Indeed throughout the new Our Health, Our Care, Our Say White Paper the role of the voluntary sector as an innovative provider is encouraged with the Government stating,

“We will encourage the independent and voluntary sectors to bring their capabilities much more into play in developing services that respond to need”.

2.13 The PDS therefore believes in order to continue to promote effective partnership working between the NHS and the voluntary sector, funding agreements must be honoured and working practices maintained.

3. THE CONSEQUENCES OF THE DEFICITS: THE EFFECT ON CARE

3.1 In addition to concerns being raised regarding the maintenance of PDNS posts across the UK, the PDS has begun to receive anecdotal evidence that NHS Trusts are asking PDNS’ to change their working practices to addresses shortages elsewhere which have resulted from cutbacks in agency staff, diverting the specialist nurse resource away from their key patient group.

36 “Our Health, Our Care, Our Say” CM 6737 January 2006 page 20.
3.2 In particular PDNS’ in the new North East and Essex Strategic Health Authorities have been asked to work back on the hospital ward one day a week when they would normally be out in the community treating people with Parkinson’s.

3.3 We would suggest that this is not a cost effective use of resources and compromises PDS as a charity. We need to be able to demonstrate both to our members and the Charity Commission that any money spent by us is for the good of people affected by Pd.

3.4 In some SHAs there is evidence that PDNS’ have been told that un-costable work such as conducting telephone clinics, which can be a vital link for many Parkinson’s patients will not be able to continue as they are not costed as part of Payment by Results. Telephone support for example is a useful medium for drug titration where the patient manages their own drug regime but sometimes needs general guidance and support in adjusting medication. Such support is an essential part of treating people in the community and preventing unnecessary and costly admissions to acute hospitals.

3.5 The PDS believes it is vital that the role of the PDNS does not become diluted in order to cover gaps elsewhere in the provision of care and treatment. The PDNS specialises in the care of people with Pd from the point of diagnosis and their expert competences include the case management and symptom control of Pd, which is so specialised and individual.

3.6 The PDNS will effectively manage the person with PD in the community for many years before their condition deteriorates to a level where a community matron will potentially be involved. Evidence shows that the services a PDNS’ provides, improves quality of life for individual patients and their families and carers without raising the cost of care.

3.7 PDNS’ can also improve clinical outcomes, make it possible for patients to be cared for at home, and ensure a more co-ordinated approach by bringing together all the services that impact on people with Parkinson’s.\(^37\) Better management of Parkinson’s by the PDNS can lead to shorter hospital stays and less frequent readmission. A study carried out at Charing Cross Hospital in 1999–2000 showed that intensive management in the community by a Parkinson’s disease nurse reduced the average length of hospital stays by 18%.

3.8 Additionally the PDNS will be central to the effective implementation of the NSF for Long Term Conditions and the upcoming NICE Guideline on Parkinson’s disease and in achieving effective practice based commissioning. A PDNS can act as a specialist resource for the education and support of other nurses and health care professionals including GPs, which is essential to improving the care and treatment of people with Parkinson’s.

3.9 The PDS is therefore concerned that where a PDNS is employed within a Trust or SHA there role in dealing with people with Parkinson’s is secured to achieve the clinical and cost effectiveness that is possible with the high level of care and treatment they provide. Indeed the role of the PDNS can be shown to save money within a local health economy with one study showing that a PDNS saved £14,600 in consultant outpatient appointments in six months. As Trusts face large deficits such cost effectiveness should be maintained rather than sacrificed for short term financial balance.

4. INTERFACE BETWEEN PDNS AND COMMUNITY MATRONS

4.1 People with PD need to be managed across the whole spectrum of the disease process from diagnosis to palliative care, this means that PDNS and Community Matrons should work in a complementary way. Community Matrons however see only the most complex patients yet they are being employed instead of nurse specialists who would see patients throughout the disease.

4.2 Community matron posts are also well resourced and often banded higher than specialist nurse posts making them an attractive alternative for nurse recruitment. For example, in Cornwall a PDNS has moved across to a Community Matron post with her skills now lost to the wider PD community. Also in the South West in a PCT where there is no PDNS available at all for the Health Economy the PCT is intending to employ at least 4 Community Matrons.

4.3 PDS has also had several applications for PDNS funding withdrawn because PCTs have decided to employ Community matrons instead of PDNS for example in Milton Keynes. This is despite the fact that the PCT already has specialist posts for Multiple Sclerosis and Epilepsy which leads to an inequity for people with Parkinson’s.

5. **Conclusion**

5.1 The PDS strongly welcomes the focus of the Committee’s inquiry into the issue of the increasing NHS deficits particularly their impact on the number of job losses and the effect on patient care.

5.2 For the PDS it is the impact on the role of the Parkinson’s Disease Nurse Specialist which is of most concern and one that is now beginning to be felt. The PDS is deeply concerned that already one PDNS has felt forced to resign her post and more recently another has been made redundant, just before the Trust would have been required to take over funding for the post.

5.3 In addition the PDS believes that changes to the working arrangements of PDNS can only have a detrimental impact on the level and quality of care PDNS are able to provide the their patients. It is clearly not desirable for specialist nurses to be moved back onto the ward to cover the role of more generalist ward nurses which the Trust is unable to provide. Nor is it desirable that effective services such as telephone consultations should be withdrawn due to not being included in Payment by Results costings.

6. **Parkinson’s Disease**

6.1 Parkinson’s disease (Pd) is a progressive, neurological disorder for which there is currently no cure. It can affect all activities of daily living including talking, walking, swallowing and writing. The three main symptoms are tremor, muscle rigidity and slowness of movement but not everyone will experience all three. Other symptoms may include a lack of facial expression, an altered posture, tiredness, depression and difficulties with balance, speech and writing. The way symptoms manifest themselves in people is specific to each individual. No two people’s Parkinson’s disease will have the same severity or range of symptoms, hence the management of the condition is also unique to each person.

6.2 There is at present no cure for Parkinson’s disease, but there are various treatments to help manage the symptoms. The main treatment used is drug therapy, which aims to control the symptoms. However the drug treatment has to be tailored to suit the individual in terms of times of the day taken and dosage because each person is different.

6.3 The drug treatment is very effective but needs to be reviewed and adjusted on a regular basis. Also long-term use can lead to disabling side effects which include involuntary movements (dyskinesias), hallucinations and something called the on/off syndrome. This can best be described as an unpredictable shift from mobility—‘on’—to a sudden inability to move—‘off’. This side effect, which can occur suddenly and unpredictably, is the cause of much misunderstanding and difficulties with management, particularly when the person with Parkinson’s is admitted to hospital.

6.4 It is estimated that as many as 120,000 people in the UK have Parkinson’s. That is one in 500 of the general population. This increases to one person in 100 over the age of 65 and one in 50 over the age of 80. Around 1,000,000 people in the UK actually ‘live with Parkinson’s disease’ as families, partners and friends who provide care and support.

7. **The Parkinson’s Disease Society**

7.1 The Parkinson’s Disease Society (PDS) was established in 1969 and now has 30,000 members and over 300 local branches and support groups throughout the UK. The Society provides support, advice and information to people with Parkinson’s, their carers, families and friends, and information and professional development opportunities to health and social services professionals involved in their management and care.

*Robert Meadowcroft*  
Parkinson’s Disease Society  
*June 2006*

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Evidence submitted by PricewaterhouseCoopers (Def 59)

**Introduction**

PwC’s UK Business Recovery Services (BRS) practice is the largest in the World, providing a range of advisory and insolvency services to lenders, creditors, companies and individuals in troubled financial situations.

In the UK we have 900 partners and staff operating out of 22 offices.

The Practice provides the full range of services for underperforming businesses, public sector bodies and their stakeholders including the management of crisis, the implementation of turnaround and advising lenders, creditors and businesses of all sizes ranging from owner-managed mid-market businesses to multinational organisations.
The Corporate restructuring team works with the management of underperforming businesses and organisations to stabilise them and turn them around. It supports such organisations by improving cash management, regaining control of the organisation and developing a platform for future stability or growth.

The Corporate Restructuring team within PwC’s Business Recovery Services practice is lead by Kevin Ellis, a PwC partner.

Kevin has specialised in providing turnaround and restructuring services to underperforming businesses and organisations in the public and private sectors for over 18 years. Kevin has extensive experience in turnaround situations, working with stakeholders in developing innovative, constructive and commercial solutions for underperforming organisations. Kevin often takes on a role of coaching and mentoring senior management during the process so as to bring about long term sustainable improvement.

PwC is able to draw upon a unique resource of over 150 Turnaround Directors from its Turnaround Panel, who can be placed at short notice into troubled situations. The PricewaterhouseCoopers LLP Turnaround Panel is made up of independent Turnaround Directors who have a proven track record of turnaround that can be placed into executive positions to provide hands-on leadership in distressed or underperforming businesses. Turnaround Directors from this Panel have been introduced into middle-market, public sector and high profile rescues.

The members of the PwC Turnaround Panel are typically experienced senior executives from a wide variety of backgrounds. The common theme is that these executives have “done it before”, bringing their sector and situational skills to bear rapidly and effectively on a distressed situation.

Panel members can fulfil a wide range of roles including Chief Executives, Finance Directors, Chief Restructuring Officers, functional directors/managers and executive/non-executive chairmen. A rigorous selection process is employed, involving interviewing and reference checking to ensure consistency of quality of Turnaround Directors. They have no subsequent contractual relationship with PwC and the final decision to utilise their services in Turnaround situations will be taken by the client or other stakeholder.

**Recent Turnaround Activity in the NHS**

1. **National Programme Office (“NPO”) for turnaround**

   Following the analysis of those Trusts/PCTs with the largest deficits performed by KPMG (Project Sands—baseline assessment) in late 2005/early 2006, PwC were invited (along with the other Big Four firms) to tender to provide a structure for and support to the National Programme Office for turnaround (NPO).

   PwC were successful in this competitive tender and as a result have secondees working for Keith Davies, an independent Turnaround Director who heads up this team and reports to the DH Turnaround Task Force chaired by Richard Gleave of the DH Recovery and Support Unit.

   The role of the NPO is to ensure turnarounds were rigorously planned and executed whilst ensuring there is a real time sharing of best practice and knowledge.

2. **SHA Turnaround Directors**

   As part of the infrastructure to support the delivery of turnaround, private sector Turnaround Directors were appointed to each of the 11 SHA Transitional Patches to support the Transitional Leaders in managing their turnaround organisations and to act as the interface with the NPO. In each case local NHS management had the final say on their appointment.

   Following a request to Deloitte, KPMG, Ernst & Young and PwC for CVs of experienced Turnaround Directors who were ready for immediate deployment, 10 Turnaround Directors were chosen from a selection of CVs provided by PwC.

   The remaining Turnaround Director is a PwC employee and Director who with over 10 years of turnaround experience who had been on secondment to the Department of Health since May 2005 working in the Performance Support Team and in November 2005 was subsequently deployed into a SHA Turnaround Director role by the DH (whilst still on secondment).

3. **Turnaround Support in Turnaround Cohort Trusts/PCTs**

   The baseline assessment (Project Sands) of the financial position of 98 organisations within the turnaround cohort highlighted that a significant number of these organisations were projecting a budget deficit during the same financial year and therefore required cost improvement/recovery plans in order to return to financial balance. The review also included the categorisation of Trusts and PCTs in terms of their likely turnaround support requirements during business recovery. Those categorised as 1 or 2, in particular, were recognised as requiring external support and assistance in order to develop robust and credible turnaround plans.
Following the baseline assessment, PwC have been invited by various Trusts and PCTs in the cohort to competitively tender for the provision of a range of turnaround support. PwC have as a result provided support to over 20 organisations within the turnaround cohort as well as a number of other Trusts/PCTs (outside of the cohort) who have independently recognised the need for external support and invited tenders.

The assignments undertaken have varied in size but generally take between six to eight weeks during which the PwC team work closely with all staff within the relevant NHS organisation in the development of a robust turnaround plan. This involves empowering and working with the clinical staff. In most cases initial ideas for recovery plans are generated by clinical and management leaders within the organisations themselves, the job of the advisory teams is to work these ideas into detailed, executable plans.

We are confident that we are making a key contribution in supporting Trusts achieve sustainable financial improvement.

PricewaterhouseCoopers

June 2006

Evidence submitted by Rethink (Def 24)

1. We are pleased to have the opportunity of contributing to this inquiry. Rethink is the charity for people who experience severe mental illness and for those who care for them. We are both a campaigning membership charity, with a network of mutual support groups around the country, and a large voluntary sector provider in mental health, helping 7,500 people each day. Through all its work, Rethink aims to help people who experience severe mental illness to recover a meaningful and fulfilling life and to press for their families and friends to obtain the support they need.

2. For the main part of our evidence, we would like to focus on the consequences of the deficits for mental health, and the effect on care. Rethink has been campaigning about cuts over recent months, and have conducted our own investigation into mental health budget cuts, and the effect that this is having on those directly affected by any changes to services—service users and carers. It is from this basis that we feel well placed to comment on how NHS deficits are felt “on the ground”.

3. The last financial year (April 2005–06) was a difficult year for those using and working in health services. Some NHS Trusts faced huge deficits and details of cuts to services hit the headlines. The effect on mental health services, according to service users and carers that Rethink are in touch with, has been particularly acute, but less well publicised.

4. According to the Institute for Public Policy Research and Rethink, mental health trusts are generally below the standards of the average health trust. The Healthcare Commission performance ratings for 2004 revealed that mental health trusts have the lowest number of three and two star trusts and the highest number of no star trusts, compared with acute, Primary Care Trusts specialist trusts and ambulance trusts. Mental health Trusts often cited funding constraints as causes for their difficulties.

5. And yet there have been huge developments in mental health services since 1999 following the National Service Framework for Mental Health in that year and the NHS Plan in 2002. New services, such as early intervention and crisis resolution teams, have supported a number of people through a crisis and helped a number of crises to be avoided. However, there is real concern that these specialised services are being delivered at the expense of other services that would help other people who do not fall into the criteria for these particular specialisms.

6. The introduction of new services—“reconfiguration”—into areas with already overstretched budgets puts mental health trusts under even more pressure, and our campaign has so far uncovered over £30 million cuts in over 30 areas in England. With little new health money in the March Budget and future funding increases under doubt as the Comprehensive Spending Review looms in 2007, there is real concern that mental health will again live up to its name as the Cinderella of the NHS. Further details of our investigations and specifics about cuts we have heard about can be seen in our report a cut too far (enclosed with this memorandum) and can be downloaded at www.rethink.org/cuts

7. It was around the end of last year that Rethink began hearing about worrying cuts to mental health services around the country. Service users, carers and staff began alerting us to plans that suggested health trusts were targeting mental health services in order to “plug” gaps in their wider budgets as the financial year was coming to a close.

8. Rethink responded by gathering as much evidence as possible from our networks to start building a picture of what was happening on the ground. We contacted the Department of Health and Louis Appleby, National Director for Mental Health, demanding an urgent investigation into the situation. Individual MPs were briefed and many helped to pursue the matter directly with the ministers in the Department of Health and made efforts to find out the situation in their particular constituency.

9. As a result, the Department of Health contacted 28 Strategic Health Authority (SHA) Finance Directors asking for specific information about their financial situation. The results were announced in a parliamentary debate on mental health services in February 2006.

10. Twenty Strategic Health Authorities reported no reductions to planned expenditure on mental health services; the remaining eight reported that there would be reductions in planned expenditure affecting 11 out of 84 mental health trusts in England. Those trusts had planned to spend £894 million in this financial year, and they are reducing their planned expenditure by a total of £16.5 million—that is 2% of the total.

11. However, these “official” figures do not sufficiently address the real fears and problems service users, carers and those working on the ground in mental health services are experiencing. Nor do they account for the widespread experience of reduced services being felt by people on the frontline—and, perhaps even more importantly, do not take account of more cuts planned for the current financial year. Some examples of the effect this is having on services users and carers can be seen through comments Rethink received in response to our campaign, from service users and carers:

12. “As a user of mental health services I am extremely worried . . . I had a relapse earlier this year and was not admitted to hospital due to lack of beds.” Service User, Cambridgeshire.

13. “ . . . what struck us all straight away was the fact that the mental health services, whose budget was not in deficit, were going to have to contribute to the overall deficit of the healthcare Trust in order to reduce this.” Carer, Cornwall.

14. “ . . . patients and carers will have to travel much longer distances for treatment and visiting, for prolonged periods in many cases, and damaging upheaval and stress is being caused by the enforced change of psychiatrists and Community Psychiatric Nurses.” Carer, Buckinghamshire.

15. “Management will not say there will be cuts. The term used is modernisation.” Carer, Worcester.

16. The new budget year of 2006–07 sees new financial and accounting arrangements being introduced across the National Health Service. Trusts are being told to budget for a surplus this year—and not just break even. Payment by Results, an internal payment system designed to encourage money to follow the patient, will introduce a new level of financial instability into a system that historically has relied on predictable flows of money from pre-set block contracts. “Tariffs”—centrally set costs for a range of medical procedures—will benefit those trusts with low costs and place a new burden on those with higher costs.

17. Of course, mental health services are—for now—excluded from the payment by results and tariff systems, but that does not mean they will be unaffected. Just as in the last financial year of 2005–06, when the NHS looked to mental health as a “soft touch” to share the pain of deficits run up in physical health, so cash-strapped trusts that fail to get to grips with the new financial regime and its in-built instabilities, will again look to mental health spending to make up the difference.

18. But there are signs that mental health is no longer such a soft touch. Campaigners took to the streets in Cambridge and Oxford when mental health was threatened last year and across the country individuals raised the issue of local mental health cuts with their MPs and local media. It is the responsibility of government to take seriously any evidence of cuts and act appropriately to prevent the negative impact they have on those using services and their carers—and on the government’s long-term mental health reform programme.

19. The very success of the government’s mental health reform programme is threatened by the cuts we and others have highlighted. But it is a reform programme that has raised the expectations and aspirations of people using mental health services, their families and the people who work in them.

20. In response to our report, the government stated that there was no evidence that mental health services were being disproportionately targeted for cuts. They are refusing to acknowledge both the scale of the existing problem, and the scale of potential problems linked to greater financial instability this year (as previously discussed above). However, Rethink has been encouraged privately by trust Chief Executives and lay members of primary care trusts, as well as senior staff in the Department of Health, to challenge the official figures provided by Strategic Health Authorities in the pre-Christmas exercise, which none of these people have any confidence in. The government are unable to accurately track financial flows from the centre to mental health locally.

21. Rethink and our networks are extremely concerned that the situation for mental health services will only get worse in the future if more is not done now. We must protect services that help support the most vulnerable members of society. Current increased investment in mental health and the broader NHS will not continue at its present rate and the government, trusts and all those involved in service provision need to work together to protect current services and safeguard them for the future.
22. We have therefore called on the Department of Health to take action and to do so as a matter of priority. This must include:

— An assurance from both government and trusts that mental health remains a key health priority both at a national and local level.
— The government must order an urgent investigation into all potential budget cuts it is alerted to, including those included in our report a cut too far.
— The government and Trusts must work together to develop an emergency plan to overcome the funding crisis.

23. We welcome the inquiry that the Health Committee has launched into NHS deficits as we feel strongly that the effect on mental health services must be included in any investigations. We would be happy to contribute oral evidence to this inquiry. Please do contact me directly if you would like any further information.

Paul Corry
Director of Public Affairs, Rethink
2 June 2006

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Evidence submitted by the Royal College of Midwives (Def 39)

1. The Royal College of Midwives (RCM) represents over 95% of the UK’s practising midwives, and is the world’s oldest and largest midwifery organisation. It works to advance the interests of midwives and the midwifery profession and, by doing so, enhances the wellbeing of women, babies and families.

2. The RCM welcomes the opportunity to contribute to the Health Committee’s inquiry into NHS Deficits.

CONSEQUENCES OF THE DEFICITS

3. Last month the RCM published the results of a survey of Heads of Midwifery, midwifery educationalists and RCM national and regional officers into the effects the NHS deficits are having on maternity services across the UK.

4. The key findings of the survey include:

— more than one-in-three managers reported that their maternity services budget had been cut;
— more than one-in-four reported that their training budget had been cut;
— more than one-in-four respondents reported that their midwifery staffing establishment had been reduced and half of all trusts have been operating a recruitment freeze;
— one-in-four managers reported that their trust had been replacing senior midwives with more junior posts and a similar number reported that support staff had been used to substitute for midwives;
— one-in-four reported that they had reduced the number of home visits by midwives.

5. This snapshot of the consequences of the deficits for maternity services further compounds the effect of the drop in midwife numbers flagged up in the latest NHS staffing survey, which revealed that the headcount number of midwives in the NHS in England as at 30 September 2005 was 36 lower than in 2004.

6. This comes at a time when more and more is expected of maternity services. Recent policy announcements such as those contained in the National Service Framework for Children, Young People and Maternity Services and indeed in the Labour Party manifesto 2005 compel every trust to meet certain commitments regards minimum level and standards of care in maternity services.

7. The Labour manifesto, for example, promises that, “by 2009 all women will have choice over where and how they have their baby and what pain relief to use. We want every woman to be supported by the same midwife throughout her pregnancy.”

8. Currently, although England’s maternity services are safe, the chronic national shortage of midwives means that we do not yet have the kind of first-class service that women, the NHS and the Government clearly want and deserve. More midwives are needed before this high-quality service can be delivered, and as a consequence of the deficits this just is not happening.

9. The view that more midwives are needed is not just a position that the RCM supports; the then Department of Health (DH) Minister the Rt Hon Jane Kennedy MP is on record as supporting this very view too. In her recent oral evidence to the Committee on NHS Charges on 16 February, the former minister confirmed the impact the shortage of midwives is having on delivery of first-class care:

“one-to-one midwifery support is part of the National Service Framework, it is a commitment we made in our manifesto. The brake on us delivering that is the lack of midwives and we are working hard, as in other areas, to increase the numbers of people in that area. I think it has increased by
2,200. Progress is being made on that score but it is slow... The only reason they are not getting it is because we do not have enough midwives to be able to provide it and that is why we are increasing the numbers and trying to raise the profile of midwifery as a career and promoting it as a career.

**Relationship Between Funding and Workload**

10. A lesson of the current deficits must surely be that in the NHS financial resources must more accurately reflect activity levels. Two tools that will help to achieve that shift are Birthrate Plus and Payment by Results.

**Birthrate Plus**

11. There currently exists a system—Birthrate Plus—by which trusts can ascertain the number of midwives they need.

12. Birthrate Plus is a framework for workforce planning and strategic decision making in maternity services. In order to determine the case mix for this model, clinical scores are allocated retrospectively to mothers and babies depending on the normality of the process and outcome of the labour.

13. Many trusts have undertaken a Birthrate Plus review of their maternity services and implemented those findings, but not all trusts have done so and not all of those trusts that have undergone a review have implemented the findings.

14. The RCM recommends that trusts use the Birthrate Plus workforce planning tool to assess workforce needs and ensure that sufficient funding is in place to implement the findings; this will ensure that maternity services employ an appropriate number of midwives at the correct cost to the trust.

**Payment by Results**

15. The rollout of Payment by Results (PbR) provides an opportunity to improve the allocation of financial resources to trusts—so that money follows the service user.

16. Indeed, according to the Department of Health website, PbR aims “to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for casemix. Importantly, this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.”

17. The RCM is concerned however about the potential impact of PbR in two respects: how robust are the existing reference costs for maternity services; and will social as well as medical costs be reflected in the tariff?

**How Robust are the Existing Reference Costs for Maternity Services?**

18. Currently, different maternity units use different calculations to work out the costs of their maternity services. So, the question arises: how robust are the existing reference costs for maternity services, especially as we suspect that many trusts run maternity services on the cheap?

19. As stated in the official explanation of PbR (above), this new system is intended to smoke out just these sorts of anomalies, where budgets exist for historic or other reasons.

20. When the PbR crunch-point comes for maternity services however there will be a choice: will the result be that a fair and accurate tariff for maternity services is calculated, offered and fully-funded; or will commissioners decide that there is insufficient money to pay for a fair and accurate tariff for maternity services and so cheaply-funded maternity services becomes institutionalised through a lower tariff?

21. Essentially, the wider question here is: how can anyone be sure that PbR will result in “payment being linked to activity and adjusted for casemix” rather than existing inadequacies in the system becoming institutionalised through shoddy tariff-setting, especially if rollout is tied up with short-termism related to trusts trying desperately under intense political pressure to balance the books?
22. An example of how this might be happening is given in the ministerial answer on 18 April 2006 to a written parliamentary question from Committee member Anne Milton MP (see below). The Minister admitted that no assessment has been made of the effect of PbR on either home births or the caesarean section rate. Additionally, although the Minister stated that no assessment had “yet” been made, he gave no date or timeframe for this work.

Anne Milton MP: To ask the Secretary of State for Health what assessment she has made of whether payment by results has had an impact on the number of a) home births and b) caesarean section; and if she will make a statement.

Liam Byrne MP: No assessment has yet been made on the impact of payment by results on the number of home births and caesarian sections.

*House of Commons Hansard 18 April 2006 (column 230W)*

**WILL SOCIAL AS WELL AS MEDICAL COSTS BE REFLECTED IN THE TARIFF?**

23. Medical costs—how much for each kind of intervention or for a caesarean section—are easier to calculate than social ones—such as a pregnant women who is also a drug user, who does not speak English, or who is a teenager.

24. Obviously there will be additional costs to care for women with higher social risk—extra care will be needed for a drug user, an interpreter will be needed for the non-English speaker, liaison work may be needed for the teenager. Given that these social costs will be different for each individual woman using maternity services then they should surely be factored into the tariff.

25. The College is currently working with North East London SHA to develop a tariff that does include elements of social cost as well as medical cost. We would be keen to share what we learn from this with others who are developing tariffs for maternity services.

26. The RCM recommends that the DH ensure that the development of PbR, which has clear potential benefits for the ongoing modernisation of the NHS, is not botched by tariffs being developed that meet the immediate needs of trusts trying to tackle deficits whilst sacrificing the long-term benefits that such a PbR system could deliver. This is an important issue not just for maternity services but for all NHS services that will operate under PbR.

Royal College of Midwives

*June 2006*

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**Evidence submitted by the Royal College of Nursing (Def 27)**

1. **INTRODUCTION**

1.1 The Royal College of Nursing (RCN) represents over 380,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets in the UK. This makes the RCN the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2. **SUMMARY AND RECOMMENDATIONS**

Summary

2.1 The RCN has been monitoring the impact of Trust deficits for a year and has raised concerns publicly and privately on a number of occasions in order for measures to be taken to minimise the effects for both patients and staff.

2.2 Currently the RCN estimates that 15,000 posts\(^\text{39}\) are at risk of being lost to the NHS and there are clear examples on where this is having a detrimental effect on patient services. Band 5 posts, into which newly qualified nurses would expect to be appointed, and specialist nursing posts are being targeted. Services for older people and those with mental health needs appear particularly vulnerable.

2.3 The NHS cannot afford to lose nursing posts. These posts were created because of patient demands and at a time when patient dependency, throughput and occupancy have risen. In addition nurse staffing establishments are not full and nurse staffing levels in NHS wards in 2005 are virtually the same as in 2001.

\(^{39}\) Appendix 1
2.4 There is a significant and growing body of evidence that clearly links higher numbers of registered nurses in the workforce with reductions in patient mortality, infections, falls, pressure sores and medication errors. Similarly there is evidence that demonstrates a relationship between improved patient satisfaction and nurse staffing levels.

2.5 The causes of deficits are complex and are associated with a significant number of new policies. However, there has been a lack of piloting, fully costed implementation and roll out plans for these policies.

2.6 The RCN supports the principle of providing care closer to home however, is concerned there has been a decline in the number of district nurses in recent years and that community nurses have an older age profile than acute sector nurses. If there is a genuine fall in the demand for registered nurses in the acute sector these nurses should be supported through transition arrangements to gain the additional skills required to work in the community.

2.7 Financial pressures rather than planned service change are the key driver behind proposals in many acute and community Trusts to reorganise or reconfigure services and staff. Whilst the overwhelming majority of Trusts do fulfil their requirements to consult in respect of staffing changes which includes potential redundancies, the duty placed on all health providers to consult over proposed changes to health services as contained in s 11 of the Health and Social Care Act 2001 is frequently neglected.

RECOMMENDATIONS

2.8 The relative invisibility of the nursing contribution to quality patient care should be made much more visible and explicit. Mechanisms to achieve this include:

— Establishing national benchmark data sets on both the numbers of nursing staff and the grade mix for different specialisms.
— Determining what the nursing contribution is for each Healthcare Resource Group which would then assist in costing the nursing contribution for the new tariff system.
— Building on the existing evidence base, commission research to consider the optimum nursing skill mix in relation to patient outcomes.

2.9 A reliable national dataset in relation to student nurses should be established and pooling arrangements agreed to ensure newly qualified nurses are offered appropriate employment.

2.10 Commitments to jointly fund specialist nursing posts with other organisations should be honoured.

2.11 Transition programmes that enable nurses working in the acute sector to gain the additional skills to work in the community sector should be made more widely available. Funding should be identified to support the development and roll-out of such initiatives.

2.12 In-patient bed occupancy should be a maximum of 85%. Proposals to further reduce bed numbers must include an impact assessment on occupancy rates.

2.13 All new policies should be accompanied by a fully costed plan for both implementation and roll out.

2.14 Because of the complexity of the reform agenda and the risk of unintended consequences, controlled pilot schemes, supported nationally and comprehensively evaluated, should be undertaken before initiatives that have the potential to significantly destabilise health delivery systems are implemented across the Country.

2.15 The principle of local engagement in the development of health services should be strengthened and penalties created for individual Trusts who avoid carrying out such consultation. This would create a system of incentives for Trusts to ensure that local discussion takes place about the impact on patient care of any cut or variation in services, so that a full risk assessment can be carried out. This would assist in ensuring that the priorities of consultation and fiscal stability become equally important and compatible.

3. THE SIZE OF THE DEFICITS AND THE SAVINGS WHICH EACH TRUST HAS TO MAKE IN 2006–07

3.1 Deficits History

In the Spring of 2005 the RCN first began to receive reports from nurses in England that some hospitals were restricting the use of bank and agency staff because of financial pressures. During the summer of 2005 the RCN began to closely monitor the situation through our extensive network of branches and activists supported by staff based in regional offices.

3.2 During the autumn of 2005 we started to receive reports that in addition to preventing the use of bank and agency staff some Trusts had begun freezing job vacancies and were considering deleting posts. On 11 October the RCN issued its first public statement warning that 3,000 posts could be lost. Beverly Malone, RCN General Secretary said, “We are putting a spotlight on this issue now before it is too late” and Barbara Tassa, Chair for the RCN Public Policy Committee said “This is a reality check for the government”. This was a central message and lobbying issue that the RCN took to all three party political conferences last autumn.
3.3 During late 2005 RCN networks began reporting that they were starting to see examples of deficits impacting on patient services such as operations and out-patient appointments being delayed or postponed. On 19 January 2006 the RCN issued another statement warning of this new development, and that “nearly 4,000 NHS posts could be lost”. This was based on declarations that NHS Trusts in Leeds, along the South Coast and East Anglia had made to their local staff side organisations about the number of posts that could be lost. At that time Barbara Tassa said that, “The Government has repeatedly said that actions taken by Trusts to balance their books would not affect patient services. This is now clearly not the case”. She went on, “We have real concerns about the stability of NHS finances, especially in view of the roll-out of reforms such as Patient Choice and Payment by Results”.

3.4 Also on the 19 January 2006 the Health Service Journal issued the results of a survey of managers it had undertaken. It was reported that 75% of Chief Executives of acute and primary care trusts said that they believed patient care would be affected by financial problems, 63% of acute Trusts had been forced to close wards, 24% had made staff redundant and 75% had brought in recruitment freezes.

3.5 At the time the Government dismissed the RCNs concerns; however, shortly after announced that turn around teams were to be appointed.

3.6 The RCN continued to monitor the developing situation and were concerned that nursing posts to be lost were being targeted in broadly two areas. These were Band 5 posts, which are the entry point for new graduates and would therefore have an impact for student nurses, and specialist nursing posts.

3.7 At the end of March 2006 the RCN issued a statement highlighting the targeting of specialist nursing posts in areas such as diabetes, multiple sclerosis and epilepsy. Other organisations such as the MS Society, Parkinson’s Disease Society and British Society for Rheumatology also expressed concern as these posts had proven highly valuable in supporting patients with long term and chronic diseases to manage their conditions in order to achieve maximum stability thereby improving the quality of their lives and preventing frequent admission to hospital.

3.8 In February 2006 the RCN commissioned an ICM poll of a 1,000 nurses. Almost 70% of respondents reported that bank usage had been stopped, 66% said posts had been frozen, 38% reported ward closures, 33% that posts had been deleted and 27% knew of treatment delays. These findings corresponded with the information the RCN had been receiving through its regional networks.

3.9 At the beginning of the RCN annual Congress in April 2006 the RCN issued a statement which contained the results of an independently commissioned survey of 920 clinical nurse managers which included ward sisters/charge nurses and modern matrons. 45% reported that their had been a reduction in the number of posts where they work in the last 12 months and that 60% said they did not have enough staff to give patients the standards of care they would like.

3.10 At the same time the RCN issued its update on the number of posts that had been identified to be lost from the service totalling 13,000. A breakdown of these posts by Trust was made publicly available with the press release.

3.11 Furthermore two thirds of managers from the survey of nurse managers said they were under too much pressure in their job, 80% said they were working unpaid overtime several times a week, with 30% saying they did this every shift and 70% said they do not have time to mentor, educate and support junior staff. Beverley Malone said “These are the people who put health policy into practice at the patients bedside on wards and in the community. They (the Government) are dangerously close to losing the goodwill of this key group of nurses”.

3.12 At the RCN Congress the RCN issued a warning that services for older people and mental health and learning disability patients were also being affected by deficits. In addition to the RCN regional networks the RCN set up a deficits mailbox for nurses to report deficit related concerns to the RCN. An analysis of these responses and information from regional activists and staff provided examples of cuts to community hospitals, rehabilitation and intermediate care services, the rationalisation of mental health services and the continued targeting of specialist nursing posts.

4. The Reasons for the Deficits

Whether the Causes are Systemic or Local (EG the Role of Poor Local Management and Poor Central Management, the Effect of Pay Awards and Government Policy Decisions)

4.1 The causes of deficits are complex but can broadly be broken down into the following areas:

4.2 National Policy Priorities

The “NHS plan” is significant in understanding the national policy drivers for expenditure and reform. The March 2000 Budget settlement detailed a growth in NHS funds by “one half in cash terms and by one third in real terms in just five years.”

40 NHS Plan, 2000. DH.
4.3 The plan gave broad commitments to overhaul regulation, inspection, performance management, training and development, working practices and clinical care. It also stated that the NHS would deliver 7,000 extra beds, the modernisation of over 3,000 GP premises, better hospital food and a modern IT system across the NHS.

4.4 Critically, this massive investment was intended to deliver increases in quality and activity. For example, ending long waits in accident and emergency departments, reducing the maximum waiting time for an outpatient appointment and for inpatient care; implementing national standards for cancer care etc. The delivery of this additional activity and quality requires substantial investment in staff, specifically, a co-ordinated training and development programme and large increases in the numbers of Doctors and Nurses (this specific matter is dealt with in more detail below).

4.5 Individual system reforms

At the same time as attempting to deliver much of the above, a series of other initiatives tackled other system reforms such as funding flows, IT and staff pay.

4.6 The complexity of implementing these system reforms has clearly been underestimated not just in terms of the delivery of project objectives, but also in terms of the unintended consequences each policy has had on the success of the other.

4.7 For example, whilst Payment by Results may not in the short-term be causing deficits, it has none the less shown significant cost variations between Trusts—it would not be correct in our view to attribute these variations solely to local inefficiency or outdated practices. In effect, some Trusts now face a loss of income against activity (compounded in many cases by poor demand management and historical patterns of referral outside of their control) as a result of the introduction of PbR.

4.8 This is not to say that there should not be reform of NHS finances. It is simply to point out that system reform has impacts beyond implementation costs which appear not to have been appreciated or costed.

4.9 Historic challenges

Across the UK it is inevitable that there will be variation in NHS infrastructure, capacity and capability. Historical decisions about the location and function of services have an impact on the extent to which some Trusts were able to deliver on national policy priorities or spend money within plan.

4.10 PFI unitary charges and uniquely high living costs are examples of pressures which may have been in place before current financial planning cycles or changes in national spending priorities. Some otherwise effectively managed and efficiently operating Trusts will therefore incur persistently large deficits because they are effectively honouring past obligations, planning decisions or demographic trends.

4.11 Management and staff capacity

There are two main challenges. One lies with the existing capacity of an organisation to absorb the increased levels of activity required by the various waiting time initiatives or policy reforms. This does not solely refer to the clinical staff required to deliver the care but should also include the Trusts capacity in terms of “backroom” staff to monitor activity, report performance, and manage personnel and finance functions.

4.12 The other issue is the skills inherent in the local management to effectively interpret national policy directives. Various Trust and SHA performance reports and Audit Commission Public Interest Reports (PIR) have hinted at the latter point in reporting on local deficits.

4.13 Target culture

Whilst targets have brought about improvements for some aspects of patient care, it would seem that some organisations, in response to deficits, are decommissioning “non-statutory”/non-contractual services or areas of activity which do not work towards meeting national targets.

5. The Consequences of the Deficits

The Number of Job Losses/the Effect on Care

5.1.1 Latest Information

During Congress 2006, the RCN published a table of Trusts who had reported either publicly or through our activist network the total number of posts they intended to delete to help address their deficit position. In total we reported that 13,000 posts were at risk of being lost to the NHS as a result of these plans.

5.1.2 We were careful to refer to posts that could be lost from establishments and did not say that these losses would all be through redundancy.

5.1.3 The loss of nursing posts has caused great concern to RCN members because they were originally included in nursing establishments in order to ensure high quality patient care was delivered. Nurses do not believe that patient needs or demands have diminished, in fact occupancy, throughput and patient episode indicators suggest the contrary, therefore nurses question the clinical evidence that exists to support a reduction in nurse staffing levels.
5.1.4 Indeed nurses have been working excess hours, the overwhelming majority of which are unpaid, in order to cover the gaps that exist in nursing establishments as a result of unfilled posts.

5.1.5 There is a paucity of national nursing workforce data, however, the RCN believes that last year approximately two thirds of SHAs had fewer qualified nurses than planned. It would therefore be wrong to assume that the loss of posts was being made from nursing establishments that were full. Add to this normal assumptions about covering annual, sick and study leave for staff and it is clear why the loss of posts is a critical issue for nurses.

5.1.6 Since RCN Congress there have been further significant announcements of posts to be lost, for example in, Nottingham, the Pennines and Oxford. At Appendix 1 the RCN attaches its most up to date list of posts to be lost which currently totals over 15,000. We are aware that some Trusts have revised previous figures both upwards and downwards and have been careful to adjust our figures accordingly.

5.1.7 An NHS Employers briefing dated 16 May 2006 gave nine examples of Trusts that were losing posts and were “able to confirm their plans and willing to be named”. There are 50+ Trusts named in the latest RCN update.

5.1.8 Through the monitoring of posts to be lost, the RCN has identified that Band 5 and specialist nursing posts are being targeted.

5.2.1 Band 5 and Student Issues

Up until very recently, the key feature of the NHS nursing workforce has been growth, reflecting an increase in admissions to pre-registration nurse education supported by increased government funding.41 There has been a sustained increase in pre-registration diploma and degree students. However, in the latter part of 2005 and early 2006, the RCN began to receive reports of newly qualified nurses (NQNs) having difficulty finding jobs, mostly in England. Difficulties related to local labour market issues or financial shortfalls in the main, leading to staffing freezes or planned redundancies in the NHS. The 2005 NHS Employers survey highlighted that 39% of those surveyed reported “oversubscription” of vacant posts.42 However, redundancies are also an issue for the independent sector with the Nuffield group announcing 460 redundancies at the end of 2005.

5.2.2 Reliable data on nursing students’ job destinations is scant reflecting a wider problem with workforce planning information. However, the Council of Deans of Schools of Nursing has recently agreed to try and determine what labour market information is available in terms of graduating students and available posts and also to talk to Universities UK about statistics Higher Education Institutions hold on first destination employment.

5.2.3 Widening access to higher education opportunities has helped increase the potential for nursing to become a more diverse workforce. Reductions in employment opportunities may impede this welcome trend. The RCN has concerns about the impact of recent decisions to reduce commissioned places for nursing students at universities.43

5.2.4 Policy approaches to employing NQNs varies across the UK. In Scotland, the Health Department guarantees all NQNs a job although not necessarily where they live or trained. There is also a scheme to help those unable to find employment through their own efforts and the Scottish Executive also recently launched the Flying Start programme, a development programme for NQNs, midwives and Allied Health Professionals. The average age of a NQN is now 29 compared with 21 in the 1960s.44 This ageing phenomenon raises issues about mobility as these days more students are likely to have children or other dependants and more keen to find local employment opportunities.

5.2.5 In the 1990s, a lack of effective work-force planning across and within the four UK countries caused a major shortage in nursing staff, which the NHS has only just recovered from. There is a difference in perception between the Department of Health, which sees the current job situation for NQNs as the nursing labour market45 coming into balance and the RCN, which considers that there is still evidence of a continuing underlying shortage, for example, working beyond contracted hours has remained broadly stable in the last 10 years at around 60% of full-time nurses working approximately 44 hours per week on average, ie an additional six hours and 20% of all respondents work more than 50 hours per week.46

5.2.6 In addition to difficulties finding a job in the first place, some NQN’s are finding that their employers are paying them below the appropriate level for the job, or that their employer is not allowing them to have the accelerated progression provided for in the Agenda for Change Terms and Conditions Handbook (TCH). Paragraph 1.8 provides for NQNs to progress through the first two points of Band 5 in six monthly steps (that is they move up one pay point after six months and a further point after 12 months) providing those responsible for the relevant standards in the organisation are satisfied with their standard of practice.

45 Oral evidence to the Health Select Committee 11 May 2006.
5.2.7 In some places across the country, nurses are being placed on transitional points (TPs) below Band 5. The minimum pay point for a newly qualified nurse is the bottom point of pay band 5 (£19,166, £19,730 from 1 April 2006). Where employers have attempted to pay less (Hull, East Lancashire Hospitals NHS Trust), the RCN is challenging locally and will continue to do so.

5.2.8 In other parts of the country (Oxford) employers are resisting the accelerated progression for NQNs provided for in Agenda for Change. The RCN believes that financial difficulties currently being experienced by employers are the key motivating factor.

5.2.9 The RCN is concerned that if newly qualified nurses are facing the prospect of no employment, this will serve as a disincentive for future potential nurses entering training.

5.3.1 Specialist Nurses

Since the publication of the NHS Plan, nurses have been encouraged to take on a range of extended and advanced roles as part of a patient-centred service and modernising the NHS. The new posts which have been developed include Modern Matrons, Lecturer Practitioners and Nurse Specialists. Under Agenda for Change these posts have been valued highly with nurses being graded at bands 7 and 8 in recognition of the increasing accountability and advanced skills. However, as Trusts seek to reduce costs, financial recovery plans have resulted in a number of strategies which have had a negative impact upon nurses who practice in these advanced roles.

5.3.2 Workforce and Process Re-engineering

(i) Downgrading

The downgrading of posts is being achieved through two means:

(a) Where services have been closed or reconfigured because of a need to overcome financial deficits, jobs have been lost and posts made redundant as managers seek to reduce service costs. As a result, existing post holders have been redeployed and offered “suitable alternative employment” at lower grades as an alternative to compulsory or voluntary redundancy, effectively downskilling the workforce. Anecdotally the RCN is aware that some of these nurses are actively considering opportunities to move overseas, and particularly the USA, where specialist nursing skills are in demand.

Example

Chesterfield Royal Hospitals NHS Foundation Trust have put the post of Endoscopy Nurse “at risk” due to organisational change. The post is graded at AfC band 7 and the reorganised structure contains only one nursing post in endoscopy services at AfC band 3.

(a) Where nurse specialist posts are frozen or lost via “natural wastage” through restructuring, the elements of the job role are being broken down and passed on to existing staff at lower grades. For patients this could well impact on waiting times as throughput falls and there will be an increased reliance on medical staff.

Example

Restructuring at Kingston PCT will result in the loss of the Lead Nurse in Sexual Health post with the subsequent loss of clinical and managerial responsibilities. The managerial roles will have to be picked up by the remainder of the team and the specialist nursing practice will be lost which is concerning given that sexual health has been identified as a priority service.

(ii) Re-rolling

This feature of deficit management takes two main forms:

(a) Where Trusts have been required to reduce costs but retain services they have redrafted the content of job descriptions and/or restructured the roles of practitioners and managers or the parameters of their role.

Example

The Royal Liverpool Children’s Hospital has altered management arrangements so that Ward Managers will now cover two, rather than one ward.

(b) Where a nurse has a combination of clinical and managerial roles within their post, the clinical component is being reduced or removed so that they can focus on their managerial function. This has particularly been the case in respect of Modern Matrons. The RCN is concerned that this approach could undermine the essence of care benchmarks of best practice for healthcare practitioners promoted by the DH.

Example

At Great Ormond Street Hospital, a review of senior grade posts has led to the loss of three Modern Matron posts and two Assistant Director of Nursing posts.

5.3.3 Revised Funding Priorities

Independent Sector Partnerships

Encouraged by government health policy, partnerships have been formed between NHS organisations and voluntary not-for-profit providers as well as private healthcare companies. Some deficit recovery plans require commissioners to reconsider the funding for these partnerships with a potential reduction in the number and range of specialist nursing posts that they have created, particularly in services for people with long term conditions.

Example

Through the Leicester City West PCT, the Rainbow Foundation employs a Specialist Nurse as a Palliative Care Consultant. The post is funded for a period of three years through a donation from charities and at the time of establishing the post it was agreed that Leicester PCTs would pick up the cost of the post in December 2006 when the initial funding runs out. Although the service given by the post-holder is county-wide and one of only two such posts in the country, due to financial recovery plans, none of the PCTs have the funding to continue the employment of this individual. This has the potential to seriously frustrate the policy of extending the range of service providers.

(iii) Partnerships with Institutes of Higher Education

Practice based learning and consolidation of theory are essential features of nursing practice and is achieved by Lecturer Practitioners. The need to establish posts of this nature has led NHS Trusts to enter partnerships with Higher Education Institutes to create posts as lecturer practitioners and practice educators. These posts are now being reviewed as part of service reconfigurations arising from financial recovery plans within the NHS. Post holders are also at risk and as a result of reductions in the level of funding for organisational and personal development being invested by NHS Trusts in HEIs.

Example

Kettering General Hospital are making 2 Practice Educator posts redundant, one in acute services graded at band 8 and funded by the Trust; and one in medical services graded at band 7 and funded by the University.

(iv) Use of discretionary funding

When funding is attached to projects which have impacts upon patient healthcare and public health targets they do not always have a “ring-fenced” status. This enables commissioners to exercise discretion in the way that they are spent. One such initiative is “Choosing Health” whereby funds were established to enable commissioners to develop health promotion and public health initiatives, in support of government targets. These monies were not ring-fenced but have helped to develop posts in areas related to health needs as diverse as Chlamydia screening in Hertfordshire, to contraception services in Lincolnshire. Funding which is not ring-fenced is being used to achieve deficit recovery targets.

Example

Staffordshire Moorlands PCT has published a report “Balancing the books—Emerging Proposals for Service Changes” which seeks to inform community organisations of their plans for expenditure for 2006–07 but does not offer opportunity for consultation. Within that plan is a statement;

“Health Improvement; Suspend commitment of unallocated Choosing Health monies and therefore suspend further progress on the Choosing Health agenda. Saving £112,000.”

5.4.1 Nursing Workload

The annual employment survey of nurses is commissioned by the RCN and undertaken by Employment Research Ltd. In 2001 and 2002 the survey asked nurses working in in-patient settings to give details of the number of staff and patients. From this data patient to staff ratios were calculated and the results are contained in Table 1.
Table 1

STAFFING AND PATIENT DATA FOR NHS HOSPITAL WARDS 2001 AND 2002

<table>
<thead>
<tr>
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<th>2001</th>
<th>2002</th>
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<td></td>
<td>Day</td>
<td>Night</td>
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</tr>
<tr>
<td>Total number of patients</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Number of Registered Nurses (RNs)</td>
<td>3.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Number of HCAs/Auxiliaries</td>
<td>2.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Mix—% of nursing staff that are RNs</td>
<td>62%</td>
<td>65%</td>
</tr>
<tr>
<td>Patients cared for by respondents</td>
<td>10.6</td>
<td>14.6</td>
</tr>
<tr>
<td>Patients per RN (across ward)</td>
<td>8.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Patients per nursing staff (across ward)</td>
<td>4.4</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Source: Employment Research/RCN 2002

5.4.2 In 2002 nurses working in NHS hospital wards typically cared for 11 patients each during a day-time shift, and there was an average of 8 patients per member of staff on duty. The difference between these numbers is because one of the members of staff reported to be on duty will be in charge of the ward for the shift and therefore have fewer or no patients in their care. There was no change in staffing relative to patient numbers between the 2001 and 2002 surveys.

5.4.3 Table 2 contains the results of the staffing data for the 2005 survey which in addition includes an analysis for respondents working on Independent hospital wards and in Care homes as well as NHS wards.

Table 2

STAFFING AND PATIENT DATA 2005

<table>
<thead>
<tr>
<th></th>
<th>NHS wards</th>
<th>Independent wards</th>
<th>Care homes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day</td>
<td>Night</td>
<td>Day</td>
</tr>
<tr>
<td>Number of beds</td>
<td>23.4</td>
<td>22.7</td>
<td>26</td>
</tr>
<tr>
<td>Total number of patients</td>
<td>22</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Occupancy</td>
<td>96%</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Number of registered nurses</td>
<td>3.3</td>
<td>2.4</td>
<td>3.9</td>
</tr>
<tr>
<td>Number of HCAs/auxiliaries</td>
<td>2.1</td>
<td>1.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Total staff on duty</td>
<td>5.4</td>
<td>3.7</td>
<td>5.4</td>
</tr>
<tr>
<td>RNs as % of all nursing staff</td>
<td>62%</td>
<td>66%</td>
<td>74%</td>
</tr>
<tr>
<td>Patients cared for by individual respondent (mean)</td>
<td>10.3</td>
<td>13.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Patients per RN (mean across all RNs)</td>
<td>7.7</td>
<td>10.1</td>
<td>5.5</td>
</tr>
<tr>
<td>Patients per member of nursing staff (mean)</td>
<td>4.4</td>
<td>6.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Weighted cases</td>
<td>822</td>
<td>316</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>240</td>
</tr>
</tbody>
</table>

Source: Employment Research/RCN 2005

5.4.4 Independent hospital wards were better resourced both in terms of overall staffing levels and in terms of skill mix. Registered Nurses (RN) made up 74% of the staff on duty during a day shift compared to 62% on NHS wards. During the day, respondents working on independent hospital wards cared for an average of 7.8 patients and the NHS figure was 10.3.

5.4.5 The overall figure of the number of patients per member of nursing staff on NHS wards was unchanged in 2005 when compared to the 2001 and 2002 surveys (4.4). There was a slight reduction in the number of patients per RN from 8.0 in 2001–02, to 7.7 in 2005. Fractionally more RNs per ward (3.3 compared to 3.2 in 2002) were reported to be on duty.

5.4.6 What is clear is that despite the headline increases in the number of nurses this has not resulted in significant increases in nurse staffing levels in NHS wards. It is for this reason, coupled with increased patient dependency and workload intensity that the nursing workforce cannot afford to lose further nursing resources either through the deletion of nursing posts or nursing redundancies.

5.4.7 Finally an analysis of attitude statements for respondents working in the NHS is presented in Figure 1. The results show that in general more respondents are negative about workload issues than positive.
5.5.1 The relationship between Nursing Inputs and Patient outcomes

There is growing evidence of a relationship between registered nurse workforce numbers and patient outcomes. The RCN commissioned an independent review of this evidence of the impact of registered nurses on patient outcomes from the London School of Hygiene and Tropical Medicine, University of London. The researchers reviewed 15 high quality studies that met strict methodological criteria. They concluded that:

Higher numbers of registered nurses and a higher proportion of registered nurses in the nursing workforce are associated with reductions in:

- Patient mortality
- Incidence of respiratory, wound and urinary tract infections
- Number of patient falls
- Incidence of pressure sores
- Medication errors

And improved outcomes in:

- Patient functional independence
- Patient experience and perception of health care

5.5.2 Professor Anne Marie Rafferty at Kings College, University of London has conducted primary research in general surgical wards of 30 NHS trusts that confirm some of the above findings (to be published in the International Journal of Health Care Management, October 2006). The risk of mortality for the patients studied was increased by 12 to 49% in wards with the lowest registered nurse to patient ratios. That is patients had an increased risk of dying when there were fewer registered nurses on the ward.

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49 Birmingham and Black Country SHA (2006). Reducing Unplanned Hospital Admissions: What does the Literature tell us?
5.5.3 Birmingham and Black Country Strategic Health Authority commissioned a review of the research literature related to initiatives which may reduce unscheduled admissions to hospital. They assessed 65,812 studies of which 186 met strict methodological selection criteria—mainly structured reviews and randomised controlled trials. They conclude that the evidence from nurse-led clinics, and specialist nurse input, suggests these both contribute to a reduction in unscheduled hospital care.

5.5.4 A Cochrane review of research that evaluates substitution of doctors by nurses in primary care concludes that nurses can achieve equivalent patient outcomes and indeed score higher on patient satisfaction.50

5.6.1 Impact on Patient Services

The RCN is concerned that measures to address financial deficits are and will continue to impact on patient services in a number of ways.

5.6.2 Examples of the impact of recovery plan and restructuring initiatives on services and patients include:

- Increasing distances and travel times to services, especially in rural areas, where services and facilities have been closed, consolidated on specific sites or relocated in rural areas, further exacerbated where Ambulance Trusts are reducing non-emergency services. (United Lincolnshire Hospitals Trust/Gloucestershire Partnership Trust)
- Loss of or reduced access to specialist services when Nurse Specialist and Modern Matron posts are reorganised. (Queen Mary’s Sidcup/North Tees and Hartlepool NHST)
- Loss of access to local specialist services due to site closures and service consolidations. (North Staffs NHS Trust/ Kingston PCT)
- Failure to meet 18 week waiting list targets due to a need for all services to meet cost improvement targets. Pioneer Trusts have already identified extensive waiting times of up to 9 months for some diagnostic and specialist services and concerns are expressed that cost improvement plans will make it impossible for Trusts to meet 18 week waiting time targets until 2009/10. (HSJ 5 April 2006)
- Increased travel and reduced access where services have reduced from 7 day to 5 day services including medical and minor injury services. (East Lancashire/Royal Cornwall NHS Trust/Gloucestershire Partnership Trust)
- Loss of potential benefits of nurse led initiatives. (Cheltenham General Hospital)
- Loss of rehabilitation and healthcare services with the extension of closure programmes for Community Hospitals in rural communities. (Wiltshire/Gloucester/North Yorkshire/Yorkshire Wolds and Coast PCT)
- Loss of mental health in-patient and day care services put pressure upon carers and patients and the potential for the establishment of large institutions through the consolidation of services and rationalisation of in-patient sites. (East Lancashire/Gloucestershire SHA)

5.6.3 Rethink, the mental health service users organisation, have accused health trusts and local authorities of singling out mental health for cuts in services to meet with cost saving programmes (10 May 2006). They highlight £30 million of enforced and potential cuts to services in England. Rethink are especially concerned that this level of cuts will add to the pressure created by the chronic lack of high quality in patient mental health beds in this country.

5.6.4 Controlling the criteria for access to services

Revising the criteria for access to services, is one way of achieving increased control over demand.

5.6.5 An example of how this can be achieved is the document “Commissioning Effective, Efficient and Necessary Care Pathways” which has been produced by the North Yorkshire and York Primary Care Trusts. This document sets limits on the types and levels of conditions that can be admitted into secondary care via the Accident and Emergency Departments of acute hospitals. It also sets criteria for access to services on the basis of clinical need without consultation with relevant practitioners.

5.6.6 Whereas existing criteria for admission to acute care is based upon the clinical evidence presented by the patient and their evident ability to cope with their condition, the criteria being introduced prescribe that:

“Patients should not be admitted solely to avoid a breach of the four hour target. Patients who do not need admission include:

- Minor strains/wounds
- Upper limb fracture
- Minor fractures
- Musculoskeletal injury
- Soft tissue injury

5.6.7 The report goes on to identify a further group of patients:
“...who may need more in-depth assessment than A&E can provide within the four hour target but do not necessarily need hospital admission;

- Minor head injury
- Headache
- Abdominal pain
- Collapse
- Ingestion/poisoning
- Angina
- Arrhythmia
- Other chest pain/Asthma
- Other respiratory
- Urinary Tract infection
- Epilepsy

5.6.8 Although the report recognises that final judgement on which patients should be admitted should be made by the senior clinical decision maker in the emergency department;

“Where a special need has been identified, which falls outside these commissioning guidelines, the PCTs will consider each request on a case by case basis.”

A process which hardly befits the nature of clinical decision making in an emergency service.

5.6.9 The RCN is concerned that the application of these forms of criteria could exacerbate health inequalities as commissioners develop varying standards of entitlement to services, as well as generally reducing access to services.

5.7.1 Staffing and Patients Perception

The Healthcare Commission has provided evidence of a relationship between improved patient satisfaction and higher numbers of registered nurses, and a correlation between lower patient satisfaction and the amount spent on temporary nursing staff—bank and agency nursing staff.\textsuperscript{51}

5.7.2 In addition the recent Healthcare Commission survey of patients who stay overnight in hospital found that 58% said there were “always”, or “nearly always” enough nurses on duty to care for them in hospital. Therefore over 40% did not believe there were enough nurses on duty.

5.7.3 The UK NHS Centre for Reviews and Dissemination also found that the number of registered nurse hours correlated to patient complaints.\textsuperscript{52}

5.7.4 A report by the National Consumers League which represents consumer interests in the US commissioned Opinion Research Corporation to conduct a randomised telephone survey of health care consumers in March 2004.\textsuperscript{53} They conclude that consumers who had been hospitalised or had a family member who had been hospitalised believed that there were too few nurses caring for too many patients.

5.7.5 In the public consultation phase of the Our Health, Our Care, Our Say White Paper the general public were clear about the benefits of nurses and the value of the nurses first contact skills.

5.8.1 Consultation

The principle of consultation over changes to health services is important to the RCN. Any national proposals for changes to the NHS require consultation with professional and patient interest organisations. This principle of consultation enables these organisations to provide expert consideration to the Department of Health in a joint approach to ensure that health services are maintained or improved. This principle is so strong for the RCN that it issued an application for judicial review in 2005 over the failure of the Department of Health to consult on a national basis on a decision that Primary Care Trusts were to end the provision of NHS services.

5.8.2 Any local proposals for changes to the NHS require consultation with staff and the public, so that the impact of potential changes can be assessed in an objective manner by the local NHS. The Government has recognised the importance of local consultation in the health democracy with s.11 Health and Social Care Act 2001 which places a statutory duty on all NHS health providers to consult over proposed changes to services.

\textsuperscript{51} Healthcare Commission (2005). \textit{Ward Staffing.}


5.8.3 The impact of deficits can provide a dilemma for local NHS bodies which also have a duty to protect and promote the principle of consultation. The RCN is concerned that these two duties may be incompatible. For example Trusts may decide that that financial stability is a greater priority than a risk assessment carried out by local public consultation of the impact of cuts on patient service.

5.8.4 The RCN is concerned that some Trusts are taking a tactical approach and looking to cut services that are small enough to appear to avoid the need for s11 consultation. Where this is happening specialist nursing posts are being targeted. In an acute Trust there may be only between 1–3 specialist nursing posts for different long term conditions, such as MS or rheumatology. Trusts have told local RCN offices that local consultation under s11 is not required because the cuts do not amount to a substantial variation in the service. Again, this is a distorted logic; for the Trust looking at the service overall, it may be insignificant. For the patients with long term conditions, cuts to specialist nursing posts and preventative community services mean their whole world is turned upside down.

5.8.5 One unintended consequence of the need to achieve financial stability is that there is now a distortion of the health services priorities of PCTs. In practical terms, patient services are being cut without a full assessment of the medium to long term health impact of those cuts. This is a distorted risk assessment for any local health economy. The RCN warns that short term cuts may mean long term health problems are being shored up for many local health economies.

5.8.6 A further concern is that many cuts are taking place in preventative services, particularly those provided by specialist nurses. This is the policy aim of the Government to reduce the focus (and cost) of unplanned acute admissions. These policy aims are endorsed by the RCN and provided by specialist nurses.

5.8.7 This lack of consideration of the need for consultation about the impact of cuts on patient services is of course, not taking place where redundancy is an issue. The evidence being provided to the RCN is that redundancy consultation is taking place and that many nurses are being told this is the same as the consultation needed under s 11. This is a further distortion of the principle of consultation. Redundancy consultation focuses on the post and does not consider the impact on patient care across a Trust.

5.8.8 One reason that redundancy consultation is taking place in a scrupulous manner by Trusts is because there are significant financial penalties which can be imposed if the Trust fails to carry out redundancy consultation appropriately. There is no such penalty on any Trust if it fails to carry out a s 11 consultation. The only remedy open to a patient who feels that his or her service reduction or cut is under threat, and has not had a consultation, is by way of judicial review. Further, if the service has been cut or reduced by the time of the hearing, there is no remedy open to the court to require that the Trust reopens the service.

Royal College of Nursing
6 June 2006

APPENDIX 1

SUMMARY TABLE OF NHS POSTS TO BE LOST AS REPORTED TO THE RCN

NOTES

— All announcements are subject to consultation with staff and their representatives although there is little doubt that cuts will be made to the total number of posts.

— The ‘total posts lost’ figure refers to the predicted number of posts deleted from the existing compliment. This figure includes voluntary redundancy, compulsory redundancy and the deletion of vacant posts.

— In some cases, Trusts have reported that the total number of posts lost will be within an estimated range. In this case, the lower estimate has been used.

— A number of NHS Trusts have announced that there will be posts cuts but have not released how many.

— The funding uplift for the coming year after efficiency returns and adjustments to the NHS Tariff is only 1.5%. This has prompted some Trusts to already declare a deficit for the year 2006–07 unless substantial cuts to services and staff are made.
All figures have been sourced from local activists, RCN regional staff, and confirmed through Trust board reports or press releases by Trusts.

**NHS Trust (inc PCT & FT)—italics denote recent changes**

<table>
<thead>
<tr>
<th>NHS Trust (inc PCT &amp; FT)</th>
<th>Total posts lost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. AIREDALE NHS TRUST</strong></td>
<td>0</td>
</tr>
<tr>
<td>2. BARKING, HAVERING AND REDBRIDGE HOSPITAL NHS TRUST</td>
<td>0</td>
</tr>
<tr>
<td>3. BARTS AND THE LONDON NHS TRUST</td>
<td>330</td>
</tr>
<tr>
<td>4. BIRMINGHAM WOMENS NHS TRUST</td>
<td>90</td>
</tr>
<tr>
<td>5. BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST</td>
<td>350</td>
</tr>
<tr>
<td>6. BUCKINGHAMSHIRE HOSPITALS NHS TRUST</td>
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</tr>
<tr>
<td>7. CAMBS &amp; PETERBOROUGH MH PARTNERSHIP NHS TRUST</td>
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</tr>
<tr>
<td>8. CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST</td>
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<tr>
<td>9. CITY AND HACKNEY TEACHING PCT</td>
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<td>10. COUNTY DURHAM AND DARLINGTON PRIOR SRV NHS TRUST</td>
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<tr>
<td>11. EAST AND NORTH HERTFORDSHIRE NHS TRUST</td>
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</tr>
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<td>14. HAMMERSMITH HOSPITALS NHS TRUST</td>
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<td>15. HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST</td>
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<td>24. NHS DIRECT</td>
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<td>25. NORFOLK AND NORWICH UNI HOSPITAL NHS TRUST</td>
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</tr>
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<td>37. QUEEN MARY’S SIDCUP NHS TRUST</td>
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<td>40. ROYAL FREE HAMPSTEAD NHS TRUST</td>
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</tr>
<tr>
<td>41. ROYAL UNITED HOSPITAL BATH NHS TRUST</td>
<td>300</td>
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<tr>
<td>42. ROYAL WOLVERHAMPTON HOSPITAL NHS TRUST</td>
<td>300</td>
</tr>
<tr>
<td>43. SANDWELL &amp; WEST BIRMINGHAM HOSPITALS NHS TRUST</td>
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</tr>
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<td>44. SHREWSBURY AND TELFORD HOSPITALS NHS TRUST</td>
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<td>48. ST GEORGE’S HEALTHCARE NHS TRUST</td>
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<td>52. THE MID CHESHIRE HOSPITALS NHS TRUST</td>
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<td>53. THE ROYAL WEST SUSSEX NHS TRUST</td>
<td>200</td>
</tr>
<tr>
<td>54. UNITED LINCOLNSHIRE HOSPITALS NHS TRUST</td>
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</tbody>
</table>
Evidence submitted by the Royal College of Psychiatrists (Def 08)

1. The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry.

Background

2. In submitting a short memorandum as requested by the Health Committee we have concentrated on the effects on care that we are sure will result from the levels of disinvestment that are being levied. Our access to accurate financial information on a national basis is limited but we have reason to believe that disinvestment of the magnitude we do know about is likely to be widespread. We understand that the deficits in health spending have been generated almost entirely within the acute and primary care sectors.

3. In March this year Professor Louis Appleby, the National Director for Mental Health, drew our attention to a rising total of £16.5 million cuts in planned funding to 11 mental health trusts. According to the mental health charity Rethink cuts have actually occurred in over 30 areas of the country (A cut too far, Rethink, May 2006). These cuts are not to do with the ineffectiveness of the mental health services but are being used to subsidise other parts of the health service going into overspend.

Examples of Cuts

4. London is facing very substantial disinvestment in mental health services. Lambeth and Southwark Primary Care Trusts (PCTs) have recently asked for a reduction in mental health services of 5% and 7.2% respectively (in addition to the London 1% surplus requirement and the 2.5% Cash Releasing Efficiency Saving (CRES)), which is to say a reduction of £4 million each from mental health services and this with only 6 weeks’ notice. This has resulted in damaging cuts to Adult Mental Health, Older Adult services and Child and Adolescent Mental Health Services across the board.

5. The Cheshire and Wirral Partnership Trust is one of the 11 noted by Rethink and acknowledged by the Department of Health to have had money withheld in 2005–06 because of serious financial problems in other parts of the local health economy. This is despite the Trust breaking even every year since its formation in April 2002. Colleagues in the area estimate that they are facing roughly £5 million of pressures of which just over £2 million is the national 2.5% CRES and the rest is cuts due to financial problems between primary care and the acute sector. At these levels they will be closing mental health services and reducing access as well as having significant job reductions including medical posts.

A Period of Recovery

6. Mental health services are in the middle of a critical period of recovery. The mental hospital closure programmes completed in the 1980s and 1990s were not balanced by the development of effective alternative community services. This was partly because there was no agreed and tested blueprint for community services, and partly because sufficient resources were not available. It was not uncommon for capital and revenue released from mental health facilities to be used to bail out overspending acute hospitals. Hence, by the end of the century mental health services were ineffective, inefficient and in crisis with dangerously overcrowded wards and increasing failures in care. Staff vacancy rates were rising to threaten the viability of services in many parts of the country.
7. The National Service Framework (1999) and NHS Plan (2000) produced a blueprint for community care that has won general approval from patients, carers, and professionals. Implementation is producing real gains in effectiveness and efficiency of mental health services. For example, “crisis resolution and home treatment teams” are reducing hospital admissions by 15 to 50%, and avoiding 10 to 25% of compulsory admissions. “Assertive outreach teams” are closely monitoring and meeting the needs of high risk patients. Many other specifically funded innovations are gradually building confidence and improving recruitment.

The Effects on Care

8. Mental health funding started from a very low base in 1999–2000. The new services that patients prefer are not yet fully functional in many areas. The star system required for foundation status shows that mental health trusts are well behind acute trusts and PCTs. The mental health service was promised a ring fencing of resources with segregation from acute trusts, which instead has lead to reduced investment relative to that provided for physical health care.

9. It is of the very greatest concern that even small cuts in planned funding will disable local programmes of service development that are still bedding in. Large cuts of 5% or more could destroy all progress made in the last five years and return us to the massive inefficiencies and risks of depending too much on hospital beds. Within the very large national budget for health, mental health is only 14% (Glover, 2005). Taking away a 5% margin of that 14% can have little value and effect on other sectors of the NHS, but will be catastrophic for mental health.

Conclusion

10. The Royal College recommends to the Health Committee that a system of much greater transparency and immediacy is established requiring Commissioners to declare/publish any intentions to transfer out or reduce planned moneys for mental health with their justifications for doing so and explanation of the consequences for patients of mental health services. Currently it is not possible to identify or challenge changes in mental health funding until well after the fact, indeed not until PCT end of year accounts are available nine months after the year in question and not until one year and nine months later to assess full year effects.

11. The Royal College supports the World Health Organisation’s statement that there is “no health without mental health” (Helsinki Declaration, Jan 2005). We are concerned that mental health services, many of which are well run, are being forced yet again to make cuts to subsidise other parts of the NHS. We feel that the Government’s commitment to mental health is being compromised by the fact that these services are the first to be cut when PCTs face financial difficulties. It is important that mental health services are valued as a core part of the NHS and that patients and their carers and families can rely on receiving the care that they need.

May 2006

Evidence submitted by the Socialist Health Association (Def 21)

1. Introduction

The Socialist Health Association was founded in 1930 to campaign for a National Health Service and is affiliated to the Labour Party. We are a membership organisation with members who work in and use the NHS. This submission is made on behalf of the Association.

2. Size of Deficits

The level of deficits across NHS Trusts does vary significantly and in many cases the Trusts with larger deficits have historic debt going back many years. The accounting regime for the NHS does disadvantage Trusts who are in deficit, in that they are doubly penalised with the result that they fall even deeper into debt in some cases. The level of deficit is not large as a proportion of the total NHS budget, nor is it new, and it has been given more publicity than it warrants, with some undesirable effects on staff morale. However it seems likely that the new financial regime is an underlying cause of the deficits (or at least is responsible for making the existence more obvious) and that there will similar and possibly bigger problems in future years. It seems likely that new skills will be required of managers who have little experience of the turbulence which can be expected in a more market oriented economy.
3. **Reason for the Deficits**

3.1 The causes of the deficits are primarily systemic in that they have arisen due to:

(a) Under-funded and inaccurately costed pay awards (eg Consultants and GP contracts/Agenda for Change).

(b) The pursuit of targets and a star ratings system which required significant financial and human resources to be deployed to meet those targets.

(c) The extra capacity required to meet the targets has resulted in over capacity in some local health systems which the NHS has had to fund.

3.2 It has to be acknowledged that under Labour governments, since 1997, waiting times have reduced significantly and access to treatment has considerably improved, but the focus on shorter term secondary care targets has required significant investment at the expense of investment in the community-based services.

3.3 Expenditure in the NHS was effectively capped by having waiting lists for treatment and access to treatment—a provider-led form of rationing. The shift to a demand led system with underdeveloped demand management mechanisms has been a major factor contributing to overspends.

4. **Turn-around Teams**

The imposition of Turnaround Teams by the Dept. of Health on specific Trusts has to some extent provided external challenge but there is little evidence to-date they have proposed measures or initiatives that NHS Trusts had not already identified. They have added a significant layer of bureaucracy and additional demands on already stretched organisations and contributed to the damaging of morale in parts of the service already under pressure. Given the significant cost of securing the services of external consultants, we believe they do not represent value for money. We believe the Dept. of Health should establish a robust peer review process to appraise local health economy recovery plans as an alternative approach.

5. **PCTs’ Funding Formula**

5.1 There is no clear correlation between PCTs’ funding formula, the tariff and the impact of Payment by Results on Trusts income and historic debt. The current PCT weighted capitation funding formula has rightly led to increased funding for PCTs serving more deprived populations and given the current level of health inequalities this should continue. This will inevitably lead to financial pressures for PCTs and their provider Trusts in some of the more affluent areas, but the movement to target has been a staged process, leaving the most deprived areas still below target 30 years after the process began. The intention was clearly to allow local health economies in less deprived areas to plan accordingly.

5.2 The implementation of Payment by Results and the development of the tariff have however led to significant financial instability and volatility across the NHS and such a major policy and system change should have been piloted/simulated for 2/3 years before its implementation. Adjustments and changes made to the tariff have had a differential impact on individual organisations and increased financial instability. The recent examples of the tariff for 2006–07 having to be withdrawn and re-issued and the phasing out of the Purchaser Parity Adjustment for PCTs with no prior notice, are further evidence of an underdeveloped and poorly implemented policy.

6. **Consequence of Deficits**

6.1 The consequence of deficits have clearly led to recruitment freezes, reduction in agency and bank staff and in some cases redundancies, mainly in Acute Trusts, although some PCTs have implemented recruitment freezes for community, administrative and managerial staff. This may lead to reductions in the volume of service provision in hospital-based services and some community services, but this could be balanced by more services being delivery in community settings in the future if this is planned effectively.

6.2 However, the effects of top-slicing PCT budgets will clearly have an impact on levels of services commissioned as well as a potentially detrimental impact on some community services and PCTs’ health promotion and public health services. This will result in the current financial year 2006–07 being very difficult for many PCTs, NHS Trusts and other organisations they commission from. This is also likely to impact in some areas on joint provision with social services and evidence is emerging of existing pooled budget and joint commissioning arrangements coming under strain, which will undermine the objectives of the *Our Health, our care, our say* White Paper.

6.3 Prospects for 2007–08 are unclear and depend on the setting of the tariff and any continued top-slicing arrangements but it is likely that many PCTs will only be able to fund the top key targets and other priority areas will not be funded as a result.
6.4 Because the level of top slicing varies in different parts of the country, the impact will be variable and as a device does not address fundamental service configuration issues that need to be resolved in some health and social care economies.

7. Achieving Financial Balance

7.1 Fundamentally, the requirement from Ministers and the Dept of Health for all NHS Trusts to achieve financial balance by the end of 2006–07, as outlined in the NHS Operating Framework for 2006–07 was an error. For many NHS Trusts with significant and historic debts this will simply not be achievable and for many others, the recent wave of reductions in staff numbers are a manifestation of a reactive and short-term response to this directive.

7.2 If changes to the current configuration of services in some localities are the long-term solution to deficits, this should be implemented in a planned and managed way. Short-term responses forced on individual Trusts without any opportunity for proper consultation will be potentially damaging to services and the NHS and social care infrastructure in the longer term and public confidence in the NHS in the short term.

7.3 Sustainable solutions require joint plans to be developed by PCTs, NHS Trusts, local authority partners and other providers and the Dept. of Health and Ministers should establish a 3-year framework within which plans can be developed and implemented. The current reactive and short-term approach which is being reinforced by the intervention of Turnaround Teams, will lead to poorly planned and implemented measures that could undermine the Government's stated intention of transferring more care from hospitals into community settings.

7.4 We have a level of acute provision in the UK, in particular in relation to hospital beds, that is financially unsustainable and has sucked in resources at the expense of primary and community services and health improvement/public health services. Therefore, some reduction in provision of hospital based services is necessary and desirable, providing it is part of a planned process that has the involvement of patients, public and local politicians. The inadequate mechanisms for involving patients and the public in decision making of this kind has left local management vulnerable to political and legal challenge.

7.5 It is difficult to quantify but there is plenty of anecdotal evidence to suggest that organisational instability is unhelpful in creating the sort of partnerships which are necessary to achieve the demanding targets without overspending. We hope that the present round of reconfiguration will be the last for some considerable time.

7.6 As has been remarked widely the achievement of financial balance in some parts of the NHS will require difficult decisions. NHS managers find it difficult to believe that local politicians will support the closure of hospital facilities given the well publicised political consequences of previous closures. In our view the lack of any legitimate local political accountability mechanisms in the NHS is the root cause of this difficulty. The work of local scrutiny committees is in some places helpful but is often inadequate and in every case is insufficient. The decisions about commissioning services should be made on the basis of a democratic mandate, and these decisions should be transferred from PCTs to elected local authorities.

Martin Rathfelder
Director, Socialist Health Association

June 2006

Evidence submitted by South East Hertfordshire PCT and Royston, Buntingford and Bishop’s Stortford PCT (Def 35)

Summary

1. The governance agenda, the Department’s performance management style, the internal market reforms and the demand management agenda are inextricably linked but the problem of how to make them all fit together towards a common goal of sound financial management in the NHS has not been solved. At present they interact to exacerbate the financial problem.

2. We think the theory behind the market reforms is that the inherent instability of the NHS (free demand, limited funding) was meant to be alleviated by the healthy tension inherent in the internal market, but the reality is that the performance management and market management have to mature to the point where they discourage rather than encourage sub-optimal behaviour. We all know what the PBR code of conduct wants us to do, but we also know that if we are the only ones "playing fair" it will disadvantage our organisations.

3. It may be that the market will only mature if it takes on some of the other characteristics of markets (eg spare capacity, and real cost to the consumer so that the consumer must make a choice as to affordability).
4. A more open financial management and reporting culture urgently needs to be developed within the NHS in order to make the most of the undoubted talent and commitment that exists within the finance function throughout the NHS. This will only happen if the current climate of strict accountability for the bottom line is replaced by one of support for self-criticism, honesty and improvement.

5. Although PCTs are in theory responsible for demand management, any demand management initiatives that PCTs might develop have little chance against some much more powerful influences that work to make hospital admissions more likely, including the powerful financial incentives for the Trusts to admit patients.

6. A significant proportion of costs for PCTs are effectively largely outside their direct control. Even if PCTs do manage demand successfully, the repayment of health economy deficits may require PCTs to make further savings, to find the money to “lend” to the local health system. Those costs within their direct control (management, administration and provider function costs) are unlikely to make much difference to their overall financial position.

7. The funding formula must be reviewed as a matter of urgency. Many health economies in the South are planning major service cuts because of structural deficits which may be the result of flaws in the funding rather than of poor financial management.

THE SIZE OF THE DEFICITS AND THE SAVINGS WHICH EACH TRUST HAS TO MAKE IN 2006–07

8. Under Resource Accounting and Budgeting (RAB), the annual deficits of individual organisations such as PCTs include accumulated deficits brought forward. An organisation can be in recurrent balance but still show a deficit in its accounts because its allocation is top-sliced for any brought forward deficit, until it finds enough savings to pay off its historic debt.

9. In addition organisations within SHAs under special measures are being asked to make savings to help pay off the local debt (whether their own or not); this is done by means of the topslice of allocation (6.5% in our case) and the setting of a control total (a financial target surplus or deficit for the year depending on the needs of the whole health economy). In our health economy all organisations are required to reduce costs by 5% in real terms.

WHETHER THE CAUSES ARE SYSTEMIC OR LOCAL (EG THE ROLE OF POOR LOCAL MANAGEMENT AND POOR CENTRAL MANAGEMENT, THE EFFECT OF PAY AWARDS AND GOVERNMENT POLICY DECISIONS)

Systemic causes at national level

10. In theory, the governance, performance management, internal market reform and demand management agendas all fit together towards a common goal—a more efficient, higher quality patient-led service. In practice, the the pressures and incentives from different parts of the system (including the Department of Health) lead to all sorts of incompatible behaviour from the population, NHS managers and clinicians. Calling it a “healthy tension” is unhelpful. At present they interact to exacerbate the problem.

11. In hindsight, the implementation of the NHS plan by the Dept of Health could have been more sensitive to local conditions. Broad NHS plan targets have been applied indiscriminately across the NHS—even in areas where access and outcomes were already generally good and where there were also deficits, organisations were encouraged to increase investment in services; for example, local delivery plans could until recently have been rejected by the Dept of Health if, say, they had not shown an increase in the numbers of medical and nursing staff to be employed.

12. The internal market provides the opportunity, and the performance management threat by the DH provides the incentive, for organisations to try to offload cost (or deficits) onto each other rather than the incentive to work together to reduce costs. There is a lack of common objectives between the various performance management regimes or regulators and the organisations who will be asked to “foot the bill” for another organisation’s recovery. For example:

— In some areas (eg North London) acute Trusts have until recently been encouraged to develop Financial Recovery Plans based partly on increasing their income from local PCTs, ignoring the fact that those PCTs are already in deficit.

— Foundation Trusts have been placed outside the normal NHS performance management regime, with the result that there appears to be little to stop them increasing their income from PCTs even where those PCTs are in serious financial difficulty (eg Cambridgeshire). Monitor has appeared unwilling to recognise the financial failure of whole systems as a failure of the Foundation Trust regime (although more recently the introduction of the FT diagnostic tool has begun to expose those strategies that depend on money that isn’t there)

— Performance management boundaries coupled with the strict accountability culture emanating from the Department encourages the export of financial problems across SHA or regional borders where possible, rather than cooperation to find mutually sustainable solutions.
Trusts are in some cases encouraged to increase their efficiency (sometimes by turnaround teams) by increasing throughput, generating more activity which local PCTs do not have the funds to buy. They are also encouraged (by their turnaround teams) to send invoices for all sorts of services previously agreed by both parties to be in the SLA contract sum.

13. In consequence organisations often spend more time in financial dispute with each other (particularly primary care versus acute sector) than working together to solve problems. The number and scale of disputes between organisations are partly the practical manifestation of the accountability culture that has grown over the last two to three years in the NHS.

14. The deficits at the end of 2005–06 were predictable. They were forecast at the start of 2005–06 by the NHS organisations, who were then informed that their initial budgets were unacceptable to the Department. As a result many organisations resubmitted their budgets which although unrealistic were now deemed to be acceptable. It is a fundamental management accounting principle that budgets need to be realistic in order to engage budget holders. We believe the NHS organisations continued subtly to try to inform the Department of the true financial position throughout the year but it seems that the Department did not want to accept that any of the deficit was due to anything other than poor local management. It appears to have been further believed that by threatening local leadership with dismissal or sanctions, the financial situation would be improved. We suspect that when the deficit budgets were replaced by balanced unachievable ones, the Department took this as evidence that their hard-line approach had worked.

Cost pressures induced by central decisions/national government

15. We would like to bring to the Committee’s attention some of the cost pressures on PCTs arising from decisions of central government.

16. Government announcements of allocation uplifts “well above inflation” have stimulated unrealistic expectations among the public and among clinicians (eg Herceptin); taken together these can be enough to wipe out the “spare growth” element of the allocation.

17. There have been numerous examples of unfunded cost pressures imposed on the NHS by policies or contracts introduced by the Department of Health. Examples follow from the new GMS contract, Payment by Results, and non-elective acute admissions.

18. The new GMS contract was inflationary.

19. The next example relates to the acute commissioning budget. With the introduction of the tariff for Payment by Results, and the simultaneous removal of the purchaser parity adjustment (PPA), SE Herts PCT (even though funded below its capitation target) will have to find an additional £9.2 million per annum from its own resources to buy the same level of activity as in previous years. The decision by the Department on PPA was a simple (and we believe, misguided) answer to a complex issue. Presenting PCTs with such a cost pressure two months before the start of the 2006–07 financial year was unhelpful. Achieving recurrent balance by the end of the following year will mean (even for PCTs such as South East Hertfordshire at or below their capitation target) that they would somehow have to find £5 million of savings within 12 months and £9 million over two years. The latter sum represents circa 10% of the acute commissioning budget. This will not be matched by above average allocation growth.
The relationship between the funding formula, the allocation of funds to trusts and the size of their deficits or surpluses

20. The funding position of the PCTs at 31 March 2006 is governed by the funding formula and pace of change policies in place at the time of setting the allocations for 2003–04 to 2005–06 (January 2003). The allocations for 2006–07 and 2007–08 are governed by the policy in place now (released January 2006).

21. Components of the funding formula: The target funding allocation for each PCT is based on its normalised unified weighted population. The calculation of the weighted populations of all the PCTs determines their share of the total available funding. (For example, the main variable affecting the weighted population for Royston, Buntingford and Bishop’s Stortford PCT is the needs index).

22. The HCHS (hospital and community health services) weighted population accounts for 77% of the unified weighted population (82% in 2003–04).

23. Key components of the HCHS index include: the age index, the needs index, Market forces factor, and ambulance cost adjustments.

24. Age index methodology is standard across the country so as long as the census is correct then PCTs should not be disadvantaged, unless the actual costs of providing care for the elderly are under-represented in the model.

25. The main variable affecting the weighted population for our PCTs is the needs index which in 2003–04 was 76.25% of the national average (South East Hertfordshire PCT 83%). By 2006–07 this index had risen to 76.33% despite a number of refinements to the formula (South East Hertfordshire unchanged at 83%). If we think of this as a financial loss of 24% of population, then a quick sensitivity analysis shows that every one percent lost from the HCHS needs index results in a capitation target funding loss of £600k (if other PCTs’ indices remain fixed).

26. There is obviously a strong link between the needs index in use up to 31 March 2006 and the distribution of severe financial problems across the country (see Allocation Exposition Book Table 4a.9 below which has been reordered to show the PCTs with the lowest needs index). The needs index is based on a number of factors. Within these, an even smaller number of factors are given a lot of weight (circulatory morbidity being the most significant). A much more detailed paper could (and, time permitting, should) be prepared on the methodological issues arising from the current needs index, including the reliability of the data sources, mainly individual level data from the Health Survey for England.

27. The methodology is explicit about certain supply side variables that are not funded in the needs index even though they are known from the modelling to have an effect on the utilisation of services. The most statistically significant of these is the proportion of outpatients seen in less than 13 weeks. This suggests that reducing outpatient waiting times will increase costs. We do not have information on the relative position of our PCTs to others on these supply-side variables.

Table 4a.9

<table>
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<tr>
<th>Code</th>
<th>PCT</th>
<th>A Crude Population</th>
<th>B Age Index</th>
<th>C Need Index</th>
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<tr>
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<td>Blackwater Valley and Hart</td>
<td>183,219</td>
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54 Source: 2006 allocations Exposition Book Table 4a.9.
<table>
<thead>
<tr>
<th>Code</th>
<th>PCT</th>
<th>A Crude Population</th>
<th>B Age index</th>
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<td>Table 4a.4 Col J</td>
<td>Table 4a.5 Col X</td>
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<td>0.9651</td>
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</table>

28. We would therefore recommend that the Committee demands an urgent review of the needs elements of the formula, since the needs index element has a major effect on PCT allocations.

29. Although the formula has recently been revised, the revision does not appear to have made much difference to the relative ranking of PCT need. The geographical concentration of structural deficits suggests that the validity of the link between the variables in the needs element of the formula and the main cost drivers in the NHS, in particular the size and location of hospitals and the number of hospital staff, is questionable.\(^{55}\) Alternatively, the theoretical link between the needs of the population, and what the money is currently expected to be spent on, needs to be better explained.

30. It also calls into question the reliability of the data sources, eg the Health Survey for England, for the purpose of allocating funds (and ultimately closing hospitals), and the validity of the unmet need component.

31. We would recommend that this review is conducted urgently and openly and is not delegated to one academic institution. The consequences of persisting with a conceptually-flawed formula could be that the requirement for hospital closures on the basis of current financial deficits is misconceived.

32. We would further recommend a close look at the adequacy of the Market Forces Factors indices for areas around the outskirts of London.

The consequences of the deficits

33. In PCTs, we are having to contribute towards the necessary staff cuts in our local health economy, even though the “direction of travel” is increased care in the community as opposed to in hospital. Our target this year is 5% reduction on 2005–06 levels, which for us equates to about 15 whole time equivalents. This will be a mix of management, administration and community nursing staff. This will have little impact on the financial position of the PCT or the whole health economy, since most of our costs are GMS, prescribing and acute hospital care.

The effect on care

34. Our community nursing teams will be providing fewer “optional extras” to their clients than in the past. Their work will be focussed on prevention of admission.

35. More generally, unless the funding formula changes, the only way to recurrent financial balance for our health economy is by a radical examination of the services (or hospitals) on offer to our patients. Common sense tells you that it is unlikely that the scope and quantity of services can be maintained at the same quality with hundreds or thousands fewer staff.

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\(^{55}\) Since the needs index purports to be based on factors which predict utilisation rates, the needs index implies that hospitals in the South are less well utilised. In other words, if the needs index is correct, then the productivity of hospitals and staff (measured in area and whole time equivalents to negate market forces factors) must be higher in the north than in the south. PCT admission rates per 1,000 crude population should also be lower in the South than in the North. Both of these propositions should be tested.
The effects of “top-slicing”, in the current and future years

36. There is a real and important conceptual discrepancy between the status of PCTs as separate statutory organisations with responsibility for commissioning and with their own financial duties, and their status as the sole receivers of allocations into the local health economy (and hence having to underwrite the health economy). The introduction of patient choice makes this discrepancy untenable in the longer term.

37. This can lead to the situation that even if a PCT sets and achieves a balanced budget, the only potential source of funding to pay off any historic or accumulated deficit elsewhere in the local health economy is the same PCT. This is taken to its extreme in “special measures” where PCTs previously in balance have to make exceptionally difficult savings decisions in order to find the money to fund Trusts’ deficits. There is no easy way to make savings of this magnitude non-recurrently, so a PCT may find itself having to make clinical staff redundant in order to underwrite the financial position of the local health economy. There is no obvious mechanism whereby the costs can be forced to come out of the local acute Trust (see above).

The period over which balance should be achieved

38. Ironically, our local health economy has a well-developed strategic plan to reconfigure onto a smaller number of sites that following a detailed consultation has been accepted and welcomed by the public. This will not deliver financial benefits until 2012. Our economy’s financial target set by the Dept of Health is recurrent breakeven by the end of 2006–07. Since it is difficult to see fixed costs reducing significantly before 2012, the significant cost reductions required to be found by the end of 2006–07 inevitably means that cost savings will have to come from the main variable and semi-fixed cost drivers, ie the number of staff, have to be reduced drastically.

39. This equates to hundreds if not thousands of whole time equivalent staff (assuming that the political will and the political mechanism to close hospitals quickly, and thereby reduce fixed costs drastically, does not exist).

40. As a PCT we have no direct control over the acute Trusts’ workforce decisions. If the savings do not materialise in 2006–07, we fear that in 2007–08 we will again have to commit to make extraordinarily high levels of non-recurrent savings in order to fund the health economy’s repayment. However a more likely scenario is that as long as the acute Trust capacity remains, the supply side of our economy will continue to draw in work which will undermine our commissioning savings plan (circa £5 million saving required in 2006–07). The consequence is that under current performance management arrangements we will have to continue funding acute capacity at the expense of our own community provision. For the internal market to work, the problem of supply-induced demand needs to be corrected.

South East Herts and Royton, Buntingford and Bishop’s Stortford PCT
6 June 2006

Evidence submitted by the Chairmen of local-authority NHS Overview and Scrutiny Committees in the South East (Def 31)

INTRODUCTION

1. We are a cross-party group of Chairmen of NHS Overview and Scrutiny Committees, drawn from the following Shire Counties and Unitary Authorities in the South East of England:
   — Brighton and Hove City Council
   — East Sussex County Council
   — Hampshire County Council
   — Isle of Wight Council
   — Kent County Council
   — Medway Council
   — Portsmouth City Council
   — Surrey County Council
   — West Sussex County Council
2. While the deficits currently being experienced in the NHS are arising in NHS bodies across the country, it seems that a significant proportion of deficits are occurring in the South of England.56

3. We acknowledge both the very significant additional funding that the NHS has received in recent years and the government’s laudable attempts to address health inequalities through the allocation of NHS funding. We are aware that the current deficits are being attributed to a range of factors—and that this issue is politically highly contested.

4. We are, though, agreed that there is strong prima facie evidence that the financial problems currently being experienced by some NHS bodies in the South East can, in some measure, be attributed to shortcomings in the NHS funding formula. These shortcomings can be summarised as the failure of the formula to take adequate account of the following factors, all of which are of importance in the South East:

- Additional costs associated with rurality
- Pockets of deprivation
- Ageing population
- Regional cost variations
- Rapid population growth

5. We hope that our argument will not be regarded as resting on “special pleading” for our region; in what follows, we will attempt to set out how we have arrived at our conclusions and indicate the supporting evidence.57

The NHS Funding Formula

6. The NHS resource allocation formula is essentially an instrument for allocating funds to meet the healthcare needs of a given population, within a given (pre-set) budget, over a given time period. The formula has been progressively refined and developed since the 1970s (when significant geographical inequities in the distribution of NHS funding were acknowledged), with the core aim of securing equal opportunity of access to healthcare for people at equal risk.58 Following the Acheson Report (1998),59 an additional fundamental objective in allocating NHS resources in recent years has been to “contribute to the reduction in avoidable health inequalities”. The formula is thus now intended to help bring about: more equal health outcomes (“vertical equity”), rather than simply equity in access to healthcare services (“horizontal equity”); and social, rather than simply geographical, equity in health.60

7. Resource allocation takes place through the medium of a “Weighted Capitation” formula, which was most recently revised in May 2005.61 This formula is used to determine Primary Care Trusts’ target shares of available resources (on which actual allocations of funds are based). Recurrent revenue allocations to PCTs cover:

- Hospital and Community Health Services
- Prescribing
- Primary Medical Services
- HIV/AIDS

8. For each PCT, crude population data is weighted under each of the above headings, as appropriate, to take account of:

- age- and sex-related need for healthcare
- additional need (over and above that accounted for by age and sex)
- geographical variations in the unavoidable cost of providing healthcare (covered by the Market Forces Factor and the Emergency Ambulance Cost Adjustment)

9. Account is taken of a wide range of indicators for health need, including some that are perceived to reflect health-related socio-economic circumstances, in order to attempt to address the goal of contributing to the reduction in avoidable health inequalities.

56 King’s Fund Briefing, “Deficits in the NHS” (April 2006), p 3. We note also the Secretary of State’s reported comment that, within the NHS, “The underspending areas have tended to be in the north, where the health needs are greatest, and the overspending areas have tended to be in the south, which are the healthier and wealthier areas”—“Hewitt sticks to her guns as problems grow”, Guardian, 9 March 2006.

57 In this memorandum, the South East region is defined as the area covered by the Government Office Region of that name, which is larger than that covered by the local authorities whose NHS OSC Chairmen have endorsed this document.


Additional costs associated with rurality

10. In recent years, a growing body of literature has argued that there are additional costs associated with the provision of healthcare in a rural setting and that, consequently, the NHS resource allocation formula needs to contain a major adjustment for rurality (a “rural premium”).

11. This literature has included discussion of the following extra costs associated with rural healthcare provision:
   - diseconomies of scale (including the cost of maintaining scattered small community hospitals with low bed-occupancy, and mobile and outreach services/branch surgeries)
   - additional transport costs
   - high levels of unproductive staff time spent travelling
   - additional communications costs
   - higher cost of accessing training, consultancy and other support services

12. There is also some evidence that people in rural areas are lower-than-average users of routine healthcare services (due to the way that healthcare need tends to express itself in rural communities)—which may, perversely, in fact lead to higher overall healthcare expenditure. People in this section of the population appear to be more likely to present at a later stage of disease (perhaps because of a culture of “rugged independence” and self-reliance, and because of lower health-expectations), when their condition has become acute. They are, thus, more likely to make use of expensive ambulance, Accident & Emergency and hospital facilities, rather than routine primary-care services.

13. The research team behind the most recent English NHS weighted capitation formula were confident that, by allowing for access costs in their service-utilisation model (used to calculate need for services), they had ensured that “Rural areas will have their different needs adequately reflected in the allocation formula”. It is also true that the Emergency Ambulance Cost Adjustment does take some account of the additional costs associated with serving a scattered population.

14. However, it seems clear to us that an explicit and substantial adjustment for rurality is still necessary in order to address adequately the additional needs of rural areas. The case for this is strongly reinforced by the fact that the NHS allocation formulas in Northern Ireland, Scotland and Wales (whose rural populations are, in absolute terms, smaller than England’s) do now include such adjustments. It is also noteworthy that funding allocation formulas in other countries in the developed world with socialised public healthcare systems, such as Australia, Canada, Finland and New Zealand, include explicit and substantial adjustments for rurality.

15. Furthermore, local-government spending allocations in England (through the Formula Spending Share), including allocations for personal social services, now include an explicit element of adjustment for rurality.

16. We also note that the new General Medical Services contract now has an explicit rurality component, through the Car-Hill allocation formula (which provides the basis for allocating funds for global sum resources and quality payments).
17. With the government’s drive to attain national quality standards in service provision, under programmes such as the National Service Frameworks, it is surely all the less tolerable now for rural areas to be provided with lower-quality services.70

18. Finally, we would refer to the government’s 2000 Rural White Paper. Our countryside: the future—a fair deal for rural England, which introduced the idea of “rural proofing” policies—a commitment by Government to ensure that all its domestic policies take account of rural circumstances and needs”. The White Paper also included the first Rural Services Standard (now the Rural Services Review)—in which explicit reference was made to the need for appropriate access to healthcare services in rural areas.71 Subsequently, the Institute of Rural Health, with funding from the Department of Health and the Department for Environment, Food and Rural Affairs, has developed a rural proofing toolkit for primary care organisations.72 The principle of “joined up government” surely indicates that “rural proofing” should be extended to the NHS resource allocation formula.

Rurality in the South East

19. The South East England Development Agency has noted that, while the South East is perceived to be “predominantly urban or suburban”, the region actually retains a significant degree of rurality. Using the 1993 Tarling study (Rural Development Commission) definition of rurality, the South East actually has the highest number of predominantly rural districts (a total of 35) of all the English regions. And half of its population (some four million people—2001 Census figure) lives in districts classified as predominantly rural—of whom two million (according to SEEDA’s research) live in small rural towns (population less than 10,000), villages, hamlets and the countryside (as opposed to the urban edges of rural areas). The region has 26 market towns with populations of between 10,000 and 20,000, 164 small rural towns (with less than 10,000 population) and at least 1,400 villages. Twenty-three per cent of all South East businesses are in rural areas. SEEDA has also noted that the region has more than 10,000 full-time (and more than 17,000 part-time) farmers, with 10% of the farms in England located in the South East. The geographical county of Kent alone has 2,396 full-time farmers, making it twelfth out of 44 counties in the size of its farming community.73

20. A new official rural-urban definition was published by the Office for National Statistics in July 2004, based on settlement patterns and population densities, and on sparsity of population (derived from population density in neighbouring areas), and resolved to Census Output Areas and electoral wards. On this definition of rurality, 82% of the South East is classified as rural; and half of the region’s district and unitary local authorities have 75% or more of their area categorised as rural.74

21. It is true that most rural districts within the South East are classified as “accessible” under the Tarling definition (only four are classified as “remote”);75 and, under the new rural-urban definition, only one Lower Super Output Area (covering part of Romney Marsh, in Kent) is classified as “Sparse”.76

22. Nonetheless, it can be argued that the issues associated with rurality are not simply or entirely a function of peripherality/remoteness from urban centres and sparsity of population. And it should be noted that in one case, that of the Isle of Wight, issues associated with rurality are compounded by the additional impact of insularity (see, for instance, comments by the Island’s MP, Andrew Turner, during an adjournment debate on public services in the Isle of Wight).77

23. Furthermore, it can also be argued that there is a marked compounding peninsula effect in Kent. Peninsularity in Devon and Cornwall has often been alluded to, but its significance in Kent is less recognised. It has historically led to regular patient flows from East Kent into the London hospital system for major clinical specialties—a patient journey that would be unacceptable in most other parts of England. This has been partially remedied by NHS capital investment in Kent hospitals in recent years, but market pressures

70 Asthana et al., op. cit. (2003), p 491.
72 Rural Proofing for Health: A Toolkit for Primary Care Organisations (Institute of Rural Health, July 2005).
75 Carter, op. cit., para 1.5, p 2.
(especially the need of London teaching hospitals—funded by the “spell” under Payment By Results—to maintain or increase their throughput) could reverse the trend.

**Pockets of deprivation**

24. As noted above, the resource allocation formula has been adjusted in recent years to take account of social deprivation (which tends to correlate with poor health and hence greater need for healthcare), in furtherance of the government’s aspiration for the formula to “contribute to the reduction in avoidable health inequalities”.

25. However, there remain concerns that the formula does not adequately capture all the forms in which deprivation occurs. Since the formula reflects the overwhelming preoccupation with large urban concentrations of deprivation, smaller pockets of deprivation in rural, and other generally better-off, areas go “under the radar”.

26. SEEDA has pointed out that:

The South East is the UK’s second most prosperous region. In this context, deprivation may not always be very visible or very measurable and it often occurs in isolated pockets. However it is evidenced by the designation of development/assisted area status in rural (eg Isle of Wight) and urban (eg Thanet) areas alike.78

27. A 2004 academic report on rural policy in the South East (for the South East England Regional Assembly, South East England Development Agency, Government Office for the South East and The Countryside Agency) observed that:

Despite the relative prosperity of the region, significant areas of deprivation have been identified in rural districts, resulting from poor accessibility and declining traditional rural based activities including agriculture. Parts of the region’s population continue to live in poverty and experience low quality housing, poor health, and enjoy limited opportunities. The national Index of Multiple Deprivation (2000) for example, ranks 119 wards in the South East as amongst the worst decile of deprived wards in the UK, of which 21 are located in rural areas. As outlined in the Sustainable Development Framework (SDF), there is a danger that in its desire to focus resources, the Government may underestimate the considerable scale and degree of hidden poverty and social exclusion in communities across the South East. Research by the Rural Community Councils in many different parts of the region has in fact demonstrated that this dispersed pattern of rural exclusion is a particular feature of the South East.79

28. The SDF itself states as follows:

The South East is the healthiest part of England, but on a number of indicators is poor by the standards of W Europe. There are also significant health inequalities within the Region, with concentrations of relatively poor health in areas of deprivation and areas with large elderly populations.80

29. We note that Gareth Cruddace, Programme Director for PCT Diagnostic and Development at the Department of Health (and a former Chief Executive of Hampshire and Isle Of Wight Strategic Health Authority), recently admitted that “Current funding formulas don’t cope well with small areas of deprivation”. We further note that Mr Cruddace also admitted that future NHS financial settlements were “likely to move money away from [the] South East, because [the] north/south divide on health inequalities [is] getting worse.”81

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79 Gallent N, Greatbatch I, Oades R, Bianconi M. Spatial Dimensions of Rural Policy in South East England (Bartlett School of Planning, University College London, March 2004), paras 3.2.4 and 3.2.5, pp 13–14. Cf. Carter, op. cit., para 2.4, pp. 3–4: The South East has 119 of [the] worst performing wards of England, with a population of more than half a million. These wards are mostly concentrated around the periphery of the region—the Kent, East Sussex and Hampshire coasts and the Isle of Wight.

The majority of these wards are urban but 15% are rural wards. — 16 are rural wards in the remote rural districts — 2 rural wards are in the accessible districts

All these rural wards are in the more peripheral areas of the South East.


Ageing population

30. The age profile of the South East reflects that of the UK as a whole—but the coastal and rural areas of the region have a relatively older population:

The Census 2001 showed that 18% of the population in rural areas is aged 65 and over, compared to 13% in urban areas. This greater proportion of older people in rural areas arises mainly from selective out-migration of younger age groups being more than matched by the in-migration of older age groups. The factors behind this trend are both work driven and retirement related moves.82

31. Furthermore, significant numbers of the older population in the South East are income-deprived. SEEDA has noted that:

There are over 176,000 older people in the South East (11.02% of the total) living in Income Deprived Households, a higher number than in North East (105,000), East Midlands (125,000), East of England (140,000) and South West (141,000).83

32. Although the NHS resource allocation formula does allow for age-related healthcare needs, it has been argued that the formula does not give sufficient weighting to this. This has been cited as another way in which the formula effectively discriminates against rural areas, since they tend to have older populations. Leading academic advocates of this argument have written that “per capita allocations for older age bands may well be conservative. This will mean that the formula discriminates against areas serving demographically older populations”.84

33. Some of the same academics have argued that, were funding allocations to be derived from a morbidity-based model (using available data on actual patterns of disease), this “would result in a significant shift in hospital resources away from deprived areas, towards areas with older demographic profiles and towards rural areas”. The authors note the “wider policy context that is generally concerned to direct more health care resources towards the poor” and call for “greater clarity between the goals of health care equity and health equity”—ie between “horizontal equity” and “vertical equity”. They note that “Whilst the former demands that the legitimate needs of demographically older populations for more health care resources are acknowledged, the goal of health equity requires real political commitment to resource broader social policy initiatives”.85

34. More recently, two of the same group of academics have argued that:

Deficits in the NHS are invariably presented as a problem of financial mismanagement, but the pattern of deficits suggests that the current resource allocation model discriminates against particular communities PCTs serving populations which are both in the most rural and the least deprived quintile are most likely to be in financial difficulties. The pattern of deficits suggests that NHS funding provides insufficient resources for rural areas, for relatively affluent areas and, most particularly, for areas that are both rural and affluent. This reinforces previous work suggesting that the current resource allocation formula responds well to the higher relative needs of urban populations, but fails to cater for the higher absolute needs of older affluent populations, particularly in rural areas which incur additional costs in delivering health services.86

35. In 2002, the Rural Health Forum reported to the Rural Affairs Forum for England that the “Rising elderly population in many rural areas” was “not accurately reflected in the [NHS] funding formula”.87

36. In a recent Commons (Westminster Hall) debate on NHS services in East Sussex, the MP for Lewes, Norman Baker, mentioned the concentration of “older older” people in his constituency (noting that “Polegate, for example, has the eighth oldest population in the country”) and queried the extent to which this is allowed for in the funding formula.88

37. Individuals tend to make greatest use of health services towards the end of their lives. Morbidity and mortality are now increasingly compressed into the eighth and ninth decades of life. These trends are of particular significance in respect of the “older older” population—and they do not appear to be adequately reflected in the age-weighting element of the NHS resource allocation formula.

38. There is a case for saying that the NHS needs to place more emphasis on caring for people in the last 18–24 months of life—palliative care structures are currently financially fragile and dominated by cancer care. Our healthcare system seems to marginalise the very old and, arguably, marginalises death and the dying.

84 Asthana et al., op. cit. (2003), p 487.
86 Asthana, Gibson, op. cit. (2005).
87 Mitchinson, loc. cit.
88 House of Commons Hansard, Debates for 9 May 2006, Col 71WH.
Regional cost variations

39. It is widely accepted that the South East is a high-cost region.89

40. We acknowledge that the funding formula does include an element (the Market Forces Factor) intended to take account of unavoidable geographical variations in the costs of providing healthcare—covering regional pay weighting (including that paid to NHS staff in parts of the South East),90 variations in land values, and additional costs of buildings and equipment.91

41. A report by Prof David Blanchflower and Prof Andrew Oswald, commissioned by the Thames Valley Strategic Health Authority (in Oxfordshire), concluded that “an inappropriate data set is currently used to do MFF calculations” and that the “funding allocation going to health authorities such as Thames Valley is too low”. The report also noted that the “steps” in the MFF between health economies within Thames Valley “do not seem to reflect the true cost of service provision”.92

42. It can be argued that NHS labour costs in the South East of England are understated, because of the relatively high use of locum and agency staff in the region. The mismatch between NHS pay rates (even with regional weighting) and the real labour market in the South East leads to workforce shortages, which are filled with locum/agency workers, with staff opting to work at locum/agency rates rather than be directly employed on low NHS rates. The funding formula needs to reflect actual labour costs.

Rapid population growth

43. With a population of some eight million (13.5% of the total UK population), the South East is the most populous of the English regions. Its population is increasing more rapidly than that of any other part of the country, and this is mostly (75%) due to migration from other parts of the UK (particularly London, which accounts for almost half of total in-migration—an average of over 40,000 people a year).93

44. Whilst population estimates produced by the Office for National Statistics are taken account of in the Funding Formula, parts of the South East are experiencing extremely rapid growth that is not reflected in ONS statistics—since these are based on observed trends and do not take account of government policy. We are pleased to note that, in consequence, the 2006–07 and 2007–08 funding allocations do include a “Growth Area adjustment”. This is paid to 44 PCTs in four areas designated by the ODPM as Growth Areas—including Ashford (Kent) and Thames Gateway (which in Kent includes substantial parts of Dartford, Gravesham, Medway and Swale district/borough/Unitary Authority areas). The following PCTs in the Kent and Medway SHA area are in receipt of the allowance: Ashford; Canterbury and Coastal; Dartford, Gravesham and Swanley; Medway; and Swale.94

45. However, population growth in these areas has already taken place and we are concerned that failure to take account of this in funding allocations prior to 2006–07 has had a detrimental effect on the finances of some PCTs. Towards the end of 2005, Kent County Council’s NHS Overview and Scrutiny Committee heard from Ashford PCT that the Trust felt they were “under funded by approximately £3m as their population continues to grow at about 2% each year” (although they were managing to break even).95

46. And there are concerns about whether the Growth Area adjustment will be commensurate with the expansion in population that is actually taking place. Ashford PCT also informed KCC’s NHS Overview and Scrutiny Committee that “the increase for 2006–07 looks conservative—compared to the increase in GP lists that they hold”; and a shortfall of £2.7 million in 2006–07 was still expected.96

47. KCC’s NHS OSC also noted that the Kent and Medway Strategic Health Authority is involved in planning health services for increases in population and lobbying for more sensitive instruments for measuring population growth. However accurate the method, funding growth still remains a function of the amount of money available and this may still not be as much as Ashford needs. The SHA will continue to push, comparing local views of population growth which do not always reconcile to those of the Office of National Statistics.97

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95 KCC, op. cit., para 5.1.12, p 32.
96 Ibid., para 5.1.13, p 33.
97 Ibid., para 5.1.14, p 33.
Conclusion

48. On the basis of the above, we believe that there is a strong case for asking the Advisory Committee on Resource Allocation to review all of these aspects of the NHS resource allocation formula. It must be established definitively whether the formula is still falling short of its objectives in terms of equity; if it is, its shortcomings must be addressed. This is all the more pressing in the current climate of mounting deficits, and with the advent of Payment By Results and other reforms that could have drastic consequences for the continued financial viability of many NHS bodies.

Councillor Alan Chell
Chairman of Kent County Council’s NHS Overview and Scrutiny Committee (and on behalf of the Chairmen of the NHS overview and Scrutiny Committees listed in paragraph 1)
6 June 2006

Evidence submitted by Southend University Hospital NHS Foundation Trust (Def 54)

1. INTRODUCTION

This paper provides some background information on financial management at Southend Hospital in the context of the Health Select Committee considering the deficits in the NHS. Southend Hospital has a sound track record of financial management.

2. BACKGROUND

Southend Hospital is an Associate Teaching Hospital providing general and acute services to approximately 330,000 people living in south-east Essex and cancer, ophthalmology and orthodontic services to approximately 650,000 people of south Essex except Brentwood.

Southend Hospital is the only acute trust in south-east Essex and is largely co-terminus with the existing two local PCTs (Castle Point and Rochford and Southend). It also has good working relationships with the other three PCTs in south Essex and social services.

NHS Trust status was achieved from 1 April 1991 and Foundation status from 1st June 2006. The hospital’s turnover for 2006–07 is approximately £195 million.

3. FINANCIAL PERFORMANCE

Southend Hospital has an excellent history of achieving its financial duties in every year since 1991–92. An income and expenditure surplus has been achieved in every year except 1993–94 and 1994–95 when deficits occurred through “below the line” adjustments for the losses on disposal of fixed assets.

The following surpluses have been achieved in the last four years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Surplus (£000s)</th>
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<tr>
<td>2002–03</td>
<td>4</td>
</tr>
<tr>
<td>2003–04</td>
<td>57</td>
</tr>
<tr>
<td>2004–05</td>
<td>17</td>
</tr>
<tr>
<td>2005–06</td>
<td>524</td>
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</tbody>
</table>

Those surpluses have been achieved with little or no planned external support and with limited use of revenue to capital transfers in the first 2 of those years.

A surplus of £5.2 million is planned for 2006–07. This sum largely arises from the gain from the full implementation of Payment by Results (PbR).

4. FINANCIAL MANAGEMENT

There a number of reasons why Southend Hospital has achieved its financial duties. These include (in no order of significance):

— Strong leadership from both the Board and Executive Team with a clear focus on finance.
— Strong finance team with 10 qualified accountants.
— Relatively low staff turnover (both in Finance and elsewhere) providing a good foundation of experience and knowledge.
— Good internal working relationships between budget holders and finance with regular monthly activity and performance reviews with each directorate.
— Excellent working relationship with all its commissioners and stakeholders and in particular the two local PCTs.
— Low reference cost index of 91 providing a tariff gain from PbR.
— Good financial risk management and systems of internal control.
— Achievement of cost improvement programmes in every year with a significant number of savings being recurrent.
— Investment in modern financial systems.
— Flexibility over the majority of pay costs with local terms and conditions (before Agenda for Change).
— Low asset (mainly buildings) cost base. Vast majority of services are provided on a single hospital site.
— Strong cash position and good cash management processes.
— Good control over demand management and activity plans.

However the Hospital recognises that it needs to continue to improve its financial management particularly as an FT and with PbR and will be:
— Development of clear links between income and expenditure at directorate level and the improved identification of cost drivers.
— Identification of clear productivity gains.
— Development of an accountability framework and reviews of the scheme of delegation.
— Improvements to cash and treasury management systems.
— Development of longer term financial strategies and plans.

5. Conclusions

The sections above provide a very brief overview of the background, financial management and performance at Southend Hospital. Good financial management is an on-going process, dealing with today’s issues, forecasting and planning for the future.

Clearly lessons learnt are transferable from one NHS organisation to another but solutions to financial deficits often relate to resolving local issues.

Brian Shipley
Director of Finance, Southend University Hospital NHS Foundation Trust

15 June 2006

Evidence submitted by UNISON (Def 18)

Introduction

1.1 UNISON is the major union in the health service. Our health care service group represents more than 400,000 employees in the NHS and staff employed by private contractors, the voluntary sector and general practitioners.

1.2 We welcome the fact that since 1997 the NHS has benefited from record levels of spending, and the fact that workforce shortages in the 1980s and 1990s have been redressed to the benefit of NHS staff and patients using the service, for whom waiting lists have fallen and the quality of care has risen.

1.3 Despite this very welcome investment, some trusts in England are facing substantial financial deficits, a situation which is leading to job cuts and placing in jeopardy much of the hard-earned goodwill towards the service, with the reduction and loss of some key services for patients. UNISON therefore welcomes the opportunity to contribute to this inquiry.

The reasons for the deficits: whether the causes are systemic or local (eg the role of poor local management and poor central management, the effect of pay awards and Government policy decisions)

2.1 UNISON does not believe it is fair to blame the deficits entirely on poor local management at trusts and Primary Care Trusts (PCTs). The Government has indicated that the deficits are largely the result of poor management within individual institutions, implying that solutions lie within the control of individual managers. Such an opinion is not, however, borne out by recent Public Interest Reports from the Audit Commission, which have singled out only a few NHS institutions for specific management failings.98

98 King’s Fund, Briefing: Deficits in the NHS, April 2006, p 4.
2.2 Where there have been local problems, there is little evidence of a structural management problem replicated across the country. Instead problems are often associated with individual circumstances, such as problems caused by capital projects funded under the Private Finance Initiative (PFI) that have cost more than expected in the longer-term. This may be indicative of one area in which management has fallen short: a failure to consider the longer-term impact of using such measures to avoid funding problems in the short-term.

2.3 Nor does UNISON believe that the funding of Agenda for Change is to blame for the deficits. Such initiatives are helping to secure long overdue changes in salary structures and are going some way to righting previous inequities. The new pay system aims to reward staff properly for the work they do, but also encourages more flexibility which should in the longer-term boost the efficiency of trusts.

2.4 The cost of implementing the new consultant contract for England has had an impact. The Department of Health has acknowledged that it will cost £90 million more than expected and research for the King’s Fund into the impact this is having on management in London trusts concluded that “the underestimation at national level has caused considerable cost pressures at local level.” Management have found the costs of the new contract producing deficits of £1 million and over.99

2.5 UNISON believes that one of the main reasons for the deficits is the continuing marketisation of the NHS. The previous Health Secretary, John Reid, claimed in 2004 that the vast bulk of health services would remain within the public sector (with no more than 15% going private), but successive policies to bring the market into health care are leading to the fragmentation and destabilisation of the service. Evidence from other countries shows that the transaction costs of administering new systems of competition between providers are high, and the Department of Health has itself recognised that new incentive-based reforms will bring some “financial volatility” to the NHS.100 Reforms set out in Commissioning a Patient Led NHS and Our Health, Our Care, Our Say threaten to fragment the health service further, forcing providers to compete rather than cooperate which will cause greater financial pressures for trusts and PCTs. Competition between providers undermines collaborative working and the sharing of good practice, both clinical and financial. The efficient provision of healthcare requires long-term workforce planning, which is undermined by the constraints of a competitive market.

2.6 The first wave of Independent Sector Treatment Centres (ISTCs) has placed severe financial pressure on PCTs. The uneven playing field established between them and NHS providers means ISTCs being paid in full by PCTs regardless of contract delivery; the commercial costs and risks are effectively transferred back to the public sector. The new centres have been able to select the cases they take, leaving the NHS with the more complicated and costly ones but without any additional funding to cover a more mixed intake of patients.

2.7 It was claimed at the outset that the ISTC programme would provide value for money. One of the main areas of contention, however, has been the cost of private sector involvement and the effects on the NHS having to pick up the bill. UNISON contends that the future of ISTCs is about a sustainable market for the private sector and not what is in the best interests of patients or the public purse. Department of Health figures show that wave one and phase two of the ISTC programme will cost the NHS over £4 billion over five years101 and the research so far has shown that ISTCs do not provide value for money, but instead place further strain on already demanding PCT budgets. Local decision making and accountability is threatened with PCTs being forced to sign up to potentially damaging contracts that are under utilised and sometimes in places where the NHS has spare capacity itself. One particularly vivid example of this from 2005 was quoted by UNISON in the evidence to the Health Select Committee on ISTCs: in the first six months of South West Oxfordshire PCT’s contract with Netcare, the company were paid £255,000 despite having carried out only £40,000 of operations and assessments.102

2.8 Despite having been only recently introduced, the move towards Payment by Results (PbR), with money following the patient as hospitals are paid a set tariff for each procedure, is already having a detrimental financial effect on both PCTs and NHS providers and is likely to have a more profound impact on finances in the future. The Audit Commission has highlighted greater financial instability for PCTs as the most significant risk of PbR.103 Under block contracts funding was not adjusted for activity levels, enabling PCTs to manage and control their costs. PbR on the other hand imposes a commitment on PCTs to pay for work done on a fee per patient basis. In addition under the old system the cost of an additional volume of operations related only the additional variable costs involved, such as additional staffing hours, but not fixed costs like providing an operating theatre. With PbR the amount charged for each additional patient reflects both fixed and variable cost, meaning PCTs are exposed to greater financial volatility and will find it harder to control their budgets. The picture of increased financial instability is replicated for NHS providers. Under the old block contract system trusts were guaranteed a certain income which enabled them to plan ahead more effectively. A trust would know the services it had been commissioned to provide and


102 UNISON, Evidence to the Health Select Committee Inquiry on Independent Sector Treatment Centres, February 2006.

103 Audit Commission, Early Lessons from Payment By Results, October 2005.
have some idea of their requirements regarding infrastructure and staff. With PbR this is not the case—a hospital could build new wards and then find they don’t have the patients to fill them. Where hospitals are funded using PFI, cost implications are likely to be particularly grave because the fixed tariff fee for each item of treatment takes no account of the inflated overhead costs that come with large-scale PFI building schemes.

2.9 The 2005 Audit Commission Report highlighted the case of Bradford Teaching Hospitals NHS Foundation Trust, which used different and higher forecasts of patient activity than its commissioning PCTs, and on this basis employed 300 additional staff. This resulted in higher costs and lower than planned income, leading to serious financial problems.104 For specialist hospitals the existing tariff is not sophisticated enough to account for the greater complexity of the operations and other procedures carried out. An example of this is the £22 million total deficit expected by four children’s hospitals (Alder Hey, Great Ormond Street, Sheffield Children’s Trust and Birmingham Children’s Trust) as a result of fixed prices for NHS procedures. UNISON was pleased to hear the Health Secretary state in April 2006 that the Department is discussing such issues with the children’s hospitals.

2.10 UNISON has been warning against the use of PFI and NHS LIFT (Local Improvement Finance Trusts) in the building and servicing of hospitals for many years. Far from being a cheaper way to run projects, PFI is allowing private companies to cream off profits while hospitals are saddled with high levels of ongoing debt. A recent example is the Norfolk & Norwich Hospital, where the hospital’s PFI joint working company took £115 million out of the scheme and replaced the money in the project with borrowed funds, leading the Commons Public Accounts Committee to criticise this refinancing deal for having “lined the pockets of the investors” while the hospital has been left to deal with a large deficit.105 In December 2005 a Price Waterhouse Coopers report for the Audit Commission warned that the deficit at Queen Elizabeth Hospital NHS trust in Woolwich would amount to £100 million by 2008–09 unless its PFI debt was restructured.106 The deal added around £9 million a year to the costs met by an equivalent hospital built with money borrowed from the Government. A further example of the failure of PFI to provide value for money is Barnet and Chase Farm Hospitals which is also financially in the red. The capital value of their PFI scheme is £54 million, yet nearly £42 million has already been paid in unitary payments over the last two years with many more payments to come.107

2.11 UNISON does not believe that the apparent switch towards NHS LIFT will provide better value for money: in evidence to the House of Commons Select Committee on Public Accounts, the example of Newham was raised where two LIFT buildings serving 8% of the population were found to be using 33% of the premises budget.108

2.12 New plans for Practice-Based Commissioning are likely to exacerbate financial problems in the future. The initial costs of setting up the new system will be provided in advance by PCTs, who will also meet any overspends. Savings made will be the only available source of funding to meet new administrative and management costs, meaning that if savings are not made budgets will automatically be overspent.

The reasons for the deficits: the findings of the “turn-around” teams, whether these findings are right and whether the turn-around teams have provided value for money

3.1 The report from the Department of Health’s finance director, incorporating the KPMG turnaround teams’ initial analysis of NHS organisations with the worst financial problems, found that “the capability of the management was inadequate to deal with the challenges of their current financial position.”109 As stated above, UNISON believes it is too simplistic to lay the blame for financial problems solely at the door of local management. To some extent our position is supported by the third key conclusion of the auditors, which states that in some cases Strategic Health Authorities “were allowing unproductive behaviour between trusts and PCTs,” which seems to be a tacit acknowledgement of some of the problems that have come about as a result of the new era of competition and a resulting lack of cooperation. Similarly, the report acknowledges that the categorisation of some trusts as needing “urgent intervention” does not necessarily reflect upon the quality of the management; for some organisations “the scale of the turnaround problems faced are such they would challenge the very best management.”110

3.2 In terms of value for money, it is hard to justify the substantial turnaround expenditure at some trusts when hospital staff stand to lose their jobs. For example, Leeds Teaching Hospitals NHS Trust is paying advisers from Price Waterhouse Coopers £100,000 to help the Trust save money. Similarly, the Surrey & Sussex Healthcare NHS Trust is reportedly paying KPMG £700,000 to help reduce costs.

104 Ibid.
105 Price Waterhouse Coopers, Queen Elizabeth Hospital NHS Trust: Public Interest Report, December 2005.
106 House of Commons written answer from Andy Burnham MP to a question from Roger Godsiff MP on Private Finance Initiative and Hospital Deficits, 25 May 2006.
107 House of Commons Committee of Public Accounts, The Refinancing of the Norfolk and Norwich PFI Hospital, May 2006.
108 UNISON (Rachel Aldred), In the Interests of Profit, At the Expense of Patients, January 2006, p 10.
110 Ibid.
The reasons for the deficits: the relationship between the funding formula, the allocation of funds to trusts and the size of their deficits or surpluses

4.1 UNISON accepts that some of the larger deficits are occurring in more affluent areas of southern England, and it is possible that certain areas are under-funded. It should be noted, however, that the deficits are not restricted to these areas; trusts in the Midlands and the north of England are struggling to balance their books as well. The funding formula is designed to take into account factors such as the cost of living, age profiles, levels of deprivation and geographical variations in the cost of providing services. It is right that funding continue to be directed towards the areas of greatest need and the Department of Health is committed to ensuring that no area is more than 3.5% below its fair funding target. For the last three years and for the next two the NHS is receiving a 9% growth in funding each year, which is a significant amount of additional money even if some areas are benefiting more than others. UNISON’s major concerns, as outlined above, are for areas where the extra money is not going towards boosting patient care or improving staff conditions but being absorbed by the private sector and leaving the NHS to pick up the debt.

The consequences of the deficits: the effect on care

5.1 A recent BMA survey suggested that 37% of medical directors were planning to reduce services due to financial difficulties and the report of KPMG’s experience with turnaround teams suggested as one its range of potential improvement opportunities for 2005–06 that there should be “capacity reductions” and “recruitment bans for back office functions.” UNISON does not agree with the contention of the NHS Confederation that fewer hospital beds will mean better care. Smaller numbers of beds can lead to greater risks of cross-infection, at a time when clinical staff and cleaners in hospitals are doing their best to combat the rise of the MRSA super bug. The Healthcare Commission’s recently released Survey of Inpatients 2005 reported that the proportion of patients that perceived their room or ward as “very clean” has fallen since 2002.

5.2 The deficits have produced situations where patients are having to wait for operations when there are doctors and theatres free to carry out surgery. Some trusts have had to change their thresholds for treatment, meaning people with mild conditions will receive less care. Similarly, some operations are being delayed until the next financial year so as not to add an extra burden to debt-ridden hospitals. Some prominent recent examples of the effect on care include flagship services such as NHS Direct where, despite some centres expanding, 12 smaller call centres are closing and there is likely to be 400 fewer operators. Similarly, the commissioning of nurse-led NHS walk-in centres, one of the most popular recent Government initiatives singled out for praise in the Government’s Let’s Talk initiative, is likely to come under threat as PCTs look to tighten their belts.

5.3 There are some telling examples of the effect on care from specific trusts. At the Weston General Hospital Trust in Weston Super Mare, savings of £1 million are being made to remove a deficit and make other savings. Although a turnaround director has been appointed, UNISON considers the trust one of the most prudent in the south west. Problems have arisen not because of mismanagement but due to the transitional arrangements of PbR. In addition local PCTs withdrew 15% of elective admissions from the hospital, guaranteeing them instead to the new privately-operated treatment centre based 20 miles away in Shepton Mallet. The result of these twin pressures on the trust is that 60 beds have been closed, the equivalent of two wards, modern matrons and ward managers posts have been halved, and nurse posts are being reviewed.

5.4 The example of the University Hospital North Staffordshire (UHNS) NHS Trust is more well-known and one of those trusts where substantial management failings have been highlighted. Such shortcomings have been compounded, however, by the pressure of attempting (unsuccessfully) to secure a PFI deal and by a failure to come to terms with the effect on budgets of new policies to divert a proportion of NHS patients to ISTCs. The Audit Commission’s Public Interest Report into problems at UHNS found that “the Trust failed to take account of the local PCTs’ financial position and commissioning intentions which sought to reduce activity with the Trust.” These problems were confirmed by the announcement in May 2006 that UHNS had lost out on a £1.5 million contract to a private sector diagnostic and treatment centre based in Burton on Trent. With the NHS Confederation acknowledging that up to 550 jobs are likely to be lost, patients will be affected with beds being closed, home care visits reduced and cutbacks for a new unit dealing with strokes.

5.5 The impact of PbR on financial planning is amongst the major reasons for a combined deficit of £38 million across Gloucestershire. In terms of patient care, this means the loss of 240 hospital beds and a number of community hospitals are being closed, with a particular impact on mental health services and maternity care.

112 Department of Health, Financial Turnaround in the NHS.
115 Audit Commission, Public Interest Report: University Hospital of North Staffordshire NHS Trust, April 2006.
5.6 It is possible that in some of the examples outlined above trusts have been able to use the deficits as a reason to close down particular services. This is something which the charity Rethink has highlighted in relation to the perceived disproportionate impact of the deficits on mental health services.116

5.7 Training is also being affected which will have a detrimental impact on patient care in the longer-term. The number of training posts for nurses and occupational therapists has been cut and the continuation of Department of Health funding for NHS Learning Accounts, NVQs and Skills for Life Frameworks may come under threat. Furthermore, UNISON fears that the current lack of job security within some trusts—whether perceived or real—will have an adverse effect on the ability of the NHS to attract staff in future.

The consequences of the deficits: the number of job losses

6.1 The deficits within the health care system are already having a real impact on NHS staff. Although the exact number of job losses is hard to quantify and estimates have varied widely, the volatility within the service is clear and workers will lose their jobs in both clinical and non-clinical professions. UNISON accepts that not all the cuts are directly related to deficits, but feedback from UNISON branches confirms a picture of uncertainty and anxiety amongst workers in the NHS, with the likelihood of more redundancy announcements in the future.

6.2 The recent claim that the cuts will affect posts not people does not tell the whole story; real people are working in these posts and although some may find work elsewhere, some will not. Where cuts apply to temporary agency employees this will still have an impact on wards, where the remaining workers will find themselves increasingly stretched. One of the Healthcare Commission patient survey’s recommended “areas for improvement” is around the fact that 40% of patients said there were not always enough nurses.117 Claims that reductions in NHS posts are predominantly among administrative and clerical staff are similarly wide of the mark. Staff in administrative or other posts are still workers and provide an invaluable service to the NHS. The importance of the team in health care is at risk of being undermined: clinical staff will suffer the knock-on effects if porters, cleaners and administrative staff lose their jobs.

The consequences of the deficits: the effects of “top-slicing” in the current and future years

7.1 The recommendation that trusts “top slice” a small proportion of their budget to hold in contingency funds to guard against overspends in the future means in effect that trusts are having to start from the point of being under funded compared to their usual figures; savings will have to be made just to balance the budget. If the end result of top-slicing is that extra funding going into the NHS is used to fend off the prospect of financial deficits in the future, there is a danger of the service failing to live up to the expectations of patients and staff, which have been raised by the extra attention and expenditure the NHS has received.

The period over which balance should be achieved

8.1 It may be necessary for the Department of Health to reconsider the length of time permitted for trusts to clear their deficits. The report of the turnaround teams acknowledges that bringing financial order to trusts with deficits “will not be achieved overnight” and yet goes on to say that “each NHS organisation should plan for in-year financial balance and in most cases immediate recovery of 2005–06 overspends.” The report accepts that in some “exceptional circumstances” the DoH may agree to recovering the overspend over more than one year.118 UNISON believes that these exceptional circumstances will need to be extended more widely to allow trusts more time to come to terms with Government reforms and new ways of working. Insisting on a one-year turnaround is likely to produce a knee-jerk reaction that leads to a reduction in jobs and a reduction in services. Properly staffed hospitals and clinics run more cost-efficiently and are the best way to ensure the patient does not suffer. Equally, an inflexible timescale for reducing debt is likely to compromise the ability of trusts to fund the very welcome agreement to end the two-tier workforce in health, as secured between unions and the Government as part of the Warwick accord.

Additional information

9.1 UNISON is not opposed to reform, and we want to see the best quality health service possible, but trusts and PCTs need a chance to take stock and adapt to new systems which have not yet been able to bed down. We are calling on the Government to halt further expansion of the role of the private sector in the NHS until there has been an opportunity to discuss the consequences of recent reforms, and to review the role and regulation of markets in the NHS. Reforms that are brought in need to be pilot-tested first, following proper consultation with those responsible for delivering change, and should only be applied more widely once it has been demonstrated they will produce genuine improvements rather than contribute to financial instability.

117 Department of Health, Financial Turnaround in the NHS.
9.2 UNISON would welcome the opportunity to give oral evidence to the Health Select Committee.

Karen Jennings
National Secretary (Health Care), UNISON
June 2006

Evidence submitted by West Hertfordshire Hospitals NHS Trust (Def 55)

1. INTRODUCTION

1.1 This paper summarises the scale of the financial problem in West Hertfordshire NHS Trust (WHHT). It describes the reasons for the problem, our proposed solutions and the associated benefits. Our approach builds on the principles established in Investing in Your Health119 and reflects national policy around the new direction for community services.

1.2 West Hertfordshire is located to the north of London, and covers an area of approximately 634 square miles. WHHT provides acute health services to the residents of Dacorum, Watford, Three Rivers, St Albans and approximately a third of the Hertsmere population, a total catchment population of around 463,514.

1.3 The Trust operates from four sites throughout West Hertfordshire at: Watford (Watford General Hospital), Hemel Hempstead (Hemel Hempstead General Hospital), St Albans (St Albans City Hospital) and Northwood (Mount Vernon Hospital). Each of the acute hospitals at Watford and Hemel Hempstead serve a catchment population of 200–225,000.

1.4 Burns and Plastics services are provided from Mount Vernon, and as a supra regional service, the catchment population is approximately two million. This service is likely to transfer to the Royal Free Hospital later this year.

2. FINANCIAL CONTEXT

2.1 The Scale of the Financial Problem

The Trust has to reduce its costs by over £40 million over the next two years, from its annual expenditure of £230 million. This is illustrated in the diagram below.

<table>
<thead>
<tr>
<th>2006–07</th>
<th>2007–08</th>
</tr>
</thead>
<tbody>
<tr>
<td>In year deficit</td>
<td>£18m</td>
</tr>
<tr>
<td>PCT Intentions, CIP, PbR</td>
<td>£9m</td>
</tr>
<tr>
<td>Deficit</td>
<td>£27m</td>
</tr>
<tr>
<td><strong>Actions in year:</strong></td>
<td></td>
</tr>
<tr>
<td>Turnaround Plans</td>
<td>£12m</td>
</tr>
<tr>
<td>Capacity Reduction</td>
<td>£3m</td>
</tr>
<tr>
<td>Savings</td>
<td>£15m</td>
</tr>
<tr>
<td>Agreed Deficit</td>
<td>£12m</td>
</tr>
</tbody>
</table>

2.2 Failure to address the financial problems now will result in the Trust’s position deteriorating even further—an accumulated deficit in excess of £100 million has been forecast by 2010 if no action is taken.

2.3 Financial stability is essential if the Trust is to sustain services and retain the prospect of the new hospital. The challenge for the Trust is maintaining and improving clinical quality and meeting NHS performance standards whilst reducing costs.

2.4 Why is the Deficit so Large?

2.5 West Hertfordshire has a history of financial deficit going back to the early 1990’s. This is attributable to a number of factors, including: activity levels above those anticipated given the good health status of the population; outflow of patients and resources to London; difficulty in recruiting staff to a high cost area and a consequent high usage of agency staff; loss of income during GP Fundholding, which was widely adopted in the area; an infrastructure in the acute sector—acute services being provided on four sites—which is too large to be sustained with the available income base. The history of deficit in West Herts, has led to a lack

119 Investing in Your Heath Beds and Herts SHA 2003 www.bhsha.nhs.uk/investinginyourhealth
of investment in core services, buildings, site infrastructure and equipment. As a consequence, despite the best efforts of our staff, this situation has resulted in a variable patient experience that is in danger of deteriorating further. The gap between income and expenditure existed even before the Trust’s inception in 2000. Figure 1 below illustrates the financial health of the Trust over the last six years. It describes the Trust’s financial position at the end of each year since 2000 when the Trust was formed. A positive financial position was achieved only in 2002–03; this was due to a one off allocation of £20 million by the NHS Bank. This cleared the 2001–02 deficit and brought the Trust back to a cumulative breakeven position. The position at the end of 2005–06 is provisional pending publication of the final accounts in July.

Figure 1

THE FINANCES OF THE TRUST 2000–06

<table>
<thead>
<tr>
<th>Year</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
<td>(11.5)</td>
</tr>
<tr>
<td>2002/03</td>
<td>11.7</td>
</tr>
<tr>
<td>2003/04</td>
<td>(4.7)</td>
</tr>
<tr>
<td>2004/05</td>
<td>(10.0)</td>
</tr>
<tr>
<td>2005/06</td>
<td>(28.3)</td>
</tr>
</tbody>
</table>

2.6 In addition, the Trust has suffered from poor financial management, a lack of operational control arising from the three mergers that have taken place in the last 14 years and a high turnover of leadership. There is also an underlying structural problem in the economy (see 2.4 above), the root causes of which have not been fully addressed previously.

2.7 In line with the experience of many other Trusts, the WHHT position has also deteriorated considerably in 2005–06. This is as a consequence of inter alia increased workforce costs, eg the new consultant contract, agenda for change, working time directive etc.

3. STRATEGIC CONTEXT

3.1 The financial pressures within the NHS have been widely reported over the last few months, with a significant number of Trusts and PCTs throughout the country experiencing financial deficits.

3.2 Financial stability within the Hertfordshire health economy has not been achieved for a number of years. This has led to the wider health community in Hertfordshire agreeing a Strategic Health Authority (SHA) wide strategy—Investing in Your Health, which was fully consulted upon in 2003.

3.3 The agreed IiYH option proposes the following service configuration for West Hertfordshire:
   — the centralisation of acute services to a new hospital on the Watford General Hospital (WGH) site;
   — the provision of planned surgical services, outpatient, diagnostic, intermediate care and urgent care services on the Hemel Hempstead site; and
   — the provision of outpatient, diagnostic, intermediate care and urgent care services on the St Albans Hospital site.

3.4 The overall timescale for the full implementation of IiYH is 2013. However given the worsening financial position across Hertfordshire, coupled with the national focus on financial balance, it has become necessary to explore how the benefits of IiYH can be delivered in advance of the new PFI hospitals.
4. **The Trust’s Approach to Achieving Balance**

4.1 The Trust fully acknowledges the need to embed high quality financial management and operational control into the organisation. This will be achieved by a radical re-structure of the Finance Department including investment in new posts and a rigorous professional development programme to improve financial management and planning skills both within the finance and business planning teams and those of the operational managers. This will be set against the implementation of a robust performance management regime throughout the organisation focusing upon accountability and achievement of key financial and service targets.

4.2 The Trust has also explored a number of other strategies over the last twelve months to deliver financial stability. Whilst this has led to some cost reductions being implemented amalgamation of these strategies into an overall package offers the greatest service and financial benefits. These strategies fall into three main categories as described below:

*Improving Operational Efficiency—Turnaround Programme*

4.3 The Trust has worked on a standard savings plan known as the Turnaround Programme. This has resulted in cost reductions in 2005–06 of £4 million and a programme of savings for 2006–07 with a target of over £12 million. Work is ongoing to find further savings in order to align cost reduction with income reductions.

*Improving Clinical Effectiveness—“Best Practice, Best Value”*

4.4 The Trust has reviewed its clinical practice and has identified that further savings can be achieved by improving clinical performance and has set a target to perform at the level of the top 20% of the hospitals in the country, in terms of clinical practice. It should be noted that in some areas the Trust’s current level of clinical effectiveness is high, with the opportunity for improvement in others.

*Reconfiguring Services—Interim iIYH Measures*

4.5 Improving both organisational efficiency and effectiveness goes some way to reducing the Trust’s financial deficit. However, this still leaves an unacceptable gap.

4.6 The scale of the financial problem suggests that the Trust’s workforce needs to be reduced by in excess of 500 posts. Whilst approximately 100 of these can be achieved by redesigning how clinical services are delivered, the remainder requires a significant reduction in service duplication. To this end the Trust has explored a number of options to reconfigure services as rapidly as possible.

4.7 Originally the Trust explored three options for service reconfiguration. However, the Overview and Scrutiny Committee (OSC) held on 8 June urged the Trust to discount one option (centralisation of acute services to Hemel Hempstead) as this configuration is counter to iIYH. The formal Consultation process has been agreed with the OSC period will commence on the 10 July for a period of 100 days.

5. **Description of Potential Options**

5.1 **Option A**

Centralisation of acute services at Watford and the majority of planned services at St Albans, withdrawal of WHHT operated services from Hemel Hempstead.

Watford General Hospital (WGH)

5.2 All the acute services, such as A&E, ITU, complex surgery and acute medicine would be located at WGH in addition to Women’s and Children’s services. Clinical support services and outpatient facilities would need to be enhanced to support increased activity. An Acute Assessment Unit adjacent to A&E will be provided. Investment would be required to improve the existing infrastructure and facilities to enable the site to accommodate the additional activity.

St Albans City Hospital (SACH)

5.3 SACH would be the focus of elective short stay and Day case surgical activity in advance of the Surgicentre. Outpatient Services and the Minor Injuries Unit would remain. The PCT would continue to provide Intermediate Care.
Health Committee: Evidence

Hemel Hempstead General Hospital (HHGH)

5.4 The independent sector treatment centre (ISTC) is planned to be operational on site in early 2008. The hospital would be used by the PCT to develop local community services. This would include an urgent care centre; out patients; diagnostics; and intermediate care services. Clinical support services would be retained at Hemel in order to support the Surgicentre and other services on site.

Mount Vernon

5.5 Burns and Plastics services are subject to a separate process currently underway and the remaining WHHT services, such as histopathology, would be repatriated, thereby withdrawing fully from the site.

5.6 Option B

Centralisation of acute services at Watford; the majority of planned services at Hemel; PCT operated services at St Albans.

Watford General Hospital (WGH)

5.7 All the acute services, such as A&E, ITU, complex surgery and acute medicine would be located at WGH addition to Women’s and Children’s services. Clinical support services and outpatient facilities would need to be enhanced to support increased activity. Investment would be required to improve the existing infrastructure and facilities to enable the site to accommodate the additional activity.

Hemel Hempstead General Hospital (HHGH)

5.8 Short stay and day surgery would be centralised at the Hemel site and undertaken within existing buildings at Hemel, with an increased compliment of theatres installed on site. There would be a considerable consolidation of services within the site. Intermediate care beds would be on site and other services dependent on PCT commissioner intentions, eg Urgent Care Centre. The independent sector treatment centre (ISTC) is planned to be operational on site in early 2008.

St Albans City Hospital (SACH)

5.9 Services at St Albans would be largely dependent on PCT plans for the development of community services. However, are likely to include intermediate care beds, as currently provided, outpatient and diagnostic services and a minor injuries unit.

Mount Vernon

6. As option A.

7. Configuration Post ISTC Surgicentre

7.1 Once the Surgicentre is operational, the majority of elective surgical services will be transferred to Hemel. Whilst health services will be provided on all three sites, it is likely that WHHT will only operate services directly on the WGH site. This is broadly consistent with Option 2 of IYH.

Watford General Hospital (WGH)

7.2 All the acute services, such as A&E, ITU, complex surgery and acute medicine would be located at WGH addition to Women’s and Children’s services.

Hemel Hempstead

7.3 Short stay and day surgery would be centralised at the Hemel site and undertaken within the Surgicentre. Clinicentre, an independent provider, will operate the Surgicentre. Intermediate care beds would be on site and other services dependent on PCT intentions, eg Urgent Care Centre, Diagnostics and Outpatient Services.

The future provision of birthing centres on the Hemel Hempstead site is currently under independent review.
St Albans City Hospital (SACH)

7.4 Services at St Albans would be largely dependent on PCT plans for the development of community services. However, are likely to include intermediate care beds, as currently provided, outpatient and diagnostic services and a minor injuries unit.

8. SAVINGS

8.1 The indicative level of net savings achievable from each of the options along with the associated indicative capital costs is described below in table 1. The income consequences as a result of the catchment changes have been taken into consideration.

<table>
<thead>
<tr>
<th>Option</th>
<th>Net Saving £m</th>
<th>Capital Cost £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centralisation of acute services at Watford and the majority of planned services at St Albans, withdrawal of WHHT operated services from Hemel Hempstead</td>
<td>11.2</td>
<td>31.4</td>
</tr>
<tr>
<td>Centralisation of acute services at Watford; the majority of planned services at Hemel; PCT operated services at St Albans</td>
<td>10.5</td>
<td>33.2</td>
</tr>
</tbody>
</table>

8.2 Capital costs are indicative and represent a worst case scenario; further review of these costs will take place as the detailed service planning and design for the selected option evolves and the business case is developed.

9. SUMMARY

West Herts Trust is in a health economy that has experienced financial difficulties for many years. The Trust faces the task of reducing its cost base by 18% and is approaching this on three levels: improving operational efficiency; improving clinical performance; reconfiguring services. These actions together provide the basis for achieving financial balance and stability, to provide the platform for a much-needed redevelopment of the hospital at Watford.

West Hertfordshire Hospitals NHS Trust
June 2006

Evidence submitted by West Sussex Health Scrutiny Committee (Def 38)

1. INTRODUCTION

1.1 This submission is made by the Health Scrutiny Select Committee of West Sussex County Council.

1.2 We also draw your attention to the following relevant submissions to your Select Committee that have been made under separate cover:

(a) A joint submission made by the Chairmen of Overview and Scrutiny Committees for the south east of England which highlights the anomalies and inequalities of the current funding formula, particularly the shortcomings of the current formula in adequately reflecting the cost of healthcare provision to the very elderly.

(b) A submission by Laura Moffatt (Member of Parliament for Crawley), which focuses on the Surrey and Sussex Healthcare NHS Trust: the size of its deficit, the reasons for the deficit and the effect on care to the population in the north-east of West Sussex.
1.3 This submission focuses on the financial state of the NHS organisations in West Sussex and explores the possible implications for service delivery due to the very high levels of deficit in the county. In particular we feel that:

(i) The current funding formula does not adequately represent the structure and needs of our community and creates an unfair and disadvantageous profile of the county, particularly because it does not take adequate account of the following factors:
   (a) Additional costs associated with rurality
   (b) Pockets of deprivation
   (c) Ageing population
   (d) Regional cost variations
   (e) Rapid population growth.

(ii) Turnaround has had a disproportionate cost and has added a very significant financial burden on West Sussex NHS organisations in the county as we have three Turnaround Teams in West Sussex which have cost in excess of £1.5 million. Whilst the appointment of these teams was approved by central government and whilst their costs will in the long term be covered by the resulting savings in annual expenditure, it will have no impact on the underlying deficit. Further impact on the annual expenditure is unlikely to be realised within the very short timeframe set by central government, particularly given the expected reduction in funding from central government in future years. The government must take ownership and responsibility for the plight of these organisations. Whilst clearly there are efficiencies to be made, in large part the failings in these trusts has been a direct result of poor and contradictory policy making over the last 10 years by the government. The government has committed huge figures to the NHS—it is only right and equitable that that money should be spent in a way which will make a real difference. These turnaround costs should be born by central government. Asking for such costs to be borne locally will simply delay the benefit of the turnaround, demoralise further NHS staff and put at risk the timely implementation of the governments new vision for the NHS.

(iii) The historic (accumulated) deficits in the county are so high that the relevant organisations stand no chance of repaying the debt in the medium to long term (let alone within the three to five year break-even period) based on their current and likely future funding allocations.

(iv) There is no capacity with the West Sussex health economy to allow for “dual running” of services as we make the transition from acute services to more focus on community-based services in line with the recent White Paper “Our health, our care, our say”. This could result in the population of West Sussex being severely disadvantaged.

2. THE SIZE OF THE DEFICITS IN WEST SUSSEX

2.1 The deficit position of West Sussex health organisations is a significant issue across the whole of the West Sussex health economy. Of particular concern is the fact that four acute trusts in West Sussex have predicted end-of-year deficits totalling £76,141,000 (including one trust with the highest deficit in the country—the Surrey and Sussex Healthcare NHS Trust with a predicted deficit of £40,834,000).

2.2 Three Public Interest Reports have been published over the past year for NHS organisations in the county:

   — Surrey and Sussex Healthcare NHS Trust (March 2005).
   — Royal West Sussex NHS Trust (June 2005).
   — The entire Surrey and Sussex Health Economy (December 2005) in which the Audit Commission said:

   “I have issued this public interest report as I am concerned about the financial position of the Surrey and Sussex health economy. Although Surrey and Sussex is not alone in facing a significant financial deficit, as at October 2005 NHS trusts and PCTs are predicting a collective deficit of £75 million by 31 March 2006. Unless this deficit is effectively addressed, it is likely to impact on services provided to patients. Whilst in some parts of the economy there have been longstanding financial difficulties, the financial position of many NHS bodies in Surrey and Sussex has either not improved or deteriorated over the past three years. There are an increasing number of organisations in deficit, and in some the financial position has got substantially worse. The health economy also faces a serious cash shortfall which will potentially impact on service delivery.”
2.3 **Table 1**: Surrey and Sussex 2005–06 predicted out-turn as at month 12 and the finance plans for 2006–07:

*(source: Surrey and Sussex SHA Board paper—24 May 2006)*

[West Sussex trusts are denoted by **bold, italicised** typeface]

<table>
<thead>
<tr>
<th>Trusts</th>
<th>2005–06 Predicted Out-turn</th>
<th>2006–07 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Trusts:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashford and St Peter’s</td>
<td>−7,560</td>
<td>2,500</td>
</tr>
<tr>
<td><strong>Brighton and Sussex University</strong></td>
<td>−11,290</td>
<td>−20,643</td>
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<tr>
<td>East Sussex County Healthcare</td>
<td>1,330</td>
<td></td>
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<tr>
<td>East Sussex Hospitals</td>
<td>−4,864</td>
<td>−4,500</td>
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<tr>
<td>Royal Surrey County Hospitals</td>
<td>276</td>
<td>0</td>
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<tr>
<td><strong>Royal West Sussex</strong></td>
<td>−13,394</td>
<td>−23,838</td>
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<td><strong>South Downs Health</strong></td>
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<td>Surrey and Borders Partnership</td>
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<td><strong>Sussex Ambulance Service</strong></td>
<td>129</td>
<td>234</td>
</tr>
<tr>
<td><strong>West Sussex Health &amp; Social Care</strong></td>
<td>2,089</td>
<td></td>
</tr>
<tr>
<td><strong>Worthing and Southlands</strong></td>
<td>−10,623</td>
<td>−11,000</td>
</tr>
<tr>
<td><strong>Sussex Partnership</strong> (from April 2006)</td>
<td>801</td>
<td></td>
</tr>
<tr>
<td><strong>NHS Trusts total:</strong></td>
<td>−81,957</td>
<td>−116,749</td>
</tr>
<tr>
<td><strong>West Sussex NHS Trusts total</strong></td>
<td>−73,923</td>
<td>−114,548</td>
</tr>
<tr>
<td><strong>PCT’s:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adur, Arun and Worthing</strong></td>
<td>2,549</td>
<td>0</td>
</tr>
<tr>
<td>Bexhill and Rother</td>
<td>589</td>
<td>0</td>
</tr>
<tr>
<td>Brighton and Hove City</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td><strong>Crawley</strong></td>
<td>121</td>
<td>0</td>
</tr>
<tr>
<td>East Elmbridge</td>
<td>−5,782</td>
<td>−10,000</td>
</tr>
<tr>
<td>East Surrey</td>
<td>756</td>
<td>0</td>
</tr>
<tr>
<td>Eastbourne Downs</td>
<td>−7,217</td>
<td>−12,676</td>
</tr>
<tr>
<td>Guildford and Waverley</td>
<td>−2,037</td>
<td>−22,507</td>
</tr>
<tr>
<td>Hastings and St Leonards</td>
<td>1,539</td>
<td>0</td>
</tr>
<tr>
<td><strong>Horsham and Chanctonbury</strong></td>
<td>−590</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mid Sussex</strong></td>
<td>−1,969</td>
<td>0</td>
</tr>
<tr>
<td>North Surrey</td>
<td>0</td>
<td>−9,000</td>
</tr>
<tr>
<td>Surrey Heath and Woking</td>
<td>0</td>
<td>−6,300</td>
</tr>
<tr>
<td>Sussex Downs and Weald</td>
<td>−3,994</td>
<td>−4,600</td>
</tr>
<tr>
<td><strong>Western Sussex</strong></td>
<td>77</td>
<td>−4,452</td>
</tr>
<tr>
<td><strong>PCT’s total:</strong></td>
<td>−15,937</td>
<td>−69,535</td>
</tr>
<tr>
<td><strong>West Sussex PCT’s total</strong></td>
<td>188</td>
<td>−4,452</td>
</tr>
<tr>
<td><strong>SHA</strong></td>
<td>12,238</td>
<td>62,313</td>
</tr>
<tr>
<td><strong>All health organisations</strong></td>
<td>−85,656</td>
<td>−123,971</td>
</tr>
<tr>
<td><strong>All West Sussex health organisations</strong></td>
<td>−73,735</td>
<td>−119,000</td>
</tr>
</tbody>
</table>

* West Sussex Health and Social Care Trust merged with trusts in East Sussex and Brighton & Hove to form the Sussex Partnership NHS Trust with effect from 1 April 2006.

2.4 The finance plans for 2006–07 show the whole health economy in Surrey/Sussex making a £124 million deficit. The situation is therefore escalating.

2.5 Brighton and Sussex University Hospitals NHS Trust will fail to meet their 3½-year breakeven position this year. The SHA is still formally considering whether to extend the break-even period to five years.
2.6 **Table 2:** The four trusts with the highest deficits in West Sussex:

(Source: Surrey and Sussex SHA Board paper—24 May 2006)

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Royal West Sussex NHS Trust*</td>
<td>15.5m</td>
<td>13.4m</td>
<td>15%</td>
<td>6m</td>
<td>23.8m</td>
</tr>
<tr>
<td>Surrey and Sussex Healthcare NHS Trust*</td>
<td>20.0m</td>
<td>40.8m</td>
<td>30%</td>
<td>17m</td>
<td>60.1m</td>
</tr>
<tr>
<td>Brighton and Sussex Univ Hospitals NHS Trust*</td>
<td>10.0m</td>
<td>11.3m</td>
<td>3%</td>
<td>10m</td>
<td>20.6m</td>
</tr>
<tr>
<td>Worthing and Southlands Hospitals NHS Trusts*</td>
<td>0</td>
<td>10.6m</td>
<td>8%</td>
<td>11m</td>
<td>115.5m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45.5m</strong></td>
<td><strong>76.1m</strong></td>
<td><strong>33m</strong></td>
<td><strong>115.5m</strong></td>
<td></td>
</tr>
</tbody>
</table>

* 3 Trusts have DoH Turnaround Teams in place to recover the financial position. Worthing and Southlands have in the past managed to break even, but this year has seen them go into deficit. They have appointed their own Turnaround Team to focus on problem areas.

2.7 **Table 3:** Deficits over the past three years:


<table>
<thead>
<tr>
<th></th>
<th>2002–03</th>
<th>2003–04</th>
<th>2004–05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal West Sussex NHS Trust*</td>
<td>1.3m</td>
<td>3.5m</td>
<td>15.5m</td>
</tr>
<tr>
<td>Surrey and Sussex Healthcare NHS Trust*</td>
<td>0</td>
<td>4.2m</td>
<td>30.7m</td>
</tr>
<tr>
<td>Brighton and Sussex Univ Hospitals NHS Trust*</td>
<td>0</td>
<td>7.9m</td>
<td>10.0m</td>
</tr>
</tbody>
</table>

* 3 Trusts with DoH Turnaround teams in place to recover the financial position.

2.8 The Department of Health agreed a deficit of £40 million for 2005–06 but this has been overspent. The overall Surrey/Sussex health economy is forecasting a deficit of £85.6 million for 2005–06. This is after £50 million support from the SHA and a non-recurrent allocation of £5.6 million from the impairments fund held by the NHS bank. Without this support the deficit would have been £141.2 million.

2.9 The deficits are substantial in relation to the 2005–06 budget. Surrey and Sussex Healthcare NHS Trust have a deficit that is almost 30% of their budget for the year. The situation has deteriorated over the past three years with little scope for financial recovery and breaking even. Potential funding changes could exacerbate the situation further.

2.10 Long term financial problems have existed but the actions taken to date have not been sufficient to improve the situation. Financial recovery and service improvement plans have not been delivered, many have relied on short-term solutions rather than taking a longer-term strategic view. There does not appear to be enough finance capacity to manage the plans. However, other targets are being achieved which shows finance targets have been given a lower priority.

3. The reasons for the deficits

3.1 The reasons for the deficits are many and complex, but the following paragraphs detail some of the reasons for the high level of deficits in the county. Reasons given by independent consultants in their review of Surrey and Sussex (Sustainable Services for Surrey and Sussex (S4)—July 2005) are:

— based on weighted population Surrey and Sussex overspends on healthcare. This is a result of higher than average levels of activity and high unit costs in some areas.

— trusts may not be operating optimally—low day case rates, high bed capacity and longer than average lengths of stay.

— high spending in primary care which is not offset by lower spending in secondary care.

3.1.1 It is thought locally that the main reasons for deficits are low historic reference costs, pay settlements, target achievements and local management arrangements.

3.1.2 In future years Payment by results (PbR) will impose national tariffs which will benefit those trusts with lower than average reference costs. PbR will result in competing demands of acute and primary trusts as they will have a differing focus. One will want to increase throughput to gain maximum income whilst the other will want to control expenditure. This will impact on the financial position of organisations and impact on the deficit situation.
3.1.3 Pay modernisation has had an adverse effect on trusts’ financial position, especially in respect of Agenda for Change and the new Consultant Contract. The high cost of temporary agency or bank staff has remained a real problem for most trusts in the county.

3.1.4 Cost pressures have not always been fully funded or planned (eg pay awards to doctors and nurses and other health staff, expensive drugs and the use of new technologies).

3.1.5 Efficiencies have not always been delivered (eg reduced length of stay, too many delayed transfers of care, insufficient numbers of day cases etc.)

3.1.6 Plans have been difficult to achieve as “silo working” often exists in acute trusts. There is often a lack of communication between departments which means managers are faced with competing demands, which are difficult to meet.

3.1.7 Many acute trusts in West Sussex are based on multi-site premises. This may result in higher than average building maintenance, some duplication of services and increased staff and travel costs. Hard decisions may be necessary to close sites, but this will obviously not be popular.

3.1.8 Some trusts have had to pay for private sector facilities (eg the Sussex Partnership NHS Trust).

3.1.9 Poor cost control and budget management.

3.1.10 Surrey/Sussex also has higher than average referrals from GP’s. This could indicate a population that is better informed and therefore more able to demand better/quicker care.

3.1.11 Other causes of deficits include higher drugs costs and longer lifespans.

3.2 The Audit Commission made the following recommendations in order to control the deficit situation (Public Interest Report—Dec 2005):

— develop and deliver robust, integrated plans across the whole health economy. This may include making radical changes;
— improve financial recovery planning and forecasting;
— strengthen performance management.

4. FUNDING ALLOCATIONS UNDER THE CURRENT FUNDING FORMULA

4.1 Table 4: Per Head Funding Allocations 2007–08

(source: Department of Health)

<table>
<thead>
<tr>
<th>PCT</th>
<th>2007–08 revenue allocation (£000’s)</th>
<th>% increase</th>
<th>Allocation per head of population (£’s)</th>
<th>Over/under England average (£’s)</th>
<th>Position in table (x/314)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England</strong></td>
<td>70,354,697</td>
<td>9.4</td>
<td>1,388</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Sussex:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adur, Arun &amp; Worthing</td>
<td>328,196</td>
<td>8.2</td>
<td>1,491</td>
<td>103</td>
<td>76</td>
</tr>
<tr>
<td>Crawley</td>
<td>141,706</td>
<td>9.5</td>
<td>1,245</td>
<td>−143</td>
<td>228</td>
</tr>
<tr>
<td>Horsham &amp; Chanctonbury</td>
<td>133,792</td>
<td>9.9</td>
<td>1,094</td>
<td>−294</td>
<td>300</td>
</tr>
<tr>
<td>Mid-Sussex</td>
<td>165,638</td>
<td>8.1</td>
<td>1,222</td>
<td>−166</td>
<td>244</td>
</tr>
<tr>
<td>Western Sussex</td>
<td>264,691</td>
<td>8.2</td>
<td>1,454</td>
<td>66</td>
<td>97</td>
</tr>
<tr>
<td><strong>Highest per head allocation:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islington</td>
<td>363,928</td>
<td>8.0</td>
<td>1,956</td>
<td>568</td>
<td>1</td>
</tr>
<tr>
<td><strong>Lowest per head allocation:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wokingham</td>
<td>155,932</td>
<td>8.7</td>
<td>1,068</td>
<td>−320</td>
<td>314</td>
</tr>
</tbody>
</table>

Notes to Table 4:

— 3 out of 5 PCTs are below the average allocation per head of population for England.
— 3 out of 5 PCTs are in the bottom half of the table in relation to allocation per head of population.
— 3 PCTs have a below average percentage increase in allocation.

4.2 The below average funding allocations to Crawley, Horsham and Chanctonbury and Mid-Sussex result in substantially lower funding. For example if Horsham and Chanctonbury were funded at the English average they would receive £36m extra funding. They therefore have less to spend which has a knock-on effect throughout the whole health economy, which is exacerbating the deficit situation further.

4.3 Some NHS Trusts may face competition from other providers (eg Independent Treatment Centres) which could result in future loss of income.
4.4 Income streams will become more volatile in the future due to Payment by Results and practice-based commissioning. This will make it even more difficult to re-pay deficits. The 2006–07 year has experienced greater financial uncertainty due to the late notification of accurate tariffs which has resulted in problems producing financial plans.

4.5 In relation to the application of the current funding formula and its adverse impact on health organisations in the south-east of England, we would draw your attention to the submission made by the Chairmen of Overview and Scrutiny Committees for the south east of England mentioned on the first page of this memorandum.

5. THE FINDINGS OF THE TURNAROUND TEAMS

5.1 Royal West Sussex NHS Trust has identified £8.8 million savings as part of its Turnaround Plan, but the turnaround plan was only approved by the Department of Health last week, so it is too early to say if the team has proved value for money and/or the findings are correct.

5.2 Brighton and Sussex University Hospitals NHS Trust has announced £10 million savings over the next year, £18.6 million savings in 2007–08, as part of its Turnaround Plan, but in March 2006 the Trust was still overspending by £1 million per month. The Trust requires £50 million new revenue by 2008–09 to cover a £34.5 million deficit that year.

5.3 Surrey and Sussex Healthcare NHS Trust announced in May 2006 that they had identified £20.9 million savings, but in May 2006 the Chief Executive informed us that the Trust was still running an overspend of £1.5–£2 million per month (as against an overspend of £3.2 million per month in the summer of 2005). He added that the Trust would need to operate at a surplus of £5 million pa over 20 years to repay their current debt. The Trust borrowed £60 million at the end of 2005 to pay staff and will have to pay £2.7 million in interest payments alone this year on all their borrowings.

5.4 Worthing and Southlands Hospitals NHS Trust’s plan has not yet been finalised.

5.5 The costs of the turnaround teams are detailed below:

— Royal West Sussex NHS Trust—around £500,000 (quoted by Andrew Tyrie in a press release).

— Brighton and Sussex University Hospitals NHS Trust—we do not have the actual cost but the SHA has made a £2 million spend to save contribution.

— Surrey and Sussex Healthcare NHS Trust—£697,896 (Gary Walker quoted in BBC News website report on 11 May). Laura Moffatt, MP’s view is that this is value for money as the Turnaround Team have “stemmed the leaking of money” and that “the savings within the first month exceeded the Team’s costs significantly”.

5.6 The striking feature is that each of the Turnaround Teams has a different approach. However, a common theme is job losses to be realised through re-grading and natural wastage with few actual redundancies. Length of stay is a major focus for some but not all trusts. New revenue workstreams have been identified as pivotal by the Royal West Sussex Trust and the Brighton and Sussex University Hospitals Trust. Estates strategy is a key capital realisation by the Royal West Sussex Trust and the Brighton and Sussex University Hospitals Trust. Cultural change is being managed in different ways although each trust has a formal programme.

6. THE IMPLICATIONS/CONSEQUENCES OF THE CURRENT DEFICIT POSITION:

6.1 The current financial position of West Sussex health organisations has already started to have the following impact on healthcare organisations and service provision:

6.1.1 The following job cuts have been announced over the past few months:

— Surrey and Sussex Healthcare NHS Trust—400 job cuts (300 temporary and bank staff with 100 redundancies, mainly in management, admin, and clerical grades, but some nursing and frontline staff could be among those to go).

— Brighton and Sussex University Hospitals NHS Trust—325 job cuts, but most are likely to come through natural turnover, retirement or voluntary redundancy.

— Royal West Sussex NHS Trust—200 posts by 2008–09, but every effort will be made to minimise redundancies although this may regretfully be necessary for some posts if no suitable alternative options are available.
The SHA believes that job losses in West Sussex will be minimal and that any redundancies will probably arise from management reorganisations. They say that clinical redundancies are unlikely, as numbers will be reduced by removing long-term vacant posts and a significant reduction in the use of agency and bank support.

6.1.2 Serious cash shortfalls have been experienced which will affect service provision in terms of ability to pay for goods and payroll.

6.1.3 As a social care commissioner and provider, the County Council is concerned that:

- NHS organisations in the county have withdrawn funding from pooled budgets as a direct result of their deficit position. In West Sussex £455,000 was withdrawn from pooled budgets in 2005–06 and £247,000 was withdrawn in 2006–07. The five PCTs in West Sussex chose to use these monies from their Learning Difficulty Development Funds (LDDF) to offset against their overspends rather than invest in developments to improve services to users. 96 people remain in long-term health provision and the LDDF could have supported the development of alternative accommodation for a number of these individuals.

- £2.1 million was outstanding to the County Council from the NHS as at 17 May 2006 (including £0.611 million relating to transactions before 2006).

6.1.4 Some trusts believe that the financial challenges within the local health economy have impacted on their ability to implement National Service Framework standards in the timescales envisaged. The vast majority of these services have been resourced by recycling existing resources.

6.1.5 Some of the acute trusts’ capital programmes in West Sussex have been top-sliced (eg Worthing & Southlands Hospitals NHS Trust has had its capital programme reduced from £3 million to £2 million). It should be noted that the capital programme pays for equipment such as scanners etc. as well as buildings, so this could have a dramatic effect on service delivery.

6.1.6 The Sussex Partnership Trust states that “the Trust has not been in receipt of large amounts of new investment for service improvement over recent years, although, services have been modernised to some extent. Any arbitrary reductions in funding would undoubtedly lead to a closure of services currently provided”.

6.2 We believe that the current financial crisis in the West Sussex health economy will have potentially very damaging consequences for health services in the county in the immediate future and beyond. We are aware of the following issues which will become increasingly important over the next year or so:

6.2.1 The SHA will be carrying out a strategic review of all health services in the area, particularly the “settings of care” which will be subject to public consultation later in the year (probably in the autumn). This review will have huge repercussions for acute services and the development of more community-based services. We believe that there will be no financial capacity to “double-run” these services while the transition takes place: it is likely that acute services will shut to release money to fund services in the community or the worst case scenario is that the money released will be absorbed by the deficit.

6.2.2 Concerns have been raised by local PPIFs that the new PCT for West Sussex (which will replace the current five PCTs) will not be adequately funded to introduce locality working and be able to support GPs sufficiently to enable them to make the most of developments in Practice Based Commissioning — starting with a deficit puts them at such a huge disadvantage.

6.2.3 The Strategic Health Authority (SHA) allocates growth monies to PCT’s each year. This equates to approximately 9% of their allocations. Six percent of the growth monies is used to fund inflationary increases in salaries, drugs etc. The SHA has decided to top-slice the remaining 3% from each PCT to distribute across those organisations in deficit to try and even up the situation. Those PCT’s in deficit will therefore receive the additional funds whilst those in surplus won’t. The SHA is effectively reducing the cash allocations to some PCT’s but so that no organisation is disadvantaged extra capital allocations will be made. The top-slicing exercise will ease the deficit situation but will not be enough to solve the substantial problems being faced.

7. CONCLUSIONS

7.1 In summary we do not believe that the current government’s response to the financial problems of its residents of West Sussex is adequate or moral. Promises that have been made to improve —not worsen— health provision has not been met. Worse, tax payers money has been squandered with no benefits—even in sight. The on-going debt of the trusts cannot realistically be resolved in isolation.

7.2 This government has to take responsibility for and ownership of the failings of the health economy of which it has had stewardship for the last 10 years. This government must as a matter of extreme urgency:

- revisit a highly flawed funding formula, which blatantly favours residents of the country where this labour government sees its voting heartland. A simple and honest analysis of the numbers would show this to be true—and such an analysis should be done;

- pay the costs nationally of all turnaround teams—and then hold to account the trusts receiving the turnaround advice to deliver;
— waive the historic deficits and cease forthwith charging these trust bodies interest on these sums which is not only immoral but entirely counter productive;
— develop, consult on and deliver a properly thought through strategy and business plan to move our health economy to one which provides better and more accessible health provision in the local community while continuing to deliver best in class acute care when and where it is really needed.

Anne Marie Morris
Chairman, West Sussex Health Scrutiny Select Committee
6 June 2006

Evidence submitted by Anonymous GP (Def 05)

The size of NHS deficits is not known because PCTs are unable to accurately report them, having moved virtual money between virtual funds and accounts so often that they do not actually know which are real deficits and which virtual now.

The reasons include: bodies keeping each other in the dark about how much they will charge at the year end, or when funding will run out; one part of the PCT not communicating to another relevant part that they are aware that the actual amount paid is not in line with the budgeted amount, that the service activity will be overachieved before the end of the year, necessitating an extra cost in paying the Trust to continue the service over the intervening months, incompetence in “corporate planning”—meaning in actually having someone with an overview and charged responsibility to know that one hand knows what the other is doing, and too many people with their own individual agendas; this last point is greatly added to by the continual changes and moving of goal-posts, such that one department thinks it is still trying to achieve last year’s target in last year’s way with an inflation-proofed budget, when in fact the item was not budgeted and the activity should have stopped. No-one in PCTs seems responsible for ensuring contracts are monitored through the year and promised funding or activity levels continued.

Another big contributor is that PCT officers do not have sufficient respect for providers. They do not believe estimates and predictions given by GPs and staff. They tend to dismiss our contribution as irrelevant, because practices are relatively small individually, not realizing that we add up to a whole that can achieve a lot if properly motivated with a clear direction, simple plan that involves us and is considerate of our needs and difficulties, and given that we know we have the confidence of the PCT to get on with achieving a clinical goal in the best way we can manage, rather than having to conform to frequently changing directions and unworkable ill-thought-out campaigns that often bear no relation to what reality can expect of the “public”.

Employee relations is the other big failure of PCTs/Trusts at the moment. Far too many staff are employed on huge locum salaries because employers offer only short term contracts with awful terms/conditions, and low remuneration—such that staff will look elsewhere in preference to making a commitment to a fixed job, yet permanent staff with less change would be more efficient in terms of costs of service delivery as well as clinical outcomes!

There needs to be some external body that looks at the achievement of PCTs and their individual staff and officers, and removes those that are not achieving, replacing them with those better able to do the job needed in an NHS culture, instead of promoting the less able and less-well-liked to positions of greater responsibility and greater salary, then employing an extra person to do the actual work.

Anonymous GP
16 May 2006

Evidence submitted by Professor Sheena Asthana and Dr Alex Gibson (Def 12)

The Relationship Between the Funding Formula, the Allocation of Funds to Trusts and the Size of Their Deficits or Surpluses

AUTHORS
Sheena Asthana is Professor of Health Policy at the University of Plymouth and Board Member of the Commission for Rural Communities. Alex Gibson is Research and Innovation Fellow at the Faculty of Health and Social Care, University of Plymouth. Jointly, they have undertaken extensive research on health care equity, specialising in the development of condition-specific morbidity-based (as opposed to utilisation-based) health needs estimates (eg *J Epidemiol Commun Health* 58:303–7; *Health & Place* 8:47–60). They were part of the first team to have evaluated a morbidity-based capitation approach to health resource allocation (*Soc Sci Med* 58:539-51) and have presented a paper on the subject to the Technical Advisory Group of the Advisory Committee on Resource Allocation on 22 May 2001 (“Resource Allocation Methodologies for the prevention and treatment of specific diseases: a critical review of the attribution and resource-weighting of condition-specific indicative prevalences”).
Through this work they identified a systematic bias in health funding against rural areas (Health & Soc Care 11:486–93), a case supported by their recent observation that primary care trusts in rural areas are significantly more likely to be in deficit than their urban counterparts (BMJ 331:1472). This work has been referred to in the emerging debate (eg House of Commons, Hansard 20 March 2006, Col 86) concerning the under-resourcing of health services in rural areas. In addition, Asthana has research expertise in health inequalities and evidence-based public health (Asthana, S and Halliday, J (2006) What Works in Tackling Health Inequalities? Pathways, Policies and Practice through the Lifecourse. Bristol: Policy Press).

Gibson and Asthana are currently investigating the service consequences of formula funding and expect to adduce further evidence relevant to the Select Committee’s enquiry over the next six months. They are submitting written evidence to the Health Committee’s Inquiry on NHS deficits as individuals, not on behalf of any organisation.

INTRODUCTION

1. The publication of the health service’s annual accounts in September 2005 revealed that 156 NHS trusts ended 2004–05 in deficit. Although these include acute, primary care and mental health trusts, most media attention has focused on the impact of deficits within acute trusts where reductions in staff and key services in response to funding shortfalls have been widely reported. However, NHS resources are primarily allocated to PCTs. As these organisations are responsible for the commissioning of acute and community care, the financial status of acute hospitals is largely dependent upon the financial status of the PCTs they serve. Against this background, it is important to consider the factors associated with deficits in PCTs.

THE PATTERN OF PCT DEFICITS: SYSTEMIC OR LOCAL?

2. NHS deficits are presented by government as a problem of local “overspending, sometimes for several years, or poor financial management, or poor organisation of clinical services”1. However, if risk of deficit is determined by the quality of a trust’s management then one would expect a broadly random distribution of trusts in financial difficulties. This is not the case.

3. For Table 1 we allocated 301 PCTs into their 2004–05 per capita allocation and deprivation quintiles2. The distribution of PCTs in deficit, as given in Table 1, illustrates how strongly deficits are associated with both the per capita allocation of funds and the level of deprivation. For instance, only four of the 60 PCTs in the most deprived quintile ended 2004–05 in deficit (6.7%), compared with 36 of the 60 PCTs in the most affluent quintile (60.0%). The former, on average, were allocated £1,166 per capita whereas the latter were allocated only £860 per capita. The systematic relationship between deprivation, level of funding and deficits shown in Table 1 suggests, as others have observed3, that poor financial and/or clinical management is a highly unlikely explanation for the financial difficulties experienced by PCTs.

Table 1

| PRIMARY CARE TRUSTS IN DEFICIT, 2004–05, BY RESOURCE ALLOCATION AND DEPRIVATION QUINTILES |
|--------------------------------------------------|------------------|-----------------|-----------------|--------------------|
| Per capita resource allocation by quintiles      | Overall          | Average per capita allocation, 2004–05 |
| Lowest per capita allocation                    | 2nd              | 3rd              | 4th              | Overall            |
| Most Deprived Quintile                          | 4                | 4                | 4                | 33 (55.0%)         |
| 2nd                                              | 2                | 1                | 2                | 4 (6.7%)           |
| Least Deprived Quintile                         | 25               | 8                | 2                | 36 (60.0%)         |
| Overall                                          | 33 (55.0%)       | 26 (43.3%)       | 19 (31.1%)       | 6 (10.0%)          |

4. Of course, the fact that per capita allocations vary is not, in itself, significant. This simply reflects one of the central tenets of resource allocation in the UK: that Primary Care Trusts should receive funding that is commensurate with the needs of the populations they serve. To that end a complex funding formula is used to distribute resources between PCTs so as “to secure equal opportunity of access to health care for people at equal risk”. This formula responds strongly to the needs of urban deprived populations and results in profound differences in per capita funding. For instance, with £1,556 per capita, Islington PCT (serving a highly deprived population) was in 2004–05 allocated more than twice the £752 per capita deemed necessary to provide for the health care needs of the relatively affluent population served by Wokingham PCT. The issue, therefore, is not whether per capita allocations should vary between PCTs, but whether the variation is appropriate relative to needs of their populations.
5. The fact that deficits are so much more common among PCTs serving less deprived communities thus raises two alternative explanations; (a) that more affluent populations are using health services at a higher rate than implied by their health care needs, or (b), that formula funding provides insufficient resources for the health needs of these populations.

**Does the Pattern of Deficits Reflect the Higher Demands of Affluent Communities?**

6. Although claims that the accessibility and use of NHS services are subject to an “inverse care effect” have become received wisdom, research evidence that demonstrates a “pro-rich” bias in health care is equivocal. For example, early reports that poorer social groups had lower than predicted rates of utilisation have been challenged by evidence that suggests that poorer people receive as much if not more health care than richer people for equal need. With respect to the utilisation of hospital care (which accounts for 62% of overall NHS expenditure), some evidence suggests that, relative to estimated morbidity, deprived groups—particularly those that are close to acute hospitals—access inpatient services to a greater extent than predicted.

**Table 2**

| DEMOGRAPHIC PROFILES OF PCT POPULATIONS, 2004-05, BY DEPRIVATION QUINTILE |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
|                             | Per cent population in selected age bands |                             |                             |                             |
|                             |                 | 0-4 | 5-44 | 45+ | 65+ | 75+ |
| Most Deprived Quintile     |                             |     |      |     |     |     |
| 2nd                        |                             |     |      |     |     |     |
| 3rd                        |                             |     |      |     |     |     |
| 4th                        |                             |     |      |     |     |     |
| Least Deprived Quintile    |                             |     |      |     |     |     |
| Overall Average            |                             | 5.88% | 53.78% | 40.34% | 16.23% | 7.71% |

7. As illustrated in Table 2, more affluent PCT populations are, on average, significantly older than more deprived PCT populations. Chronic conditions such as heart disease, stroke, arthritis and cancers become more prevalent in later years. Because gradients in the prevalence of these diseases are significantly steeper across age bands than across social class bands, demographically ageing populations could well have higher absolute levels of morbidity than demographically younger populations, even if their relative health needs are lower. Thus, with reference to underlying morbidity, PCTs serving more affluent areas might be expected to make greater use of health services. The fact that they do not, as illustrated in Table 3, supports the notion that affluent populations are not profligate users of health services.

**Table 3**

<table>
<thead>
<tr>
<th>HOSPITAL EPISODE STATISTICS, 2004-05</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT Deprivation, IMD 2004, by quintiles</td>
</tr>
<tr>
<td>Most Deprived</td>
</tr>
<tr>
<td>2nd</td>
</tr>
<tr>
<td>3rd</td>
</tr>
<tr>
<td>4th</td>
</tr>
<tr>
<td>Least Deprived</td>
</tr>
<tr>
<td>Overall Average</td>
</tr>
</tbody>
</table>

| Finished Consultant Episodes per capita | 0.31 | 0.29 | 0.28 | 0.26 | 0.25 ** | 0.28 |
| Hospital Admissions per capita         | 0.28 | 0.28 | 0.25 | 0.23 | 0.22 ** | 0.25 |
| Emergency Admissions per capita        | 0.107 | 0.096 | 0.088 | 0.083 | 0.074 ** | 0.090 |
| Day cases per capita                   | 0.083 | 0.082 | 0.082 | 0.076 | 0.074 * | 0.079 |
| Bed days per capita                    | 1.25 | 1.13 | 1.10 | 1.07 | 0.97 ** | 1.10 |

**The difference between the most deprived and least deprived quintiles is significant at 0.01.
* The difference between the most deprived and least deprived quintiles is significant at 0.05.

**Does Formula Funding Reflect the Needs of Affluent Communities?**

8. The cost implications of managing long-term chronic and/or degenerative conditions among older people are considerable. For instance, recent analysis of a longitudinal English data set found a 30% increase in costs from age 65 to 85. The fact that rates of mortality are highest in the oldest age cohorts also has important cost implications. Progressive and fatal illness is strongly associated with the provision of high intensity care, increasing costs tenfold from five years prior to death to the last year of life. Against this background, one would expect PCTs serving affluent areas comprising demographically older populations to be allocated more resources on the basis of their populations’ higher levels (in absolute terms) of morbidity and mortality. This is not the case. As shown in Table 1 above, average PCT per capita funding allocations steadily decline from the most deprived to the most affluent.
9. This reflects the fact that, in effect, equal weighting is given to the age-related and additional needs elements of the weighted capitation model that underpins formula funding. The extent to which formula funding captures the actual health care needs of demographically and socially diverse communities rests on whether this is in fact appropriate, and on how the age-related and additional need indices have been calculated.

A CRITIQUE OF THE WEIGHTED CAPITATION MODEL

10. The problems associated with the empirical model which underpins formula funding are well rehearsed. Deriving health care needs from an analysis of existing patterns of health care utilisation, for instance, presupposes that historical patterns of service uptake between different care groups (as revealed by utilisation) are appropriate, a problematic assumption that can lead to the perpetuation of resource bias.

11. For example, although the age-cost curves that are used in all three components of the current weighted capitation formula acknowledge the rising costs of care for older age groups, there are widespread concerns about ageism in access to health care, particularly with respect to specialist interventions. If, as is accepted by the National Service Framework for Older People, older patients can and should gain from more intensive treatment, then per capita allocations for older age bands may well be conservative.

12. Our particular concern, however, is with the approach taken to assessing, and then incorporating within the final weighted capitation model, “additional needs”. These indices are designed to capture health care needs over and above those accounted for by age. Some are derived from small area modelling of utilisation statistics (where needs indicators are identified as those socio-economic and health-related variables that most closely correlate with patterns of utilisation). Reading “additional needs” off utilisation statistics is problematic. This element of the Hospital and Community Health Services (HCHS) formula captures the relatively high rates of hospital use made by urban deprived populations. However, use of health care is not synonymous with health care “need”. As noted above, some evidence suggests that, relative to estimated morbidity, deprived groups make greater use of inpatient services to a greater extent than predicted. It is quite plausible that higher rates of hospital use by urban deprived communities are not an indication of “additional needs” but of inappropriate hospitalisation. If this is the case, it would be more effective to strengthen primary and community management in these areas than to provide “additional” funds for hospital services.

13. The additional needs index of the HCHS formula also incorporates socio-economic variables that are associated with the age- and sex-standardised predicted prevalence of a number of long-standing illnesses (the “additional morbidity” variables). These are designed to capture the effect of unmet need. However, it is debatable whether the overall effect of the additional needs element is to capture “additional”/“unmet” need for health care or to highlight the fact that, once differences in the age structure of populations are controlled for, urban deprived communities have higher relative needs (more commonly referred to as health inequalities). This is an important distinction because the goals of health care equity and health equity require very different policy responses.

14. Deprived groups that experience higher rates of premature disease must of course have access to high quality treatments and procedures as these can play a significant role in improving quality of life and risk of mortality. Thus, it is essential that additional burdens of disease associated with deprivation are proportionately met in allocations for core services. However, we should not overlook that fact that the goal of reducing health inequalities is essentially about prevention. It is generally agreed that the NHS (and particularly national hospital services) has relatively little to contribute towards this goal compared to other sources of variation such as income distribution, education, housing and lifestyle. Directing resources to provide curative services for urban deprived populations over and above those deemed necessary by absolute morbidity levels would be an ineffective response to health inequalities and would result in an inequitable distribution of resources.

15. This is what presently occurs. Demography is a more significant determinant of morbidity than deprivation (demographic gradients in disease prevalence being significantly steeper than social class gradients). Yet equal weighting is given to the age and additional needs elements in the weighted capitation model. This has the effect of overestimating the health care needs of demographically younger deprived populations and underestimating the health care needs of demographically older affluent populations. This would in large measure explain the pattern of deficits revealed in the 2004–05 accounts.

16. However, it does not entirely explain that pattern of deficits. In December 2005, we published a letter in the British Medical Journal noting that PCTs serving affluent rural populations were the most likely to be in financial difficulties. Thus 17 of the 25 (68%) trusts that were in both the least deprived and most rural quintiles were in deficit at the end of 2004–05, compared to only 3% (one of 34) of the PCTs serving populations in the most deprived and most urban quintiles. The problem lies, once again, with formula funding.

17. In addition to including adjustments for age-related need and additional need, the HCHS component of the resource allocation formula adjusts for variations in the “unavoidable costs of providing health care”. Like the adjustments made for need, this element of the formula is strongly biased towards urban England. For example, the Market Forces Factor (MFF) captures relatively high wage rates in metropolitan areas...
and the low pay effect present in many rural areas. Yet, most NHS staff are paid on national pay scales and the overall cost of staff is more a function of their seniority than their location. Thus as Andrew George, MP for St Ives noted earlier this year with respect to his own constituency, although “Cornwall is at the bottom of the earnings league table for both the public and the private sector, those employed in the NHS tend to be found at the upper end of their pay scale. If anything, we should be getting more money to reflect that, rather than less.”

18. Nor, despite sustained critique, does the formula consider rurality to be a legitimate cause of variation in “costs” of providing services (with the exception of emergency ambulance provision). In this respect, health resource allocation differs from local government allocations in England and is at odds with other countries in the UK.

19. Reflecting these weaknesses in formula funding, as well as the fact that rural PCTs tend to serve more affluent populations, rural PCTs receive lower than average resource allocations (Table 4). Yet, as rural PCTs tend to serve demographically older populations, they might be expected to have higher absolute levels of morbidity and mortality. Against this background, it is hardly surprising that the prevalence of deficits rises steadily from the most urban to the most rural areas, notwithstanding the fact, according to the 2005 State of the Countryside report, rural residents make less use of the National Health Service than urban residents.

Table 4

<table>
<thead>
<tr>
<th>Per cent population in villages and dispersed settlements</th>
<th>Average per capita allocation, 2004-05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Deprived Quintile</td>
<td>Overall</td>
</tr>
<tr>
<td>1st</td>
<td>4 (6.7%)</td>
</tr>
<tr>
<td>2nd</td>
<td>6 (10.0%)</td>
</tr>
<tr>
<td>3rd</td>
<td>7 (11.7%)</td>
</tr>
<tr>
<td>4th</td>
<td>8 (13.1%)</td>
</tr>
<tr>
<td>Least Deprived Quintile</td>
<td>9 (15.0%)</td>
</tr>
</tbody>
</table>

20. In summary, the formula funding introduces a systematic bias in favour of deprived and urban areas and against affluent and rural areas because of the way in which it assesses “need” for health care and because of the way in which it compensates for unavoidable variations in the costs of providing health services.

21. These systematic biases are not new. However, in the past, large and heterogeneous health authorities could accommodate differences between localities in their need of health resources (with the exception of relatively homogeneous rural areas such as Cornwall which has experienced long term difficulties in its level of funding). With allocation to PCTs, Strategic Health Authorities have continued to shift resources around the system to support trusts in financial difficulty. The government now insists that all NHS organisations have to “live within the resources available to them.” According to Patricia Hewitt:

“In the NHS in the past—this goes back decades—deficits in a minority of organisations were covered up. Money was moved around the system from a surplus organisation to a deficit organisation. The deficit trusts, those parts of the NHS that were overspending, were bailed out by other parts of the NHS that often had equal or greater health care needs. There was no incentive in the system that we inherited from the Conservatives to change or to improve. That is why we are changing the system.” (Patricia Hewitt, Secretary of State for Health, 15 November 2005).

22. The government’s decision to put a stop to such brokerage is the main reason why longstanding biases in the funding formula against affluent, and particularly rural affluent populations have become manifest in the form of deficits. With an ongoing shift of resources away from precisely those areas that already suffer this bias in funding, differences in services will inevitably worsen.
an additional £588 per capita by 2007–08.\textsuperscript{18} The 10% least deprived PCTs, meanwhile, were allocated only £773 per capita but were still 5.1% above target. These PCTs will receive, on average, only an additional £382 per capita by 2007–08.

24. For some PCTs, the relative shift in funding is pronounced. For instance, Easington PCT’s initial 2003–04 allocation (based on the previous year’s allocation) would have been 22.2% below its weighted capitation target. Westminster PCT’s initial allocation, meanwhile, was 31.7% above target. Positive efforts are being made to reduce these “discrepancies” or Distance from Targets (DFTs). Thus, by the end of 2007–08 Easington’s DFT will have been raised to only 3.5% below target whilst Westminster’s will have been trimmed to 11.6% above target.

25. With this progressive shift of resources the financial difficulties facing PCTs that are already in deficit can only get worse. Table 5 shows that, by the end of 2004–05, only four of the 60 (6.7%) PCTs with the greatest funding increase between 2003–04 and 2004–05 were in deficit, compared to no less than 34 of the 60 (56.7%) PCTs with the smallest increase in funding\textsuperscript{19}. Thus, PCTs in deficit are receiving significantly lower than average increases in funding.

Table 5

<p>| PRIMARY CARE TRUSTS IN DEFICIT, 2004–05, BY INCREASE IN ALLOCATION 2003–04 TO 2004–05 AND DEPRIVATION |</p>
<table>
<thead>
<tr>
<th>-------------------------------------------------</th>
<th>----------------------------------</th>
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<th>------------------</th>
<th>------------------</th>
<th>------------------</th>
<th>------------------</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Deprived Quintile</td>
<td>4 (6.7%)</td>
<td>£106</td>
<td>£106</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Quintile</td>
<td>6 (10.0%)</td>
<td>£92</td>
<td>£92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd Quintile</td>
<td>21 (34.4%)</td>
<td>£84</td>
<td>£84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th Quintile</td>
<td>22 (36.7%)</td>
<td>£79</td>
<td>£79</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least Deprived Quintile</td>
<td>36 (60.0%)</td>
<td>£72</td>
<td>£72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>34 (56.7%)</td>
<td>22 (36.7%)</td>
<td>19 (31.1%)</td>
<td>10 (16.7%)</td>
<td>4 (6.7%)</td>
<td>89 (29.6%)</td>
</tr>
</tbody>
</table>

26. There is a real danger that by the end of the current funding round in 2007–08 formula funding will have created what Tony Baldry, MP for Banbury in Oxfordshire, described as the “two Englands”\textsuperscript{20}. One, predominately urban and northern, will be served by an increasingly well-resourced health service. The other, a largely rural, suburban and relatively affluent England, will have to contend with an ever more hard-pressed service adjusting to progressively lower levels of relative per capita funding.

THE TWO ENGLANDS: EMERGING DIFFERENCES IN LOCAL NHS SERVICES

27. Evidence of significant differences in the level of service available to patients in different PCTs is already becoming apparent. As shown in Table 6, at the PCT-level average waiting times vary according to deprivation. Thus patients in the 60 most affluent areas had to wait, on average, 16.5 days longer for an inpatient appointment than patients in the 60 most deprived areas. As waiting lists are a key method of managing demand, this suggests that NHS services are already under significant strain in the more affluent areas.

28. In terms of length of stay and bed days per admission and episode, Table 6 shows that there is little difference between PCTs in the different deprivation quintiles. However, as noted in paragraph 7, patients from more affluent PCTs are, on average, significantly older than those from more deprived PCTs. As age is usually associated with a greater degree of co-morbidity and thus a greater demand on hospital resources, it might be expected that the older set of patients from the more affluent PCTs would, on average, stay in hospital longer than the younger set of patients from the more deprived PCTs. That they do not may indicate that relatively low per capita allocations are affecting patterns of treatment. In fact, once the average age of patients and overall level of deprivation is controlled for, there are strong positive correlations at PCT level between per capita allocations and mean and median length of stay (r = 0.406 and r = 0.218 respectively), average bed days per admission (r = 0.430) and average bed days per episode (r = 0.522). In other words, allowing as best we can for any co-morbidity associated with demography and deprivation, the greater the resource available to PCTs the longer their patients are staying in hospital.
Table 6

HOSPITAL EPISODE STATISTICS, 2004–05

<table>
<thead>
<tr>
<th>PCT Deprivation, IMD 2004, by quintiles</th>
<th>Most Deprived</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Least Deprived</th>
<th>Overall Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Waiting Time (days)</td>
<td>74.28</td>
<td>80.95</td>
<td>86.43</td>
<td>91.37</td>
<td>90.73 **</td>
<td>84.76</td>
</tr>
<tr>
<td>Median Waiting Time (days)</td>
<td>46.22</td>
<td>52.48</td>
<td>54.80</td>
<td>59.77</td>
<td>60.18 **</td>
<td>54.69</td>
</tr>
<tr>
<td>Mean length of stay (days)</td>
<td>7.00</td>
<td>6.80</td>
<td>7.13</td>
<td>7.25</td>
<td>7.17</td>
<td>7.07</td>
</tr>
<tr>
<td>Median length of stay (days)</td>
<td>1.87</td>
<td>1.92</td>
<td>1.97</td>
<td>2.05</td>
<td>1.98</td>
<td>1.96</td>
</tr>
<tr>
<td>Bed days per admission</td>
<td>4.60</td>
<td>4.49</td>
<td>4.51</td>
<td>4.63</td>
<td>4.43</td>
<td>4.53</td>
</tr>
<tr>
<td>Bed days per Finished Consultant Episode</td>
<td>4.03</td>
<td>3.89</td>
<td>3.98</td>
<td>4.09</td>
<td>3.96</td>
<td>3.99</td>
</tr>
<tr>
<td>Mean Age of Patients (years)</td>
<td>46.75</td>
<td>48.48</td>
<td>50.41</td>
<td>51.27</td>
<td>50.32 **</td>
<td>49.45</td>
</tr>
</tbody>
</table>

** The difference between the most deprived and least deprived quintiles is significant at 0.01.
* The difference between the most deprived and least deprived quintiles is significant at 0.05.

Recommendations

29. There should be an immediate relaxation of the government’s ban on brokerage. Deficits are systematic and not due to local inadequacies in management and, whilst the existing formula funding system is in place, brokerage offers the only means of moderating its pernicious effects.

30. There should be an immediate investigation of how service provision varies across the country, particularly in the context of the health needs of populations and the resources currently allocated to address those needs. Our own use of Hospital Episode Statistics to investigate PCT-level service variations is exploratory and there is clearly scope for a detailed critique of the service consequences of formula funding. As a matter of priority this investigation should consider alternative methods of assessing healthcare needs, particularly the opportunities afforded by synthetic estimation\(^{21}\). PCT-level service utilisation and resource allocation data are only meaningful in the context of the local need for health care, and reliable estimates of health care need are essential if the equity or otherwise of existing patterns of resource allocation and service use is to be properly assessed.

31. The weighted capitation model needs to be revisited, both with respect to how the health care needs of populations are assessed and with respect to how it seeks to compensate for unavoidable geographical variations in the costs of providing health services. This should be informed by the results of the above investigation, but should also reflect the outcome of a separate investigation of actual cost variations in providing services, particularly in rural areas.

32. The funding consequence of the move to practice-based commissioning must be explored in detail. Simply as a function of their smaller size, practice populations are both more internally homogeneous and more socially and demographically diverse than PCT populations. This will sharpen the effects of formula funding. Experience with PCTs demonstrates that it will be extremely difficult to avoid introducing a systematic bias against particular populations. This would inevitably result in severe geographic variations in service provision.

Professor Sheena Arthana and Dr Alex Gibson
University of Plymouth
2 June 2006

References

1. Patricia Hewitt, Secretary of State for Health, House of Commons Hansard Debates for 15 November 2005, Col 850.
2. Our analysis excludes Walthamstow, Leyton and Leytonstone (5C6), Chingford, Wanstead & Woodford (5C7), and Redbridge (5C8) PCTs as these were reconstituted as Waltham Forest (5NC) and Redbridge (5NA). PCT allocation were taken from the Department of Health’s Unified exposition book: 2003–04, 2004–05 and 2005–06 PCT revenue resource limits (18 December 2002) [internet only]. Available from: “http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4069292&chk=T1gwZr” [Cited 22 May 2006]. Per capita rates were calculated using HCCHS population data included in the Exposition Book. PCT level deprivation is estimated using the Office of the Deputy Prime Minister’s 2004 Index of Multiple
Deprivation (IMD2004) score (http://www.odpm.gov.uk/index.asp?id=1128440). The IMD2004 is not made available at PCT level, so PCT scores have been calculated as the household-weighted average of each PCT’s constituent output area scores.


7. ibid.


11. House of Commons Hansard Debates for 14 March 2006, Column 377WH.


19. More generally, by the end of 2004–05 no less that 55 of the 150 PCTs receiving less than average increases in per capita funding were in deficit (36.7%), compared to only 16 those PCTs receiving greater than average increases in per capita funding (10.6%). Put another way, over 77.5% of the PCTs that ended 2004–05 in deficit had received a less than average increase in funding 2003–04 to 2004–05.

20. House of Commons Hansard Debates for 4 March 2006: Column 383WH.

WHY NHS TRUSTS HAVE FINANCIAL DEFICITS!

— The NHS operates in a “closed” market.

The amount of money available to each health economy is capped and although there are local freedoms there is very little real flexibility on what can and what cannot be provided. Service developments are almost always funded through cash releasing efficiencies and are very rarely the result of a parallel service reduction or substitution. When a new player is introduced (as in “Choice”) this creates a level of uncertainty for existing providers who have to mitigate the risk through service changes or transfers. The “marketing” potential is strictly limited to non-complex elective care or highly complex or expensive tertiary care.

— Increasing the number of independent providers (~5% of volume) has created unsustainable capacity and loaded high cost treatment onto the NHS.

The independent sector does not have to cover the highly variable costs of emergency care or complex care but can provide low risk non-complex care at a cost that creates a operating profit and pays extra to the same consultant medical staff that would have provided the care in the NHS. There is a popular myth that the NHS needs more permanent capacity to sustain waiting times reduction. This would only hold true if the number of patients being referred onto the waiting lists was increasing. Whilst the threshold for referral is being lowered the real increase in surgical intervention is negligible because of improved diagnostic imaging and scoping technology. The additional capacity is necessary only to achieve the one off reduction in waiting times. In recent years this has been at the rate of three months per year. In other words 125% of the annual capacity has to be treated to reduce the waiting time by three months overall. In practice the percentage is less because of less double counting and other non-interventional removals from the list. Once the system is in equilibrium there should be no need for any significant increase in surgical capacity. The real capacity bottleneck is medical diagnostic and surgical time. Whilst all this was funded through “badged” waiting times money the system could absorb the additional throughput and capacity but the Payment By Results process does not bring new money into the system therefore the larger Hospital Trusts can only lose business (and money) to smaller bespoke specialist centres.

— The high proportion of fixed costs in the system suppress flexibility.

A typical hospital Trust operates at 70% staffing and employment costs. About half of that is nursing and midwifery and about 20% is medical staff costs. The European Working Time Directive means that each specialty team needs a minimum of 5 doctors at each level (SHO, Registrar and Consultant) to operate a “legal” rota of 48 hours per week with leave cover. Larger Trusts may have more than five doctors in some teams but most average hospitals will struggle to fill the rota particularly at middle (registrar) grade because of post-graduate teaching allocations. They make up the gaps with permanent staff grade doctors (very often immigrant doctors who are not qualified to apply for a consultant grade appointment). This system leaves almost no flexibility when there is a need to reduce capacity therefore hospitals have to carry excess “doctor” capacity when there is a shift of “business” to another provider in order to maintain legal rotas.

— The medical consultant lobby is very powerful and resistant to change.

Real cost reductions can only come from strategic change in the modality and location of care. This often means achieving economies of scale in facilities and or support staff and as a consequence a change in location of certain aspects of care (like surgical intervention). Many hospital consultants build their working life as a relationship between themselves and their general practitioner (GP) colleagues and between NHS and private practice. They do not welcome a change in working arrangements that may de-stabilise the referral base that they have spent years developing. They will find “clinical” reasons why the change is not a good thing for patients and managers have a tough time persuading the media and patient groups that change is necessary especially if it involves a change of location.

— The media (public) are hostile to NHS management. (White coat good—grey suit bad syndrome)

The public perception of NHS management is poor and not helped by politicians using management as the easy target when things are not going as well as planned. Managers have a limited range of freedoms to implement political policy at local level. Almost all that I know are committed to the service and dedicated to improving patient experience and care. They do not have the backing of politicians when policies are being challenged at local level and are often have to pay the “price” of policy failure or unpopularity. It is easier to make financial management secondary to performance management and be seen to achieve political targets than to cut costs and risk failing on the key target areas. Experience shows that financial failure was less career limiting than performance failure up until 2004.
— Politicians (local and national) do not support strategic changes unless they are to enhance local services.

The solution to most health economy based financial crisis is a result of sustaining the existing generalist services and locations whilst trying to develop modern specialist services and facilities. This can only be achieved with strong leadership, excellent (staff and media) communications, political support and medical involvement. It is almost impossible to convince the general public that it is in their interest to move an emergency service 10 miles away to improve the outcomes for patients but very often this is the case. There are countless examples of MPs and local politicians publicly supporting public campaigns to stop service transfers. The result is that strategic changes are opposed in most cases and the Trusts have to carry the burden of uneconomic facilities and additional staff for much longer than any private or commercial operation would tolerate.

— The proliferation of PCTs in 2002 weakened NHS management.

In 2002 the NHS appointed over 300 new Chief Executives and Finance Directors to the new PCTs. Whilst several proved to be innovative and capable leaders many struggled with the new responsibility. With hindsight it was optimistic in the extreme to assume that such a cadre of new talent could be recruited within a few months. The result in many cases was second rate management on first rate pay doing a third rate job. All these new organisations had to justify their existence and were encouraged to develop locally based services. In some cases the public misunderstood this for reopening or sustaining local acute hospitals. The PCTs, understandably, wanted community based service development and planned to fund this by shifting the work from the acute hospitals to their budget in the PCTs. Many very good community services were established and the new services attracted new referrals for “overworked” GPs who seen this development as a way of offloading their “at home” patients. The trouble was (and is) the services at the hospital for all the reasons stated above never really transferred and most of the patient referrals continued to arrive in the hospitals. The overall service had improved and expanded but the funding was being stretched beyond breaking point. As the PCTs were both fund holder and provider they were able to withdraw hospital funding and protect their own financial base.

— Much of the new money was absorbed by residual cost pressures and pay awards.

Most large Trusts have revenue budgets in excess of £120 million or about £300,000 per day. Budgets are set on predicted patient flows and work plans and the system grinds along and reports retrospectively on what it is spending. The expenditure is very predictable with pay being 70% of the total. There are variations with agency cover and new high cost drugs but overall it is predictable to within 1% or 2% of the total. It is important to stress that 2% of £120 million is £2.4 million! Actions can be taken to claw back 1% to 2% by aggressive local management but anything more than that will inevitably mean a tactical or strategic change in the way that a service is provided. Most trusts were sitting on unfunded cost pressures like pay drift and unfunded service developments and new money is quickly absorbed in these areas. The consultants’ pay award was a disaster for the service with almost no productivity gain and massive disruption and dispute over who does what and how much they get paid. In many cases it has turned existing consultants (and new consultants) into service timekeepers and made our most valuable asset into clock-watching shift workers.

— The latest proposals for management changes have created strategic inertia in the system.

It goes without saying that the recent announcements about changing the Structure yet again have brought a great deal of uncertainty and resentment into the system. It was both predictable and necessary as even the Department of Health was beginning to realise that it had created an uncontrolled monster with over 300 PCTs. It will take a couple of years for the changes to bed in and in the meantime PCTs are protecting their positions both managerially and financially at the expense of the acute and mental health sectors. No one seems to be in charge at local level and this has created a strategic vacuum.

— The changes to the financial regimes exposed the underlying deficits.

Up until 2003–04 the NHS operated on a three to five year financial break even cycle. This allowed cost pressures in one year to be planned over a three-year period and financial plans were a “rolling” year on year dynamic process. The change to year-end balance or RAB as it is known exposed the slack in the system and many Trust were caught without plans to recover cost pressures in year. Given the tight nature of the budgeting and the lack of flexibility in what can and cannot be provided this greatly increases the financial exposure of Trusts.

— The “payment by results” systems will increase the level of risk and generate more deficits (although it is fundamentally and conceptually a good thing).

The Department of Health has had several attempts over the last 20 years to introduce resources management to the systems. Payment by Results (PbR) is the latest and most challenging yet. By setting a national tariff for all care it forces out the inefficiencies of some Trusts and rewards the efficiencies of others. In practice though many of the inefficiencies are embedded in the fabric and
structure of the organisations and will take years of development and strategic change to put right. In the short-term many Trusts will be put at financial risk as the systems beds in and the PCTs play the market in final demonstration of commissioning power.

Any Trust with a deficit of more than 5% of its revenue budget has a structural problem that cannot be managed out by Turn Around experts or more efficient management. These large deficits reflect victims of the system that has change faster than they could (or are allowed to).

Like many endangered species some hospital Trusts may need protecting to ensure their survival in the longer term.

Ken Cunningham
June 2006

Evidence submitted by David Drew MP (Def 23)

There has been widespread and sustained outrage across Gloucestershire at the drastic nature and extraordinary scale of proposed cuts to local health services, currently subject to consultation. If these are ultimately implemented, there will indisputably be a disproportionate impact on services in the County, given the level of deficits incurred by local trusts.

The reality is that our area is having to unfairly carry the burden for the high levels of historic overspend in other areas, exacerbated by a questionable interpretation of government requirements on achieving financial balance by the Avon, Gloucestershire and Wiltshire Strategic Health Authority— and which has not been sufficiently challenged by local trusts. The result is that the SHA area is being asked to make savings amounting to a staggering 5.3% of turnover, compared to an average of 3.4% elsewhere, and the highest in the country. Such savings will have a devastating impact on local services, professional teams and, most importantly, on the health of our communities; and Gloucestershire is being expected to bear the brunt of these cuts.

This situation is totally unreasonable and unacceptable, and I would like to formally request that the Health Committee take an urgent and specific look at the Avon, Gloucestershire and Wiltshire SHA area, as part of its inquiry, as a test case that would highlight key issues. Why has our SHA area, and Gloucestershire in particular, had to bear such a heavy cut in budgets? Does it really need to wipe out all historic and current deficits in this financial year? Why, alone in the SHA area, have Gloucestershire Trusts not received any assistance from Special Funds, or loans to help them through a difficult transitional period?

I am keen to provide evidence to the Committee on the specifics of the situation in Gloucestershire and look forward to being invited to appear before it during the course of this important inquiry.

David Drew MP
5 June 2006

Evidence submitted by David Dufty (Def 20)

Personal Background. Selected almost direct from the national NHS administrative training scheme to run a major district general hospital, I served as deputy group secretary in West Suffolk and district administrator to East Suffolk, bar Waveney before becoming an African specialist health management consultant. In August last year, because of the developing NHS financial crisis in Suffolk, I joined Suffolk Coastal PPIForum. Since then I have produced one paper to inform Suffolk OSC and Suffolk PPIForums discussions on the funding crisis and have been ensuring HM Opposition Parties have been updated on any NHS developments, particularly in Suffolk and East Anglia but also nationally.

Summary. Blame for the overspending generally is laid squarely on the Department of Health, mainly for misapplying the funding formula to Trusts but also listing numerous more minor funding failures.

1. Reasons for the deficits. There are very many reasons but undoubtedly the major factor has been disregard by the Department and possibly Cabinet, of the timing for implementation of the
recommendations in the Black and Wanless Reports. As a result financial allocations have been made based mainly on mortality and morbidity levels compared with the national average, with complete disregard for the initial steps required, in both reports, before that stage was reached.120

2. The remaining mistakes will undoubtedly be reported to the Committee in depth but can be summarized as:

Misunderstanding of the financial impact of PFI building projects on trust budgets.

Misapplication of Gershon Report recommendations ie The large 2004–05 consultant contract salary increases were only 70% funded to trusts.

Extraordinary generous new contract terms for both consultants and GPs. The GPs contract increased out of hours overheads substantially despite a negotiated reduction in GPs income for opting out of oncall. It is understood the Prime Minister undertook to raise NHS income to the average level in Europe: not to make our senior medical staff the highest paid in Europe, which appears to have been how the Department understood it.

Poor Department ISTC contract negotiations resulting in large financial losses to trusts.

Central enforcement of targets which required extra expenditure eg Additional weekend operating sessions on very high rates of pay.

Retention of a nurse training programme with excessive wastage rates (Which is commonly held by many senior nurses to develop a nurse lacking in “TLC” (Tender loving care attributes for which UK trained nurses were acknowledged international leaders).

Failure to make any funding allowance for inappropriate distribution and size of health buildings (Surrey and Sussex seem to be the hardest hit).

Failure to make any funding allowance for the additional travel required in rural areas.

3. This list identifies the causes as Department of Health systemic. Of recent years it appears to have become routine for the Department to blame local management for deficits without prior self-analysis (An essential management step before any other consideration of blame is taken). In any large organisation there are bound to be some below average performers but the experience in Suffolk would indicate the need for an HR assessment throughout the UK NHS to ascertain if redeployment at senior level has been excessive and wasteful of valuable staff resources as a direct result of this somewhat inept performance. In this connection the profound statement by Peter Hoima, Chief Executive St George’s Healthcare Trust reported 16.2 06 is apposite: “Troubled organisations often get the most inexperienced leadership. The troubled organisations need to get the most experienced managers, who should regard it as among their most important career challenges to have the privilege of helping transform an organisation and liberate the talent. A lot of relatively inexperienced individuals appointed to work in troubled trusts become casualties— not because they are not good, but because the system has not cared for them. We have done some scandalous things. Second, we need to move from slogans to precise diagnosis and action. We use slogans as a substitute for deep thought and that’s not good enough. Third, we think in quantum leaps but we implement in small steps”.(HSJ P.23)

4. Effect on Care & Job Losses. Suffolk, so far, thanks to recently appointed capable management, has not suffered greatly. It is the general view amongst recently retired consultants and GPs that unless there is soon some adjustment in the funding, standards will fall in a number of areas. It is already evident that hospital nurse staffing levels are inadequate to reduce hospital generated infections fast enough and care correctly for the elderly.

There was a contract dispute between Suffolk East PCT and the Ipswich Hospital NHS Trust that went to arbitration and which favoured the PCT. As a result the hospital is having to lose staff. It is easy to understand the drastic impact this could have when one knows peak winter ward occupancy with present staff is frequently well over 90% which is far too high to consistently maintain quality care.

5. Period over which the Balance should be Achieved.

If my first major point is accepted this should cease to be a problem in many trusts though, due to bountiful largesse in others, it may create some financial problems.

If it is not accepted, then at least three years as a minimum but in the case of those trusts hit by the problem mentioned in paragraph 2, until a major building reconfiguration is completed, additional financial support is likely to be a sine qua non. Even given the extended period, quality and standards are likely to suffer.

120 It has been reported that a very recent survey by The Journal of Health Service Research and Policy (Published by the Royal Society of Medicine) supports this argument.
A simple example of this is in the recent White Paper’s requirement, very rightly, to expand community hospital services. Most of the deficit trusts include at the very least “rationalisation” of their community hospital to save money. The aims are incompatible.

I have no objection to giving oral evidence.

David H Dufty
Health Management Consultant
5 June 2006

Evidence submitted by Mrs Jane Galbraith, University College London (Def 06)

1. Mervyn Stone and I are statisticians (emeritus professor and honorary research fellow) at University College London. We have studied the derivation of the Department of Health’s funding formula which is partly based on selected recommendations in RARP 26, a report to the Department of Health entitled “Allocation of Resources to English Areas” (reference 1). Our refereed article in the Journal of the Royal Statistical Society, Series A (Stone and Galbraith, 2006, reference 2) gives a critique of the methodology developed in RARP 26 (reference 1) and refutes any claim that the selected socio-economic and health related variables provide a valid and reliable measure of need for health care expenditure.

2. The methodology of RARP 26 (reference 1) is extremely complicated partly because the underlying theory is unclear and inadequate (see paragraph 3 below) and partly because numerous subjective decisions are required such as which variables to include, what scales of measurement to use, what units of analysis to use, and whether the formula should be additive or multiplicative or a mixture. These decisions will affect the funds allocated to individual Primary Care Trusts. For example, the decision to use within-Health-Authority regression coefficients but not the Health Authority intercepts in the Acute and Maternity Index will favour Trusts in previously low spending Health Authority areas. Further complexity arises when the formulae recommended in RARP 26 are combined to produce the “unified weighted population” on which the target allocation of funds is based.

3. (a) Because a direct measure of need for health care expenditure is not available, RARP 26 (reference 1) tries to obtain an indirect measure. Their formula expresses the actual expenditure as the sum of three parts. The intention is that the first part should depend on need, the second part should depend on supply factors (such as waiting lists or distance from a hospital), and the third is a residual or unexplained part. If the “supply” and unexplained parts were unrelated to true need and if the “need” part were a good measure of true need then the “need” part could provide an appropriate guide for the allocation of funds. But these conditions do not hold.

(b) An article in Health Economics by the same authors, Gravelle et al (reference 3), attempts to explain and to illustrate their methodology for identifying the “need” part by considering the multiple regression of age-adjusted expenditure for acute hospital episodes on a selection of socio-economic and health related variables (proxies for need) together with selected variables chosen as proxies for supply and some “other” variables. The (over-optimistic) theory is that the partial regression coefficients for the “need” variables will be the correct coefficients for relating them to need-based expenditure. Gravelle et al (reference 3) conditions on the chosen “supply” variables and “other” variables by setting them at their national averages (which fixes the constant term) and uses the resulting partial regression equation to estimate the needs-based part of the age-adjusted expenditure for each unit (electoral ward or Primary Care Trust).

(c) There are some problems which undermine this theory and remove any justification for the methodology of RARP 26 and Gravelle et al (references 1 and 3). These include:

(i) Some of the socio-economic and health related variables used to measure need are not pure measures of need but are also partial measures of supply. An extreme example is PEN, the proportion of non-whites in the population, which is thought to be positively associated with need but which had a negative coefficient in the multiple regression. Because the sign was counter-intuitive Gravelle et al (reference 3) could identify that there was a problem and try to resolve it. Similar but less extreme problems with other “need” variables might not be identified because, although their coefficients might be affected by their supply content, this might not result in counter-intuitive signs.

(ii) Conversely the “supply” variables may be partial measures of need, which would make conditioning on them inappropriate. RARP 26 (reference 1) and Gravelle et al (reference 3) discuss the related problem of endogeneity. Their proposed solutions side-step rather than solve the problem.

(iii) The choice of national averages for the “supply” and “other” variables is arbitrary and results in the constant term of the partial regression being small. The relative sizes of the constant and the partial regression coefficients determine how strongly the formula responds to differences in the variables which are proxies for need. Although it is desirable that the formula should respond appropriately to true need, the response should not be excessive (I
may have slightly greater need than you but that would not justify me in having hugely greater resources). Also the “need” variables used are only proxies which may not be good measures of true need.

(iv) Some of the unexplained variation may be due to aspects of need that have not been covered by the selected “need” variables, in which case, using the partial regression equation to estimate needs-based expenditure will be unreliable.

4. Need for health care is related to age in a non-linear fashion (the very young and the very old are more expensive). The Department of Health funding formula attempts to separate the effects of age from those of the selected proxy variables for need. The resulting formula for the “unified weighted population” has the effect of giving more emphasis to differences in the socio-economic variables which are proxies for need than to differences in age profile. Primary Care Trusts with an elderly population might feel discriminated against.

5. The Department of Health uses the “unified weighted population” to obtain a target allocation for each Primary Care Trust. If we define the Target Index to be the ratio of the “unified weighted population” to the (estimated) population of a Trust, then the Department of Health’s aim is that the Target Index should give the relative cost per capita of providing the same level of health care in different Primary Care Trusts. If the Target Index varied a lot between Trusts it would give some Trusts much more per capita than others. Compared with the previous formula (Carr-Hill et al, 1994, reference 4) the current formula gives a much wider spread of per capita funding. The Target Index would allocate up to twice as much per capita to some Trusts than to others. Is this sensible? If the formula is wrong it has potential to do harm. We have no reason to suppose that it is right.

6. I would favour the development of direct measures of need, met and unmet, possibly though a combination of medical records (for met need) and sample surveys (for both met and unmet need). Initially these could be used to validate any funding formula based on proxy variables but ultimately it might be possible to estimate need for health care expenditure directly. Since funds are limited, such an approach would require explicit value judgements giving some needs greater weight than others.

7. In order to examine why some PCTs have deficits, it might be informative to compare the funding they receive now with what they would have received were the same total expenditure distributed under the previous formula. Whether or not one formula is fairer than the other it seems likely that the transition would create difficulties (even though the new formula is being phased in slowly).

8. My colleague, Mervyn Stone, is making a separate written submission which gives more detail on some of the above points as well as making some different points.

9. The views expressed above are my own and this evidence is submitted on an individual basis. My work in this area is unpaid and my concern is for the correct use of statistics and for the efficient and equitable use of resources for the National Health Service.

10. I would be happy to give verbal evidence or to answer questions in writing if that were useful to the Committee.

REFERENCES


Janie I Galbraith
Department of Statistical Science, UCL

22 May 2006
Evidence submitted by Andrew Lansley MP, Shadow Secretary of State for Health (Def 48)

1. I welcome the Committee’s Inquiry. The worsening NHS financial position at a time of unprecedented resource increases is a matter of great public concern. The reasons for the deficits, their consequences, and the means of resolving them are all insufficiently clear. I hope the Committee’s Inquiry and subsequent report will assist in clarifying these issues.

2. As the Shadow Secretary of State for Health, I have sought to identify the scale of, and resources for, the deficits over the course of the last 15 months.\textsuperscript{121} This stands in contrast to the Government’s complacent line, exemplified by the assertion towards the end of the 2004–05 financial year, by the then Minister of State at the Department of Health, John Hutton, who said that:

“It is not unusual for the NHS to be reporting deficits at this time in the financial year. Past experience has shown that the overall position has improved by the year-end and the NHS has achieved overall financial balance for the last four successive financial years.”\textsuperscript{122}

3. In fact, 2004–05 saw a deficit in NHS Trusts, NHS Foundation Trusts, and Primary Care Trusts (excluding Strategic Health Authorities (SHAs)) of just over £624 million. Only when the surplus of just over £373 million generated by SHAs in 2004–05 is taken into account was the system-wide NHS deficit reduced to £251 million.\textsuperscript{123}

This was the first NHS-wide deficit since the £129 million deficit recorded in 1999–2000\textsuperscript{124}—even though funding for the NHS in 2004–05 was, in real terms, 56% higher than the level in 1999–2000.\textsuperscript{125}

4. The scale of the deficits has clearly been persistently underestimated by the Department of Health. In July 2005, the Secretary of State used unaudited figures to estimate a net year-end deficit in 2004–05 of £140 million, excluding NHS Foundation Trusts.\textsuperscript{126} In September 2005, however, the Department of Health’s audited figures showed it was 56% higher, at £218 million--a figure since revised by the National Audit Office to £214 million.\textsuperscript{127} When the £36.9 million deficit run up by NHS Foundation Trusts is also included, the overall deficit in 2004–05 rises to £251 million—some £111 million higher than that previously admitted by the Government.\textsuperscript{128}

5. It is not clear to what extent the Department of Health has known the size of, or whether it has been wilfully ignorant of the scale of, the deficits. In November 2005 the motion for our Opposition Day Debate on NHS Finance highlighted my estimate, derived from the Board Papers of Strategic Health Authorities, that the NHS was facing a year-end gross deficit in 2005–06 approaching £1 billion.\textsuperscript{129}

During the Debate, Ministers failed to confirm or deny my estimate. However, just over two weeks later, the Department of Health published its estimate of the year-end deficit showing that the NHS was forecasting a collective year-end gross deficit of £948 million.\textsuperscript{130} These figures were those provided to the Department of Health by Strategic Health Authorities at month six of the 2005–06 financial year (ie end-September 2005), and would have been available for the Government to inform our Opposition Day Debate in November. It chose not to make this information available to Parliament at the time when it would have been most useful.

6. The Committee will recall that, in December 2005, the Secretary of State believed that the deficits for 2005–06 could be managed down to a net total of £200 million—ie lower than 2004–05.\textsuperscript{132} The Department of Health’s figures, based on unaudited figures, published on 7 June 2006, reveal a net deficit of £512 million.\textsuperscript{133} suggesting that the overall impact of the measures introduced to control deficits in the latter part of 2005–06 failed to offset an even larger deficit than that incurred in 2004–05, and failed to restrict the net deficit to that aimed for by ministers.

7. It is clear to me that the Department of Health was aware—at least by early 2005—of the risk of significant deficits, because it was around this time that it chose to make use of “control totals” as an internal and new mechanism to secure a specific financial outcome. The control totals set for 2004–05 should have secured a system-wide deficit of £70 million (Appendix 1), and those set for 2005–06 should have secured a


\textsuperscript{122} Cited in BBC Online, £340 million deficit predicted for NHS, 3 March 2005.

\textsuperscript{123} National Audit Office, Financial management in the NHS, 7 June 2006.

\textsuperscript{124} Hansard, 8 February 2006, Col 1318WA.

\textsuperscript{125} Hansard, 12 December 2005, Col 1812WA.

\textsuperscript{126} Hansard, 12 July 2005, Col 688.

\textsuperscript{127} DH, Audited summarisation schedules, September 2005.

\textsuperscript{128} National Audit Office, Financial management in the NHS, 7 June 2006.

\textsuperscript{129} National Audit Office, Financial management in the NHS, 7 June 2006.

\textsuperscript{130} Hansard, 15 November 2005, Col 833.

\textsuperscript{131} Hansard, 1 December 2005, Col 37WS.

\textsuperscript{132} Oral Evidence to Health Committee by the Secretary of State for Health, Sir Nigel Crisp and Mr Richard Douglas, Questions 317-318, 6 December 2005.

8. It is sometimes argued that the deficits which are occurring in the NHS today are the same deficits which occurred in the past, but which were then obscured by brokerage (eg, through the NHS Bank), and which are now exposed by a more transparent accounting system. However, brokerage can only offset deficits in individual organisations; a system-wide deficit would still have been disclosed in the past—whether or not accounting for individual organisations within the NHS was transparent.135

It is apparent that the system-wide problem of deficits began in 2002–03 and has consistently increased since then. For example, the National Audit Office (NAO) reported last June that six SHA areas were in net deficit in 2002–03, and seven SHA areas were in net deficit in 2003–04.136 In 2004–05, 16 SHA areas were in a net deficit, and in 2005–06, 17 SHA areas were in net deficit.137

It is also clear that, while some areas of England, regarded as “healthier, and wealthier” ran into deficit earlier—as a result of a failure of allocation methodology to reflect accurately the disease burden—the deficits have become more widespread. Some years ago, serious deficits did occur in a number of Trusts (eg in North Bristol, Royal United Hospital Bath, and in the Mid-Yorkshire Hospitals), but these were the exception. However, this situation has since worsened. The Government confirmed on 7 June 2006 that 31% of NHS organisations ran a deficit in 2005–06.138

9. If system-wide deficits have occurred when resources have been rising rapidly, what are the causes? Four principal causes have been cited to me, in the course of my discussions during visits to over one in four NHS Trusts over the past two and a half years:

(i) **Centrally controlled cost pressures.** In the hospital sector, the costs of the consultants’ contract, Agenda for Change, NICE appraisals and new drugs, the costs of information technology, and blood costs—among others—have increased. A measure of these rising costs is given in the Department of Health’s own calculation of the tariff: the uplift to the tariff in 2004–05 as compared to 2003–04 was 9.7% prior to efficiency savings; and the uplift to the tariff in 2005–06 as compared to 2004–05 was 7%—again prior to efficiency savings.139

(ii) **The European Working Time Directive (EWTD).** The EWTD has significantly increased the number of doctors required to fulfil a 24/7 rota: on average, up from five to 10 doctors. This has significantly increased staffing requirements—simply in order to maintain the same level of care. Since its introduction, the Government has attempted—but failed—to secure agreement amongst members of the European Union to reclassify “on-call time” so as to negate the impact of the SIMAP and Jaegar rulings of the European Court of Justice (Hansard, 10 March 2006, Col 1820WA).

(iii) **Rising emergency admissions.** Between 2002–03 and 2004–05, the hospital sector saw a rise in the number of emergency episodes of care of 475,200 (12%),140 and between 2002–03 and 2005–06 it saw a rise in the number of attendances at accident and emergency (A&E) departments, walk-in centres and minor injuries units of 4,393,747 (31%).141 An ageing population means demographic and cost pressures which require increased real resources. A combination of rising costs, increased unplanned demand, and extra staffing relative to output has pushed costs beyond even the recent real terms increases in resources of several percentage points above inflation.

(iv) **The impact of targets.** The Government’s waiting time and A&E targets, in particular, have required significant extra resources in order to meet specific targets which do not guarantee proportionate improvements in patient care. For example, in the view of many to whom I have spoken, the increase in the four hour A&E target from 96 to 98% has required substantial additional resources for no clinical benefit, since a larger proportion than 2%—perhaps some 5% of A&E attendances—would have benefited (or at least not have been harmed) in A&E whilst their diagnosis or treatment was completed. The clear imperative up to mid-2005, however, was to meet these targets rather than adhere to budgets.

A number of these factors, in particular the cost of Agenda for Change and (for PCTs) the GP contract, have become even more significant in 2005–06.

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134 Oral Evidence to Health Committee by the Secretary of State for Health, Sir Nigel Crisp and Mr Richard Douglas, Questions 317–318, 6 December 2005.
135 Except to the extent that, until 2003, NHS organisations were able to undertake capital-to-revenue transfers, which would have obscured recurrent revenue deficits in earlier years.
140 Department of Health, Hospital Episodes Statistics classified by Primary Diagnosis, December 2005.
141 Department of Health, Hospital activity statistics, Attendances at accident and emergency, 12 May 2006.
The net system-wide deficit in 2005–06 masks a much larger gross deficit: £1.277 billion. This continues the trend set in 2004–05, when a gross deficit of £759 million was largely offset by a total underspend by SHAs of £373 million. The Department of Health has since revealed the scale of the total underspend by SHAs in 2005–06: £524 million. These underspends by SHAs reflect cut-backs in training budgets, and postgraduate deaneries in 2006–07 are already expecting a further 10% reduction in their training budgets, implying 4,000 fewer training posts. Such cuts in training contribute to short-term financial reconciliation, but at a long-term cost to the service.

10. The Department of Health has met a potential £620 million deficit in 2005–06 by means of:
   (i) £200 million use of year-end flexibility for 2004–05;
   (ii) £200 million underspending on Connecting for Health (an incidental effect of delayed delivery on NPfIT contracts);
   (iii) £112 million access to the contingency reserve; and
   (iv) £116 million reduction in central budgets.

In 2004–05, accounting changes made by the NHS Litigation Authority achieved a reduction in its provisions of £1.497 million, and thus gave the Department of Health a substantial underspend in its central budget. These accounting changes, however, stand to increase liabilities in subsequent years.

11. The turn-around teams appointed in December have not significantly reduced the overall deficit below the levels predicted in September 2005 (ie a net deficit of £623 million; a gross deficit of £948 million). Their identification of the deficiencies in financial management, of the lack of control over cost factors, of the lack of effective procurement, and of the unconstructive relationships between SHAs, PCTs, and Trusts are, however, all useful insights. Many of the responses they advocate are, of course, not new: excessive agency staff costs, for example, have potentially been significant in contributing to Trust deficits in the past. However, since expenditure on agency staff has been decreasing since 2002–03, it can be discounted as a factor in explaining the worsening financial position since then (Appendix 2).

12. Other factors which improve efficiency (such as reducing the average length of stay in hospital, increasing day surgery, and scrutinising follow-up appointments after treatment) were among the high-impact changes already recommended in 2004 by the NHS Modernisation Agency.

13. While, for resource accounting purposes, PCTs recording a deficit are required to repay it as a first charge on their subsequent year’s allocation, NHS Trusts can carry forward deficits (with the one caveat that their overspending represents a charge against the Department of Health’s Departmental Expenditure Limit (DEL) which must be offset within the three-year DEL period).

Therefore, it is NHS Trusts which are carrying forward a large deficit of approximately £1.1 billion as at the end of the 2005–06 financial year. This has accumulated over just three financial years.

14. The increasing accumulated deficit specifically amongst NHS Trusts in part explains the actions they have taken over the last three months order to cut costs. In addition, however, two key failures in the management of the NHS tariff have also precipitated the cuts:
   — (1) Final details of the tariff were not available until 17 March; and
   — (2) Against recognised cost pressures of 6.5%, NHS Trusts have received an average increase in the tariff in 2006–07 of only 1.5% above the levels they received in 2005–06.

Nor can NHS Trust managers compensate for this by increasing the volume of their activity: first, many PCTs in financial difficulties are attempting to maintain financial control by restricting referrals to the acute sector; and second, if emergency admissions rise above a certain threshold, NHS Trusts will only be paid at half the tariff value. Therefore, many NHS Trust Chief Executives have no option but to cut costs quickly. The consequence has been that around 60 trusts have announced some 17,500 job losses in recent months (Appendix 3). The lack of primary care capacity to compensate for this reduction in secondary capacity shows that these are financially driven cuts, and not the result of a planned shift of resources into primary care settings into which any prior investment has been made.

146 Hansard, 13 February 2006, Col 1784WA.
147 Hansard, 1 December 2005, Col 37WS.
149 Personal Communication, National Audit Office.
15. There is no financial equivalent of the seventh cavalry about to ride over the horizon. It is necessary for NHS organisations to live within their means and for their carried-forward deficits to be recovered. It is also important not to bail out financial incompetence, which would send out the wrong signals for the future.

16. The Department of Health’s intention, as set out in its Operating Framework for 2006–07, is for the NHS to achieve an overall surplus in 2006–07. To achieve this, all organisations have been required to plan for a balanced budget and to recover any deficit from previous years. According to the Framework, only exceptional cases are permitted to carry a deficit forward to 2007–08.150

However, in a letter of 12 April 2006 to me, the Secretary of State significantly amended this aim. Her new intention is for:

“All organisations that are overspending to show improvement during 2006–07, and by the end of the year everyone should have monthly income covering monthly expenditure” (Appendix 4).

This is, of course, a wholly different financial discipline and is consistent with the possibility of a substantial deficit continuing into 2007–08. The Secretary of State’s account on 7 June did little to clarify how the latter requirement applying to individual organisations can be consistent with a return to overall balance without significant surpluses being generated by many PCTs.

17. In order to achieve financial stability, several steps are required:

(i) The Government must ensure that resource allocation more closely matches disease prevalence. Data from the Quality and Outcomes Framework, in addition to other sources, show that many “healthy and wealthy” areas have levels of morbidity higher than that implied by the aggregate data based on deprivation indices which are currently used for resource allocation. The current review must be accelerated for the introduction in 2007–08 of a revised method of resource allocation.

(ii) The Government must impose no new central cost pressures and, wherever possible, give greater control to NHS Trusts of their costs, in the context of an environment in which freedoms for providers facilitate competition.

(iii) The Government must align financial incentives with decision-taking responsibility by making GP budget-holding a reality. This necessitates GPs being able to hold real (rather than indicative) budgets, able to reinvest any savings they build through the commissioning of more cost-effective patient care, and able to negotiate and hold contracts with providers. This will ensure that GPs taking clinical decisions are fully aware to the need for financial discipline, making demand management both real and practicable.

(iv) The tariff-setting process must be independent, so that NHS Trusts and other providers have to respond to the benchmarked costs of efficient providers, in a more predictable framework.

(v) The Government should allow opportunities within agreed protocols (eg in the fourth quarter of the financial year) for marginal pricing of extra capacity, so that capacity utilisation can be optimised and demand met, rather than left unused with the treatment of patients delayed until the next financial year.

(vi) The Government should require PCTs to return to recurrent balance in 2006–07 and, where they have a past deficit, pay it back through having their budget top-sliced over a period of up to three years. The indiscriminate top-slicing of all PCT budgets is inherently undesirable since it masks deficits and leads to short-term financial pressures in Trusts and PCTs which are otherwise working within their budgets; it clearly distorts the whole structure of resource allocation.

(vii) The Government should require NHS Trusts to achieve recurrent financial balance by 2007–08 and, if they achieve Foundation Trust status with the requisite degree of financial control, the Government should be prepared to convert this past debt to equity (ie public dividend capital). The performance of Foundation Trusts has been exemplary: at the end of the 2004–05 financial year Foundation Trusts had a collective deficit of £37 million; and a year later the collective deficit has been managed down to £24 million.151 The financial control regime for Foundation Trusts clearly has out-performed that of the rest of the NHS.

(viii) NHS Trusts and PCTs which do not meet these financial criteria must expect the Board and Management to be removed. It is essential that, as the NHS moves to a more open, competitive environment, the role of regulation needs not only to set out the requirements for the licensing of providers and the arrangements for meeting the universal obligations, but also to set out a failure regime, the penalties to be received by and the framework for turnaround for failing organisations.

As it stands at present, when an NHS Trust breaches its statutory break-even duty (as St. Peter’s and Ashford NHS Trust has done) no-one knows what happens. Explicit statutory failure requirements need to be put in place. The Department of Health’s “Wider Review of Regulation” (due Spring 2006) needs to make provisions for this in forthcoming legislation.

18. I look forward to reading the Committee’s conclusions on the way forward. I would be glad to give oral evidence if the Committee would find this helpful.

Andrew Lansley MP
June 2006

APPENDIX 1

Letter from Lord Warner to Andrew Lansley

Dear Andrew,

NHS Financial Management

Further to my previous letter (our ref: P05018391) about your request for information under the Freedom of Information Act, I am now in a position to respond more fully. Please accept my apologies for the delay in responding substantively.

I was considering applying an exemption on the release of the information under section 33(1)b for the Freedom of Information Act. I have, however, had time to think about your request for the 2004–05 control totals and have decided, upon reflection, to release the information you have requested—please see the enclosed table.

I will start by explaining the role of control totals in the financial management of the NHS:

— We expect NHS organisations to plan for and achieve financial balance each and every year, including 2004–05.
— We monitor the financial performance of NHS organisations throughout the year.
— There are 575 Primary Care Trusts (PCTs) and NHS Trusts in the NHS, and in a minority of these organisations financial management falls below acceptable standards.
— It is the responsibility of Strategic Health Authorities (SHAs) to performance manage the NHS, including financial management.

As part of the Department of Health’s monitoring process, as we approach the end of the financial year, we take a view of the likely financial outturn for each SHA’s health economy. In order to achieve the best possible outcome—as close as possible to financial balance—we agree a control total with each SHA. The aim is for control totals to be challenging, but achievable. We do not set control totals for the individual PCTs and NHS Trusts within SHAs, although SHAs may set these locally.

I have attached the control totals agreed with SHAs towards the end of the financial year. Irrespective of the control totals set, SHAs carry forward deficits and surpluses to the following financial year. This ensures organisations do not benefit from having a deficit, and are not disadvantaged by having a surplus.

Although the final audited accounts will not be available until the Autumn, we expect the final position for the NHS to be within a fraction of the funding available. The NHS is currently forecasting a deficit for 2004–05 of around £140 million, which is 0.2% of overall resources. This is the first time in five years that the NHS has forecast a deficit. We are working with SHAs to restore financial balance.

We do not set specific savings targets for NHS organisations, but funding assumptions include improvements in cost efficiency of 1.7% in 2005–06 across the NHS. However, at a local level, cost improvements may vary.

In relation to the Freedom of Information process, if you are unhappy with the way the Department has handled your request, you may ask for an internal review. You should contact the FOI Unit, 360c Skipton House, 80 London Road, London SE1 6LH if you wish to do so.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at:

Information Commissioner’s Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Norman Warner
8 August 2005
Enc: 2004/05 Control Total and the Provision 2004/05 Outturn
### 2004–05 CONTROL TOTALS AND THE PROVISIONAL 2004–05 OUTTURN

<table>
<thead>
<tr>
<th>SHA Name</th>
<th>Control total</th>
<th>Under/(Overspend) £000</th>
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<tbody>
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<td>Norfolk, Suffolk and Cambridgeshire</td>
<td>(25,000)</td>
<td></td>
</tr>
<tr>
<td>Bedfordshire and Hertfordshire</td>
<td>(20,000)</td>
<td></td>
</tr>
<tr>
<td>Essex</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>North West London</td>
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</tr>
<tr>
<td>North Central London</td>
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<td></td>
</tr>
<tr>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>South West London</td>
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<tr>
<td>Northumberland, Tyne and Wear</td>
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</tr>
<tr>
<td>Count Durham and Tees Valley</td>
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<td></td>
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</tr>
<tr>
<td>West Yorkshire</td>
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<td>South Avon, Gloucestershire and Wiltshire</td>
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<tr>
<td>South West Peninsula</td>
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<tr>
<td>Dorset and Somerset</td>
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<tr>
<td>Trent</td>
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<td>Leicestershire, Northamptonshire and Rutland</td>
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<tr>
<td>Shropshire and Staffordshire</td>
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<td></td>
</tr>
<tr>
<td>Birmingham and the Black Country</td>
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</tr>
<tr>
<td>West Midlands South</td>
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### APPENDIX 2

**NHS Expenditure on Agency Staff**

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<th>Staff category</th>
<th>Percentage of NHS expenditure spent on agency staff</th>
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<td>Medical</td>
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<tr>
<td>Dental</td>
<td>0.01</td>
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<tr>
<td>Nursing, midwifery and health visiting staff</td>
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<tr>
<td>Scientific, therapeutic and technical staff</td>
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<tr>
<td>Administrative and clerical</td>
<td>0.37</td>
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<tr>
<td>Healthcare assistants and other support staff</td>
<td>0.17</td>
</tr>
<tr>
<td>Maintenance and works staff</td>
<td>0.02</td>
</tr>
<tr>
<td>Ambulance staff</td>
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<tr>
<td>Other employees</td>
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<td>Total</td>
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*Source: Hansard, 8 March 2006, Col 1618WA.*
## APPENDIX 3

### NHS job losses to date

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<th>Trust Name</th>
<th>Job Losses</th>
<th>Previously Announced</th>
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<tr>
<td>Barking, Redbridge and Havering Hospitals NHS Trust</td>
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<tr>
<td>Barnsley Hospital NHS Foundation Trust</td>
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</tr>
<tr>
<td>Birmingham Women’s Healthcare NHS Trust</td>
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<tr>
<td>Blackpool, Fylde and Wyre Hospitals NHS Trust</td>
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<tr>
<td>Brighton and Sussex University Hospitals NHS Trust</td>
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<td>Buckinghamshire Hospitals NHS Trust</td>
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<tr>
<td>County Durham and Darlington Acute Hospitals NHS</td>
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</tr>
<tr>
<td>Dudley Group of Hospitals NHS Foundation Trust</td>
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<td></td>
</tr>
<tr>
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<td>100</td>
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<tr>
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<td></td>
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<tr>
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<td>George Eliot Hospital NHS Trust</td>
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<tr>
<td>Gloucestershire Hospitals NHS Foundation Trust</td>
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<td>Hammersmith Hospitals NHS Trust</td>
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<td>Homerton University Hospital NHS Foundation Trust</td>
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<td>Ipswich Hospital NHS Trust</td>
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<td>James Paget Healthcare NHS Trust</td>
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<td>Lewisham Hospital NHS Trust</td>
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<td>Medway NHS Trust</td>
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<tr>
<td>Norfolk and Norwich University Hospitals NHS Trust</td>
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<td>North Tees and Hartlepool NHS Trust</td>
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<td>North West London Hospitals NHS Trust</td>
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<td>Peterborough Hospitals NHS Trust</td>
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<td>Poole Hospitals NHS Trust</td>
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<td>Queen Elizabeth Hospital NHS Trust</td>
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<td>Rotherham NHS Foundation Trust</td>
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<td>Royal Berkshire and Battle Hospitals NHS Trust</td>
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<tr>
<td>Sandwell and West Birmingham Hospitals NHS Trust</td>
<td>800</td>
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<tr>
<td>Sheffield Children’s Hospital NHS Trust</td>
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<tr>
<td>Shrewsbury and Telford Hospitals NHS Trust</td>
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<tr>
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<tr>
<td>St George’s Healthcare NHS Trust</td>
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<td>Trust</td>
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<td>------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Surrey and Sussex Healthcare NHS Trust</td>
<td>400</td>
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<tr>
<td>Swindon and Marlborough NHS Trust</td>
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<td></td>
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<tr>
<td>The Royal Wolverhampton Hospitals NHS Trust</td>
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<td>United Lincolnshire Hospitals NHS Trust</td>
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<td>University Hospital of North Staffordshire NHS Trust</td>
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<tr>
<td>West Hertfordshire Hospitals NHS Trust</td>
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<tr>
<td>West Suffolk Hospital NHS Trust</td>
<td>260</td>
<td>260</td>
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<tr>
<td>Weston Area Health NHS Trust</td>
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<tr>
<td>Worcestershire Acute Hospitals NHS Trust</td>
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<tr>
<td>York Hospitals NHS Trust</td>
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<tr>
<td>Total job losses (to date)</td>
<td>17,474</td>
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<td>Total (excluding previously announced)</td>
<td>14,106</td>
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The data above are drawn from a variety of sources including local news clippings and a survey by the Royal College of Nursing.

APPENDIX 4

Letter from Patricia Hewitt to Andrew Lansley

Dear Andrew

Thank you for your letter of 14 March about the financial management of the NHS.

You refer to my Department’s response to your request for information relating to the forecast year-end financial position of the NHS (our reference P000000067538), and request a review of the decision conveyed in that response. I confirm that this request has been passed to the Departments Review team, who will write to you regarding the findings of the review as soon as possible.

You also request further information, under the Freedom of Information Act, relating to control totals. I estimate that it will take an additional 20 working days to take a decision on where the balance of the public interest lies. Therefore, we plan to let you have response by 15 May.

If you are unhappy with this decision, and wish to make a complaint or request a review of our decision, you should write to:

Freedom of Information Unit Department of Health
Room 360c
Skipton House
80 London Road
SE1 6LH

If you are not content with the outcome your complaint, you may apply directly to the Information Commissioner for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by the Department.

The information Commissioner can be contacted at:

The Information Commissioners Office
Wycliffe House
Water Lane Wilmslow Cheshire SK9 5AF.

In relation to the points that you raise about payment by results, I can only apologise for the fact that the 2006–07 tariff, issued on 31 January, had some errors which led to its withdrawal. I recognise that withdrawing the tariff will have delayed NHS organisations refinement of their financial and service plans for 2006–07. On behalf of the Department, I regret very much that NHS staff have had their work disrupted by this error.

The 2006–07 tariff has now been corrected, validated with the help of the NHS and re-issued. NHS organisations have now resumed their planning for the new financial year, and a background note on the Department of Health website provides more detail about the tariff corrections which were required. This can be found at: www.dh.gov.uk/paymentbyresults. Clearly, there are lessons to learn for the future about the tariff setting process, and we have therefore commissioned a review to be led by John Lawlor, Chief Executive of Harrogate and District NHS Foundation Trust.

Turning to your concerns about “topslicing”, the new Strategic Health Authorities (SHAs) will take the lead locally in developing and implementing a service and financial strategy for managing the financial position within their locality. This will include creating local reserves to deal with local problems. The size of the reserves and the contribution from each Primary Care Trust (PCT) will vary according to local circumstances, but the underlying principle will be fairness. We expect the following:
SHAs to maintain the integrity of the allocations system with PCTs entitled to repayment of an contributions over a reasonable period not usually exceeding the three year allocation cycle;

— SHAs to have full regard to the financial and service position of each organisation in determining how reserves are generated and applied;

— transparency both in the creation and use of reserves; and

— all organisations that are overspending to show improvement during 2006–07, and by the end of the ear everyone should have monthly income covering monthly expenditure.

There are a relatively small number of NHS bodies with large deficits, so creating SHA reserves from across their patch will allow SHAs to balance their books whilst the SHAs and turnaround teams performance manage the overspending organisations back to financial balance.

I hope this response clarifies the Department’s position.

Patricia Hewitt
12 April 2006

Evidence submitted by Robert Lapraik (Def 10)

1. Summary

1.1 The generally held perception is that NHS Trusts are paid on an equal basis for each patient they treat and that therefore their financial bottom line gives a fair indication of their performance. Sadly, this is not the case. Over the last few years there have been large variances from the norm payment (national tariff) and in reality those furthest below the norm are penalised the most in terms of their slow rate of movement to tariff.

1.2 This short paper explains how an excellent medium-sized acute Trust has been consistently underpaid with the full knowledge and assent of the SHA, the DH and Ministers. This under-payment led to an operating deficit and, as a result of Resource Accounting and Budgeting, the apparent deficit rapidly increased year on year to the point where financial recovery was not possible. At significant cost, a turnaround team was called in to tackle the Trust deficit although the issue lies predominantly outside Trust control ie in the price being paid for each patient, rather than inefficiency in the provider. The turnaround is likely to be unsustainable and the adverse effects on service quality substantial as the underlying issues of under-funded activity and high demand from an elderly population remain unresolved.

2. Introduction

2.1 The Royal West Sussex NHS Trust (St Richard’s Hospital) is a 420 bed acute general hospital serving the 212,000 people living in western West Sussex and East Hampshire. Nearly 25% of the local population is over the age of 65 and therefore the hospital caters for the needs of an unusually elderly population. The Trust has a turnover of £100 million.

2.2 The Trust has an excellent balanced scorecard of performance in cost efficiency1, clinical outcomes2,3, patient4,5, and staff satisfaction6 and a strong reputation for quality but has run at a deficit for the last five years. This brief paper identifies the key reasons for the deficit. Each of the key issues is supported by evidence in the references.

3. Financial Background

3.1 The nub of the issue is that, despite being efficient, the Trust has been paid well below the national tariff for each patient treated. Caroline Flint MP acknowledged this issue in the debate7 in Westminster Hall on 6 July 2005, where the minister stated, “hospitals such as St Richard’s have not been receiving the payment they deserve . . .”

3.2 Delays in implementing the tariff and the slow transition from historically low prices have denied the Trust up to £16 million per year. In 2004–05 the Trust was paid at only 80% of tariff8. The Trust would have returned a surplus across the last five years if it had been paid national tariff for each patient.

3.3 Despite being challenged via the “arbitration process”, Surrey and Sussex SHA agreed the decision for PCTs to pay the Trust substantially below tariff for the steadily rising numbers of patients requiring treatment. The distance from national tariff, reaching some £16 million per year, provides an objective quantification of this historic “under-payment”. This explains how a hospital Trust can, at the same time, be both efficient and in deficit.
4. **Escalating Deficit**

4.1 The deficit created by under-payment rapidly escalates under the NHS accounting system known as Resource Accounting and Budgeting (RAB), whereby the deficit in one year is removed from the Trust’s income the following year. Over a 5-year period (of consistent deficit) RAB triples the accumulated deficit compared with normal accounting. This results in Trusts quickly reaching an unrecoverable position.

5. **Impact on Local Health Services**

5.1 Owing to this systematic underpayment, the “problem” was perceived to lie in the Trust. A turnaround team, costing £0.5 million was sent into the Royal West Sussex Trust, which was already operating at better than average efficiency, while the under-funded demand for acute care has not been addressed. By focusing on an already efficient provider, the main effect of turnaround intervention is likely to be a diminution in the quality of service, morale and clinical effectiveness of the hospital. Furthermore, this will not produce a sustainable health economy as the underlying causes remain unresolved.

6. **Conclusion**

6.1 It is not widely understood that hospitals have been paid vastly different prices across the country for the treatment that they provide, some significantly above and some significantly below the national benchmark (tariff). However, even when tariff is being paid by PCTs, the historically low-priced hospitals, such as the Royal West Sussex Trust, have not received tariff owing to the DH cap on the rate at which the transition to tariff prices can take place.

6.2 The deficits created by this under-payment for each patient are not easily resolved by the Trust as treating fewer patients simply reduces Trust income. In addition, the effect of RAB is to escalate the accumulated deficit in a way that makes financial recovery impossible. Finally, the impact of a turnaround team, in these circumstances, is likely to be detrimental to the hospital Trust and fail to resolve the underlying issue of under-funded activity and high demand from an elderly population.

Robert Lapraik
Ex-Chief Executive, Royal West Sussex NHS Trust
1 June 2006

7. **References**

3. Dr Foster. (2005) *Dr Foster Hospital Guide—Top 3 Hospitals in Country*.

---

Evidence submitted by Peter Mellor (Def 19)

I am a member of “Save Felixstowe Hospitals”, whose aim is to retain the excellent services of our Community Hospital for Felixstowe and a Convalescent Hospital for East Suffolk. For over a decade I have attended most of the local Board meetings (Suffolk Health Authority (SHA), Suffolk Coastal PCG/T) as a member of the public (often alone). I have witnessed with dismay the onslaught of changes from the DoH with which local Boards have tried to comply and the gradual increase in deficit which began to dominate the provision of good healthcare in late 2004.
SUMMARY

In my opinion the Department of Health (DoH) headquarters is the main cause of deficits through their micro-management and their plethora of changes, each inadequately planned and underfunded. The DoH insistence on franchising its peripheral and core services to the private sector is transferring several percent of the NHS budget to multi-national organisations, many of unsatisfactory integrity. The Strategic Health Authorities (STHA) are an almost total and unnecessary overhead (over £4 billion in 2004–05), without which there would be a significant saving and little effect on healthcare. The Primary Care Trusts (PCT) are a bit wasteful through incompetence but they waste more as puppets of the DoH who demand too many underfunded, ill-considered changes. None of the above shows any sign of accountability to their patients or the public. Many rural PCTs (such as my Suffolk Coastal) are underfunded by more than their deficit, cumulatively. Unlike the NHS deficit of about 1%, many PCT deficits are around 5% which cannot reasonably be repaid by April 2007 without serious cuts in healthcare. Curiously, as clinicians lose out to executives, the management has worsened so much that healthcare is now being cut despite the huge increase in NHS funding.

PCT DEFICIT AND REQUIRED SAVINGS

Suffolk East PCT (unofficial merger between Ipswich, Suffolk Central and Suffolk Coastal) has made several cuts during 2005–06 which has resulted in a substantially increased deficit for Ipswich Hospital NHS Trust (IHT). The resulting deficit at April 2006 was £20 million £16 million at April 2005. The DoH funding for 2006–07 is about £390 million. In October 2006 we expect SEPCT to join with Suffolk West PCT (SWPCT) and the deficits will no doubt be combined (not yet published but roughly similar) and continue. Even if the new (un-named but may be SWPCT) PCT were effective immediately, the savings of over 5% of the total budget by April 2007 will necessitate cuts in healthcare. It will take over a year for the new PCT to anything but concentrate on the deficit and cuts to reduce it. Just when Ipswich Hospital is announcing ever-increasing deficits and bed closures it is building additional capacity (Garrett-Anderson centre), presumably with PFI—none of us can understand the duplicity but perhaps it is an opportunity for the private sector to gain control of the whole hospital.

REASONS FOR THE DEFICITS

SEPCT gets about 90% of the national average allocation. My perception is that an average allocation would have kept SEPCT in financial balance, despite two big factors: (a) the debt inherited from SHA in 2002; (b) the high and increasing proportion of elderly residents for which a 12% uplift was expected. I have tried to get the PCT to challenge the DoH funding but in vain. Some of the figures in the funding formula are questionable but the PCT accepts the allocation, regardless of accuracy or fairness. In July 2005 I was told that Agenda for Change was employing 70 SEPCT staff (part-time) and that it needed 200 to complete by the target date (September 2005). The Process, still ongoing, and additional salaries have been underfunded and therefore contribute to the PCT deficit. The GP Contract was negotiated nationally but its consequences have resulted in additional underfunded costs for the PCT, especially for Out-of-Hours cover. Two years after the Contract the DoH is now saying that it wants GPs to offer their services when the public wants them—no organisation the size of the NHS should twist and turn at that rate. It is destabilising and wasteful.

The National Tariff has made the use of step-down beds artificially uneconomic due to double charging of their portion of treatment. It is a market concept with no clinical justification. Patient records in Ipswich Hospital continues to cost £600k pa and the National Computer Records system is still unavailable—a local cost but the responsibility and fault of the DoH. Choose & Book is being operated in a fashion by the SEPCT but at its own expense because the DoH system is unavailable—again a local cost but the responsibility of the DoH.

Fortunately I don’t think our area has yet suffered major additional costs of PFI (PPP) or LIFT but that will change in the near future; they are required by the DoH but funded by local Trusts for the next 30 years. The DoH is determined to reduce the number of acute and Community hospital beds. Trusts with PFI commitments are finding the charge per patient rise with consequences on their deficits and patient care. Probably the largest contribution to the waste of NHS money is the out-sourcing of NHS services to the private sector. The PFI programme for hospitals is now accepted to have cost at least 40% more. The waste of tax-payers money as the private sector bites deeply into Primary Care is unknown but likely to be of similar order. Even worse, the dominant objective will be for profit, not the care of patients.

FUNDING FORMULA

I have been unable to check whether the formula has been correctly applied for our PCT: the Finance Director considers it a waste of his time to try to understand it because the DoH would not change their allocation even if a mistake were found. The DoH simply directed me back to the PCT. I wonder whether any member of the Select Committee understands the formula and the resultant allocations to PCTs. The population served by a PCT is an important factor in the formula but the figures used for Suffolk Coastal
PCT cannot be understood and are questionable; exactly the same figures are used for succeeding years in the Financial Report Summaries and yet we know that the population is rising. I agree that some differentiation between PCTs is necessary and a formula is justified. However, in view of its crucial importance to deficits, the allocation of funding ought to be transparent and fairly implemented. PCT fundings in the constituencies of notable members of the Government and DoH are above the national average. Perhaps that is justified—who knows?

CONSEQUENCES OF THE DEFICITS

To avoid double charging under the National Tariff and to get money for the building given to the area, the SEPCT proposes to close the Bartlet Convalescent Hospital and replace it by Care in the Community, most of which should be provided by means-tested Social Services. Unfortunately the lack of trained staff and the big deficit will probably mean that the Bartlet closure will simply be money saving for the PCT and the loss of a much-wanted service. Ipswich acute Hospital (IHT) has already closed about 80 beds and many more are being considered. It has had a long-standing problem of “delayed transfers of care” and this must surely get worse, despite an aggressive programme to keep patients out of hospital, (a) because of closed IHT beds and (b) because of closed Convalescent Hospitals.

Acute hospitals without deficits will become foundation hospitals first and their market objectives will favour the “easy” jobs, not those requiring long term care who will either use the other acute hospitals or be turned away completely. It is important but uncertain what will happen when all acute hospitals get foundation status. Presumably long term care will be completely excluded from the NHS; as a 68 year old I fear for my future healthcare and savings. The DoH claims to support Community Hospitals but they are forcing PCTs to close them. The PCT deficits are now closing Convalescent Hospitals and we are promised increased Care in the Community. For some patients this is good news, even though most will have to pay for the Social Services care and the army of staff have yet to appear. For an important minority, care in their own home would be unsafe and they will have to try to find a nursing home for their recovery. In all areas with whom I have been in contact, patients want to retain the NHS Convalescent Hospitals but it seems that the “Patient-Led NHS” does not mean what it says. In rural areas Care in the Community will require considerable car travel and travel time by carers and it looks to be unsustainable as fuel prices and congestion increase. At that time local hospitals will be sold and there will be no local alternative. The monitoring of Care in the Community staff, for their quality of service, kindness and to prevent the abuse of patients, will be much more difficult than in hospitals but is ignored.

In 2004 our PCT produced A Fresher Future for Felixstowe with announcements and commitments made in public and before our MP. Beds were closed but the rest of the package was dropped through lack of money. Our PCT has actually admitted that the local public does not trust them. We used to trust government departments but now find their words and deeds are different. As both major parliamentary parties favour privatisation the cost and quality of healthcare, especially for the longer-term patients, will worsen until either: (a) a public revolution and/or (b) a new Beveridge emerges to take the NHS back to its founding principles.

SOLUTIONS

Instead of reorganising the STHAs I would scrap them. Apart from the savings it would put the DoH into direct contact with the Trusts—better understanding and the extra load would reduce the number of new ideas from the “bright boys and girls in the DoH”. Take a very careful look at the funding formula and funding allocations, make any necessary changes and make them understandable. Provide a longer period for the repayment of deficits if they still remain. Reverse the headlong slide into privatisation. The British and foreign companies will increasingly fleece the NHS and grow fat on tax-payers money. Return control to those with clinical experience. The “un-managed NHS” was more efficient than it is and will be. Minute accounting and statistics never cured anyone but give an increasing burden of administration. New schemes should be much more carefully thought out before being implemented (eg GP Contract). Computer schemes especially should be tested much more thoroughly before being released to Trusts.

I thank the Health Committee for the opportunity to contribute. You have a heavy responsibility to serve the nation.

Peter Mellor
Save Felixstowe Hospitals
June 2006
INTRODUCTION

As Member of Parliament for Crawley I have been actively engaged on the subject of local NHS finance and performance since first being elected in 1997. My local acute trust, Surrey and Sussex currently has the largest single deficit in the NHS. A succession of Chief Executives have failed to control the budget which has therefore increased year on year. Pertinent issues such as the high level of agency staff have not been effectively addressed. The reasons for the deficit are complex, however the substantial progress made since the “turn around team” have been working with the trust management would seem to indicate that this has fundamentally been an issue of poor strategic management.

SIZE OF THE DEFICIT AT SURREY AND SUSSEX NHS TRUST

The deficit at the end of the financial year 2004–5 was £30.7 million with the forecast operating deficit for 2005–06 being £28.6 million. The Trust started last financial year spending £3.2 million a month over income. By December 2005 that figure was reduced in month to £2 million. Including the carry forward of historical accumulated debt—the total deficit for 2005–06 is forecast to be £58.2 million. Arrangements are in place for transitional support from the Surrey and Sussex Strategic Health Authority of £17 million.

REASON FOR DEFICIT FROM TURNAROUND TEAMS FINDINGS

The turnaround Team went into Surrey and Sussex NHS Trust in January 2006.

Their findings relating to the reasons for poor financial and performance delivery included:

— The lack of a culture of ownership and accountability.
— Ambiguity of objectives and targets.
— Constant change of direction causing both confusion and blurring of targets.
— Poor data and information to support the control environment.
— Failure to follow through necessary actions.

EFFECT ON CARE

The effects on care have at times been significant.

Planning for service reconfigurations has appeared inadequate and on occasion resulted in an unacceptable level of service to patients.

Examples include:

— Ambulances waiting for hours outside East Surrey A&E following the transfer of complex acute work and the downgrading of Crawley A&E to a Walk In centre.
— Breaches on several key target areas including waiting times in A&E, waiting times for routine surgery and cancer treatment.
— Crawley patients being discharged from East Surrey A&E in the middle of the night with no transport available.
— Failure to transfer patients back to Crawley Hospital to complete their recovery following the acute phase of their care at East Surrey.
— Poor communication with staff surrounding service transfers leading to unnecessary anxiety and confusion amongst staff, local media, patients and the general public.

JOB LOSSES

The Trust announced at the beginning of April 2006 their intention to reduce posts at the Trust by around 400 of which permanent staff reductions were predicted at around 100.

With a normal annual staff turnover of between 4–600 staff, the hope is that the reductions will be managed through re-training and natural wastage.
Laura Moffatt’s Conclusions and Recommendations

The Turnaround team at Surrey and Sussex NHS Trust (SASH) have been very helpful and there is general agreement that their impact has been positive. The nine “work streams” identified provide a real focus for the team now working on turning around finance and performance at the Trust.

I believe they have demonstrated value in spite of the additional cost burden (around £700,000) as they have effectively “stemmed” the leaking of money. The savings within the first month exceeded the team’s costs significantly.

There remain issues of relating to capitation which need to be addressed. Extra support ceases when a Trust reaches 11%.

My primary concern has always been the quality of patient care.

Significant improvements have already been seen with performance at the Trust and that must be recognised.

— Waiting times for surgery are at their lowest ever—12–14 weeks on average with a maximum of six months.
— Cancer waiting times are now amongst the best in the country.
— The wait for routine outpatients is now around 11 weeks.
— There have been dramatic improvements in A&E waiting times (within two point of target) when a year ago SASH had one of the lowest levels of performance in England.

The interface between deficits and the campaigning undertaken by some organisations has been unhelpful. It is important to deal in facts particularly relating to the changing models of modern healthcare as set out in the White Paper and in the joint statement from the Royal Colleges of Physicians and General Practitioners—Making the best use of doctors’ skills—a balanced partnership.

This refocusing on care delivered out of the acute hospital setting, combined with the transfer of Crawley Hospital to the management of the PCT means Crawley is potentially well placed to develop cutting edge services for the future. The resulting and inevitable post transfers and workforce restructuring do not necessarily represent job cuts or service deterioration.

However there needs to be rigorous and on-going scrutiny of both finance and performance across the local health economy.

Laura Moffatt MP
7 June 2006

Evidence submitted by Professor Calum Paton, Keele University (Def 03)

My comments below are supported by the Non-Executive Directors who were on the Board of the Trust with me, and by Mr Dave Crowley, former Chief Executive of the Trust and previously Director of Finance (at the Trust from 1998 to 2005).

1. Deficits Overall

There are both national and local reasons for the NHS “deficit crisis”. Equally, deficits affect a variety of types of Trust—those which have had good reputations and demonstrated good performance as well as those which have not.

2. National Reasons

The factors listed below apply to different extents in different Trusts. Those Trusts in greatest deficit may be victims of “many external (national) factors hitting”, internal/efficiency problems or both.

On the “supply side”, there are five main factors causing financial pressure: Agenda for Change, the workforce and pay reform; the cost of the new consultant contract; the cost of the new GP contract; the cost of continuing implementation of the European Working Time Directive; and the cost of implementation of the national “IM and T” strategy. The government (and Department of Health) (DoH) failed to cost the employment contracts correctly (I assume you will acquire the quantitative data on this). Individual Trusts may also have pressure from other factors, such as the cost of the Clinical Negligence Scheme for Trusts.

On the “demand side”, the target regime has included meeting the government’s access targets up to 2005 (pre-election, as it happens) in particular, as well as seeking to achieve the Prime Minister’s and Department of Health’s ambitious “2008 targets” by planning appropriately for the future. Even with ambitious reconfiguration, these targets are expensive. The “politics of the NHS”—or rather of governmental decision-making—mean that central “commands” are issued without proper account for their effects upon overall NHS strategy and finance. In a nutshell, it’s “targets one year; finance the next…”
Furthermore some of the targets (such as 98% compliance with the “four hour wait” target in A and E have had a very high “opportunity cost” at the margin, especially for hospitals facing high emergency activity as a result of failure to tackle the causes of these in the wider (local) health economy.

But there are key factors beyond this creating financial pressures, which might be termed the “three Ps” (four, if you add “pay”, above):

Firstly, “PCTs and purchasing”: “Shifting the Balance of Power” (StBoP) (2001) created a highly expensive and dysfunctional structure for “commissioning” (a euphemism—mostly purchasing, or indeed financial panic at year-end, in practice). It can reasonably be estimated that it cost £1.5 billion per annum in “management overhead” (even before its dysfunctional effects had wider disadvantages eg failure to organise and co-ordinate commissioning for secondary and tertiary services at the right level to reflect clinical networks, natural catchment areas for services et al).

The “new re-organisation”, set in train through Commissioning a Patient-Led NHS’ (July, 2005)—one of the reasons for Nigel Crisp’s resignation—was intended to rationalise some of this. It has been botched through local political compromises (as evidenced by the outcome, announced on 16 May 2006) in the context of the government’s weakened position in Parliament and generally.

Those Trusts (mostly hospitals) which faced “too many too small” PCTs were most at risk. Additionally there was simply not enough “quality management and leadership” to go round when 100 health authorities were replaced with nearly 350 PCTs. Some areas of the country fared better (eg Birmingham, where the PCTs were larger and more “fit for purpose”).

Secondly, “private deals”: some Trusts faced expensive PFI deals (and expensive capital (eg “impairments”) costs in preparing for imminent PFIs. Additionally, central revenue moneys were top-sliced in order to “pump prime” the “new independent sector” (ie to entice new private providers). Again, this is a national policy with varying local effects.

Thirdly, policy confusions: to the “commissioning” issue above, add the costs of the “new market” (choice/Choose and Book plus Payment by Results (PBR)); the costs of fragmentary central “command and control” targets; the costs of all the new institutions to regulate, inspect and ensure compliance; and the costs of “managing local collaboration” (against the grain of the incentives created by the above).

A reasonable estimate of the cost of all this (including StBoP) is more than £3 billion ie three times the national deficit. The King’s Fund has recently estimated the national deficit at £1.2 billion (up from £200 million predicted before Christmas—suggesting both that the Strategic Health Authorities and the DoH were “out to lunch” as regards the true picture—see my earlier note to you on the “kiss up, kick down” culture).

3. Local Issues

Just as the national factors “play differently” in different localities, the local factors often (although not always) have national associations.

Firstly, it is argued (eg by the PM) that “reform is always painful” ie “no pain, no gain”. The bad news is that it is only from this Financial Year onwards (2006–07) that “reform” (especially PBR) is really “kicking in”. Last year, many hospital Trusts were victims of the more disreputable elements of the “old system” pre-PBR (when local PCTs often “passed the buck” ie failed to control activity for hospitals through effective primary and community services, but then also failed to pay the hospital for what became necessary admissions). This year, the financial “swings and roundabouts” will presumably more whopping deficits, unless national policy is amended on the hoof (as is already happening, admittedly!)

Secondly, some local Trusts had concealed deficits or had had received persistent year-on-year brokerage funds, often “written off”. The Secretary of State is partly right—some “deficit Trusts” did. But others did not, but were “bought low” through poor commissioning, buck-passing (see above) et al. The Trust I chaired broke even legitimately for six years, and only in the last of these was a limited amount of “non-recurrent” money necessary. This was small beer by reference to the total deficit.

Thirdly, it was argued by Ministers until recently—although increasingly implausibly—that deficits were the exception that proved the rule, with soundbites like “50% of the deficit in 7% of Trusts”. What about the other 50% (ie a superficially plausible but meaningless soundbite). Perhaps more importantly, deficits are “politically concentrated” with SHAs seeking to minimise the number of organisations (PCTs, NHS Trusts and Foundation Trusts) with big deficits (eg by allowing some PCTs to “break even” or minimise deficit by underpaying the hospital). Even post-PBR, 2006–07 onwards, PCTs will seek to limit their outgoings through restrictive contracts.

Fourthly, the “turnaround” regime is too stark (eg the “double whammy” whereby structural deficit—for lots of the above reasons—has to paid off in one year; indeed twice, as both cost-reduction and repayment of the previous year’s debt has to occur in 2006–07. This was half-admitted by the Secretary of State on Panorama some weeks ago, when she said she’d ask the Audit Commission to examine it when under pressure during interview.
But perhaps more importantly, “turnaround” is occurring in a fragmented way (because of the “old market” ie “the purchaser/provider split”, which was never abolished but enhanced through StBoP, and also the “new market” which sets PCTs (now in a confusing relationship with GP practices as a result of Practice-Based Commissioning) against hospitals. Crucially, each agency solves its own financial problems without things being “joined up”—for example, the Trust I chaired will be making cuts assuming enhanced community facilities (eg to allow radical action on length of stay in hospital) whereas PCTs are actually cutting those facilities!

Professor Calum Paton
Director of Centre for Health Planning and Management
Keele University
May 2006

Evidence submitted by Jillian Pritchard (Def 04)

It would be sensible to consider all the targets imposed over the last few years and measure the number of posts introduced to measure the achievement of targets. Cost those posts. Then look at all the ways in which every target can be misinterpreted and manipulated and the time and trouble and cost so to do. Next ask the appropriate professional bodies to show you all the clinical guidelines which exist to achieve the same ends. Cost what it needs to implement the guidelines adequately and reallocate the target related money to do this. I suggest there will be both financial savings and an improved health service.

Further, why the obsession with “modernisation”, “reform”, “change”. These are not synonymous with good or improved practice. I suggest that any good practitioner is constantly reviewing clinical practice against research, reviews and peer recommendations and updates policy in line with these. “Modernisation” is often banded about—my department submitted ourselves to a half day session to see how we might “modernise” only to demonstrate what we could have told anyone in the first place that we had already done what was described as modernising and more. We called it keeping our practice as effective as possible. Why can’t politicians just get off our backs, thus save money and improve the NHS in the process. We are not charlatans who need to be controlled but clinicians who want the best for our patients and NHS colleagues and are prepared to work very hard to achieve it.

Dr Jillian Pritchard
St Peter’s Hospital, Chertsey, Surrey
1 May 2006

Evidence submitted by Christopher Reynolds (Def 22)

This submission gives details of the NHS Deficit on the funding of mental health budgets in Hertfordshire and the potential impact of up to £12 million reduction in funding on services.

1. Following a family suicide in 1985 I have been actively involved in the mental health provision in Hertfordshire as a trustee for Mind in Dacorum, on the North West Herts Community Health Council, as the lay member on the board of the Dacorum Primary Care Group, and on many other committees.

2. I am currently vice-chair of the Hertfordshire Partnership Patient and Public Involvement Forum. In this role I represent the Forum on the Board of the Hertfordshire Partnership NHS Trust (which provides mental health and learning disabilities services), the Joint Commissioning Partnership Board (which commissions mental health and adult care in Hertfordshire and involves eight PCTs and the Hertfordshire County Council), and the Hertfordshire County Council Health Scrutiny Committee.

3. I was actively involved in the Investing in Your Mental Health consultation, the findings of which were agreed in December 2005. This looked at how better primary care and community services could improve recovery rates and reduce the number of long-term disability patients and the demand for expensive in-patient beds.

4. In making a submission to this committee I am concentrating on the relevance to mental health issues in Hertfordshire and when I criticise local management decisions I am aware that national decisions and policies may have ruled out more rational local actions.

5. A significant problem relates to the acute hospitals—and the rejection of a consultation in the late 1990s to centralise on a new site due to public pressure from those who lived close to the hospitals. Multiple site working on less than ideal locations is at least part of the financial “cancer” which has infected the acute hospital budgets, and spread to the PCTs. The result has been a comparative squeeze on the mental health budgets, with the end of year expenditure being a smaller percentage of the actual spend compared with the start of year budget.
6. When the eight Hertfordshire PCTs were set up in 2001 the Joint Commissioning Partnership Board allowed them to delegate responsibility for mental health. While things have improved with the SHA led *Investing in Your Mental Health* consultation, the delegation arrangements meant that the subject was comparatively ignored at the primary care level. Some PCT Boards seem to have initially considered it as little more than a black hole in the financial spread sheet. It seems that the comparatively low profile of the medical aspects of mental health at the PCT board level have made it “easier” to put pressure on its finances.

7. Since it was formed in 2001 the Hertfordshire Partnership Trust has balanced its books in every year. It income has increased during this period (but at a slower rate than some other areas of health in Hertfordshire) and it has been increasingly under pressure to subsidize the overspend elsewhere. For 2006–07 the SHA advised the PCTs to apply a 5% top slice to all trusts—with no medical risk assessment being made to see if this could be done without significantly disadvantaging patients. HPT assess that this brings the total “efficiency” and other cuts it has been asked to make to £12 million over two years. For those working in the voluntary sector there is good evidence that some of the efficiency savings made in 2005–06 have proved to be real cuts in the level of service to patients.

8. Because the decision to make a 5% top slice came only a couple of months after the major *Investing in Your Mental Health* consultation had been approved it was clear that there would need to be a consultation. This was rushed through on a shortened timescale, received overwhelming opposition and £3.2 million of the cuts have been referred to the Secretary of State by the County Council Scrutiny Committee. The cuts are now in a state of limbo—which is no good for patients or staff.

9. If cuts have to be made it is important that one is honest about them. To present them as if viewed through rose-coloured spectacles misleads both the public and also the Secretary of State as to the real risks to patients and carers. The following examples come from the consultation (I could give many more)—but I am sure they are commonly used to misrepresent the effects of cuts across the NHS.

9.1 Mental health support is provided by many agencies and not just the NHS. It was assumed that other agencies would have the spare capacity to provide services to replace those which were being cut. However the PCTs knew full well that voluntary sector services were already inadequate in many parts of the county—and their funding was being reduced. Nowhere were there any mentions of the quality of any replacement service of patient support.

9.2 The consultation ignored what would happen to patients between the time the cuts were made (immediately) and the time other agencies could fund (where from???) and establish replacement support services. This would be a period of significantly enhanced risks.

9.3 The consultation specifically asked for risks associated with each cut. Over sixty organisations from user and care groups, through to clinicians in primary and secondary care provided written submissions indicating significant risks ranging from increased suicide rates to cuts which would prove to be false economies. These were all ignored in some cases without the area of perceived risk even being identified.

9.4 1984 newspeak type arguments, often robbing Peter to pay Paul, were used to justify cuts. For example continuing care services were transferred to Hertfordshire Partnership Trust—but under-funded. This represented a cut of circa £1 million pa in core mental health funding and a saving of £3 million pa by the PCTs. The fact that the PCTs had previously overspent was used as an argument for further cuts on core mental health services.

9.5 The problem with this consultation, and I suspect many others, is that the consultation was carried out by managers with little first-hand understanding of mental health (see para 6) and who were under orders to make the cuts regardless. I would like the committee to consider the following recommendation, to ensure that cuts in medical services which could adversely affect patients are seen to be approved by suitably qualified expert committees, and not just by managers.

10.1 When any consultation involves cutting services for financial reasons the consultation document, and the final response document, should contain signed reports by the clinical governance committee of all relevant trusts (and the equivalent from any relevant support agencies) relating to patient safety and welfare issues.

11. The national weighting of per capita payments protects the more needy geographical areas of the UK. The committee might consider proposing a mechanism to protect the interests of the more vulnerable members of society, so that money is not taken from mental health and learning difficulties to bail out overspending acute hospitals.

I will be very happy to provide further evidence if requested.

*Chris Reynolds*

6 June 2006
Evidence submitted by Professor Mervyn Stone, University College London (Def 07)

Mervyn Stone is emeritus professor of statistics in the Department of Statistical Science at UCL.

His pro bono interest in the PCT funding formula began in 2002 in response to the wider concerns of The Community Voice, the NW London & SW Herts organisation that represents the interests of NHS patients in at least three PCTs.

SUMMARY

Graphical and tabular evidence is presented to suggest that unfairness in the current funding formula might account for some Primary Care Trust deficits. Evidence is tabled that the formula has been constructed by indefensible statistical methods. An attempt is made to communicate a wider understanding of that evidence in non-technical language.

1. Per Capita Figures

1.1 Figure 1 of Annex A plots data for the 301 PCTs out of the 303 listed in the Department of Health’s document for which figures are available for both axes. The y-axis is the (presumably cumulative) surplus (negative if deficit) by the end of 2004–05, expressed as a percentage of the 2004–05 turnover. The x-axis is the PCT’s target index for the period 2003–06, defined as the (per capita) ratio of the formula-derived unified weighted population to the estimate of the population for which the PCT is responsible.

1.2 Table 1 gives the numbers and column percentages of PCTs in the six categories generated by two classifications of the points in Figure 1.

<table>
<thead>
<tr>
<th></th>
<th>Target index below average*</th>
<th>Target index above average*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus</td>
<td>98 (57%)</td>
<td>110 (86%)</td>
<td>208 (69%)</td>
</tr>
<tr>
<td>No surplus or deficit</td>
<td>4 (2%)</td>
<td>2 (2%)</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>Deficit</td>
<td>71 (41%)</td>
<td>16 (12%)</td>
<td>87 (29%)</td>
</tr>
<tr>
<td>Total</td>
<td>173 (100%)</td>
<td>128 (100%)</td>
<td>301 (100%)</td>
</tr>
</tbody>
</table>

*Weighted by PCT population

Table 2 does the same for the six-month forecasts of the surplus/deficit percentage for 2005–06 as rounded to one decimal place in the DoH table.

<table>
<thead>
<tr>
<th></th>
<th>Target index below average*</th>
<th>Target index above average*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus</td>
<td>11 (6%)</td>
<td>20 (16%)</td>
<td>31 (10%)</td>
</tr>
<tr>
<td>In (−0.05%, 0.05%)</td>
<td>113 (65%)</td>
<td>90 (70%)</td>
<td>203 (67%)</td>
</tr>
<tr>
<td>Deficit</td>
<td>49 (28%)</td>
<td>18 (14%)</td>
<td>67 (22%)</td>
</tr>
<tr>
<td>Total</td>
<td>173 (100%)</td>
<td>128 (100%)</td>
<td>301 (100%)</td>
</tr>
</tbody>
</table>

*Weighted by PCT population.

1.3 Tables 1 and 2 and Annex A’s Figures 1 and 2 reveal a strong positive association between surplus (whether actual or forecast) and target index. For Table 1, only 12% of PCTs have a deficit when their target index is above the national average, compared with 41% when their index is below the national average—the association is so clear that most statisticians would not bother to test it formally. For Table 2, it is statistically significant at $P < 0.001$. The association poses a sceptical question for anyone claiming that deficits of such magnitude are due to nothing more than mismanagement by the responsible chief executives.

1.4 Such a claim rests on the implicit assumption that the target index has helped to create a reasonably level playing field with respect to the variation of health needs between PCTs. Managers should therefore not complain about the up to two-fold differences in per capita funding (over the years during which deficits have been accumulated). If accepted, the “nothing more than mismanagement” claim implies that:

Recruitment of managerial ability by individual PCT boards has been strongly influenced by factors correlated with an index whose values were first ascertainable in 2002—so that PCTs getting below average target indices have (on the whole) recruited less competent chief executives than PCTs with above average indices.
Here I use the term “ascertainable” rather than “published” since I have not been able to find the per capita figures on the DoH website, where the unified weighted population and the estimated age-weighted population are listed in separate tables without bringing them together anywhere.

1.5 An alternative hypothesis is that the distribution of managerial talent has been effectively random across the PCTs of England and that we must look closely at the integrity of the allocation formula that generated the index and that has influenced and continues to influence the per capita funding of PCTs. A third possibility is that the formula is truly fair between PCTs and that there are historical pressures associated with differential funding that happen to be correlated with the largely innocent index.

1.6 That the formula can be taken to be fair between PCTs is hard to square with the independent analysis here reported, which suggests that fairness could only be fortuitous. I suggest that the reality may involve both a degree of administrative mismanagement in some fraction of PCTs and, almost certainly, some influential defect in the formula itself. Others will have to decide whether the Department of Health’s allegations of mismanagement are based on evidence that goes beyond the size of the deficit and is not just tautological: a good starting point would be to try to find a joint explanation of the interesting features of Figure 1 and the other graphs in Annex A. The next section will document the evidence that the current funding formula is indefensible.

2. A Formula Based on Faith not Science

2.1 The funding formula introduced in 2003 has undergone some changes for the 2006–07 and 2007–08 allocations. The changes are documented in the 5th edition3 of DoH’s helpfully detailed explanation of the formula. The original formula has lasted three years and is the one that may well have influenced the 2004–05 deficits. It was constructed by DoH’s resource allocation team from a variety of recommendations whose details are richly documented in the report4 from the Information and Statistics Division of NHS Scotland. That report was available for a while in electronic form as DoH’s RARP 26 which is how I will refer to the Scottish report. Copies are now obtainable only by personal application to ISD Scotland or, for personal use subject to copyright, from my own UCL webpage.

2.2 In 2003, in Written Answers for 8 January (pt 19), the Secretary of State for Health described the ISD Scotland research as “research into the new formula”. The Health Committee should be aware that there appear to be only five5–9 pieces of published research on the formula in its integrated operational form. I therefore request that these items be “put on the (evidence) table” despite their sadly uniform provenance.

2.3 To the best of my knowledge there is only one other paper in the academic literature that is directly relevant to the matter in hand. That is the “horse’s mouth” account10, by Professor Gravelle and the other members of the RARP 26 team, of the theoretical underpinning of one of the statistical models recommended in RARP 26 (a refinement of the “basic model” for acute care). Since this particular model was not adopted by DoH Leeds, it plays no role in the formula, but I will try to provide a readable explanation of the underlying theory in Annex B. The same theory was used to justify the two models (for acute & maternity services and mental health services) that were pieced together by DoH Leeds to make the formula we now have. Together with the more readable sections of Refs 5–7 and the downloadable graphs from Ref 8, Annex B offers those who can tolerate a little symbolic mathematics a route to a deeper understanding of the formula and its provenance than some of its defenders appear to have.

2.4 The whole critique of a PCT funding formula still based on the ISD Scotland research—and of the machinery of government that imposed it on NHS England—can now be placed in a broader context:

(i) England has been promised an NHS computer system that will bring all NHS GPs into a mutually accessible information data-base of continuously updated patient records that will encompass hospital and pharmacy data.

(ii) GPs are the gate-keepers to the bulk of health expenditure by PCTs and are likely to be the gatekeepers whatever fate awaits PCTs.

(iii) The Treasury may wish to devise new ways of funding that continue to respond to different needs for health resources in different areas of the country.

(iv) Is it conceivable that the Treasury would want to perpetuate any way that depended on the use of socio-economic proxies rather than on some form of direct measurement of health needs?
(v) It is now four years since RARP 264 held that:

The allocation of resources for health care across geographical areas in the NHS is based on the principle that individuals in equal need should have equal access to care, irrespective of where they live. To implement the principle it is necessary to measure need for health care in different areas. But those allocating resources do not have sufficient information to measure need directly [my italics].

(vi) The utilisation/proxy approach to the problem of inadequate information has failed to do more than placate political pressures—in different directions at different times. I suggest that a research programme be initiated that would aim, when implemented, to ensure that allocators would have enough information to measure most needs directly, to allocate funds fairly and to collect the evidence of that to satisfy the National Auditor.

(vii) Such a programme would have to throw light into some dark corners, just one of which would be the use by DoH of the phrase “equal health care for equal need” (echoed by RARP 26) which neglects the question of how to judge the priorities of widely different and competing types of health care—a question that an ill-comprehended formulaic approach may have served to conceal.

2.5 For some of us, statistical puzzles are better resolved by verbal rather than written explanation. I would therefore be willing to give a complementary oral account of the evidence.

Annex A

Table A1

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Definition or source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target index</td>
<td>(Unified weighted population)/(PCT population): Table 4.3, col G(^{11}); Table 5.2, col H(^{11})</td>
</tr>
<tr>
<td>2004-05 surplus (% of turnover)</td>
<td>DoH document for Health Committee(^{1})</td>
</tr>
<tr>
<td>2005-06 forecast surplus (%)</td>
<td>DoH document for Health Committee(^{2})</td>
</tr>
<tr>
<td>2003-04 per capita allocation (£000s)</td>
<td>Table 4.1, col F(^{11})</td>
</tr>
<tr>
<td>2003-06 allocation increase (%)</td>
<td>Table 4.1, col U(^{11})</td>
</tr>
</tbody>
</table>

There are 301 points in each of the appended scatter-plots—one point for every PCT with data for all the variables in Table A1. Such graphs suggest questions but do not resolve them. Curiosity about the possible interaction of target index and the variation in the large increase in allocations between 2003 and 2006 (in their relationship to deficits) leads one to Table A2—a further breakdown of the surplus/deficit numbers of Table 1 but excluding the six PCTs with neither surplus nor deficit.

Table A2

<table>
<thead>
<tr>
<th>NUMBERS AND PERCENTAGES OF PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004—05</td>
</tr>
<tr>
<td>Surplus</td>
</tr>
<tr>
<td>Deficit</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

\(^{a}\) Below average target index or 2003-06 allocation % increase

\(^{b}\) Above average target index or 03/06 allocation % increase

Looking at the percentages in the first two columns of the table, there is an indication—no more than that—of an association, among PCTs with below-average target index, between the deficit and the 2003 to 2006 allocation % increase (high increase goes with deficit!). The association is formally significant at \(P < 0.03\) not allowing for selection of feature.
Figure 1
THE ASSOCIATION BETWEEN DEFICIT AND TARGET INDEX

Figure 2
FORECAST SURPLUS VERSUS TARGET INDEX
Figure 3

SURPLUS VERSUS 2003–06 ALLOCATION INCREASE

Figure 4

2003–04 ALLOCATION PER HEAD (£000s) VERSUS TARGET INDEX
Figure 5

2003–06 ALLOCATION INCREASE VERSUS TARGET INDEX

UNDERSTANDING THE THEORETICAL UNDERPINNING

This attempt to express a verbal understanding is necessarily discursive. It uses minimal mathematical symbolism to bridge the gap between airy verbalism and statistical calculation.

B1 The first half of the summary of Gravelle et al10 reads well, even when broken down by sentence:
1. “Many health-care systems allocate funding according to measures of need.”
2. “The utilisation approach for measuring need rests on the assumptions that use of health care is determined by demand and supply and that need is an important element of demand.”
3. “By estimating utilisation models which allow for supply it is possible to isolate the socio-economic and health characteristics which affect demand.”
4. “A subset of these variables can then be identified by a combination of judgement and further analysis as needs variables to inform funding allocations.”
5. “We estimate utilisation models using newly assembled data on admissions to acute hospitals, measures of supply, morbidity and socio-economic characteristics for 8,414 small geographical areas in England.”

The 8,414 areas here are the electoral wards for which values were found to be available for all of the variables thought relevant to the RARP 26 study.

B2 The abstract concepts of “demand”, “need” and “supply” have to be related somehow to more concrete quantities. For demand and need, however, it seems that nothing more is required than that we postulate a single quantity $D$ that varies from ward to ward and expresses the demand for some particular category of health service (acute admissions in Gravelle et al10) by individuals in a ward, and then a single quantity $N$ that similarly expresses the need for that service. We do not have to define the quantities involved in order to express the quantitative sense of part of sentence B1.2 as the simple equation

$$D = N + N_{\text{not}}$$

where $N_{\text{not}}$ is the part of demand that is not need.

The theoreticians we are trying to understand are happy for us to leave both $D$ and $N$ at this less than concrete level. In contrast “supply” can be represented quite concretely by a number of immediately quantifiable variables. Table 1 of Gravelle et al10 lists the eight supply variables from “mean waiting time for elective admissions” to “accessibility score for private beds” that were selected from a much larger number. The multidimensional character of supply calls for a distinctive notation for which bold $S$ will serve.
B3 The remainder of B 1.2 claims that “utilisation” or “use” (U say) is “determined by demand and supply”. If the word “determined” means anything, it means that there must be a some formulation of U, that, as a function f of three arguments, matches the ward’s utilisation. The idea is that the variation of U would be maximally explicable by the variation of D and S from ward to ward, but that a possibly multidimensional element of pure randomness R is needed to make the function fit perfectly. Being strictly random, R is quite unpredictable, and the equation here would represent “truth” in the sense that there is no closer or more truthful “determination” of U than would be provided by S and, if we knew them, D and f—leaving R in the lap of the Gods.

B4 We need even more general theory before we can get to grips with B1.3! Let P stand for the “socio-economic and health characteristics” of an electoral ward that are taken to affect the demand in that ward. The symbol P stands for proxies—socio-economic factors are manifestly proxies for health need (such as the percentage of 17-year olds not going to university) and even the “health characteristics” that find their way into the Gravelle et al\(^{10}\) formula, such as the census-based “standardised illness ratio” and “percentage of babies of low birthweight”, are proxies for any direct measures of ill-health. Table 1 of Gravelle et al\(^{10}\) lists the 17 proxies that were initial candidates for inclusion in the formula that finally emerged.

B5 The theory then expresses the not-necessarily causal relationship between the proxies P and need N:

\[
N = g\{P, r\}
\]

where r is the random element that, when combined with P in the function g, matches the hypothetical value N of the ward’s need. Since N can remain undefined, so can the function g!

B6 We can eliminate the nebulous N between the equations in B2 and B5 and put the resulting expression for the equally nebulous D into the B3 equation. After all that, we still have a mystery wrapped in an enigma:

\[
U = f\{g\{P, r\} + N_{\text{foot}}, S, R\}.
\]

This equation may seem to take us a little closer to applicability because it does contain the observables U, P and S. But the unspecified functions f, g and the nebulous entity N_{\text{foot}} forcibly remind us that such general theory cannot dictate what reality may have in store. We may have got rid of the fine words but we are no nearer to having edible parsnips. The real point in setting out such nebulous mathematics, is to add force to the question—how has the NHS been able to make the transition from enigmatic to pragmatic? How has the formula that is claimed to measure need been able to emerge from something so insubstantial?

B7 This is the stage where, in the view of many independent statistically savvy observers, the RARP 26 investigators have gone well beyond the “judgement” referred to in B 1.4 and have substituted a faith that works wonders for a science that may be unattainable, when pursued along the lines of the general theory just formulated.

B8 The first act of faith was to replace the nebulous expression on the right-hand side of the equation in B6 by a simple combination of the variables S and P, calculable for each ward. The combination involves numerical coefficients that weight the individual contributions of those variables. The coefficient values were adjusted so that the surrogate formula came as close as it could to reproducing the variations of different standardisations of U from ward to ward within each of the 95 health authorities in existence when the building blocks of the funding formula were constructed. (The latest formula continues to use, in the two blocks selected by DoH Leeds, the original values of the adjustable coefficients.) Most of the adjustments were drastic—namely exclusion of the corresponding variable either because it was not statistically significant on some criterion or because its inclusion was judged to be unreasonable in the context of the surviving variables.

B9 The second act of faith was to go beyond isolating (in B1.3) and identifying (in B1.4) a subset of the proxy variables that might merely “inform funding allocations” (in B1.4). At the end of the Gravelle et al\(^{10}\) summary and in the body of the paper, there is more than a suggestion that a fitted formula can usefully influence directly the construction of a utilisation-based allocation formula. As just noted, the suggestion was taken up by DoH Leeds without any changes to the RARP 26 formulae that were adopted.

B10 It becomes clear that faith in subjective judgement is at the heart of the utilisation-based approach when one considers an admittedly unrealistic hypothetical scenario—the kind of extreme case that is widely used to test the logic of propositions in mathematics. Suppose that the RARP 26 investigation had discovered a smoothly varying function of the observables P and S (with a modest number of adjustable coefficients) that fitted well-nigh perfectly the values of the then current utilisation U in 8,414 wards. Could it be confidently asserted that the function would serve as a funding formula to help meet real need? The RARP 26 investigators would be right to say “No!” to that, and to argue that judgement would have to be used to strip out the socially unacceptable content—not willing to echo Alexander Pope’s “One truth is clear, Whatever is, is right.” But what assurance would we have that such judgement would leave a formula that would express real need with the precision that any funding formula requires?
B11. Specifically, how strong is the statistical support for the RARP 26 judgements and recommendations relating to the two need indices, for acute and maternity services and for mental health services, that DoH Leeds took from RARP 26? Detailed and rather technical critiques of these are given in Refs 5–7, for which what follows offers a readable summary.

B12. So here is an outline of how the need index for acute and maternity services (I in Ref 5) was extracted from a huge data base of values of U, P & S for 8,414 electoral wards and the knowledge of which health authority the ward had been in during the years to which the data refer.

B12.1. The “simple combination” introduced in B8 is taken to be a product of two expressions:

\[ U = U_{\text{national}} \times M \]

where \( U_{\text{national}} \) has no adjustable coefficients, being the calculable estimate of ward utilisation you get when you cost every individual by the national average for the individual’s age-band alone (so that males quite reasonably share the cost of maternity services). Even before looking at the formulation of the ward-specific multiplier M that raises or lowers the ward’s \( U_{\text{national}} \), it is noteworthy that this particular product is what is dictated (by a simple mathematical argument I will not reproduce here) by two construction principles:

(i) For each ward, the formula for utilisation should be the sum of contributions from each individual that are the same for individuals in the same age-band.

(ii) The ratio of the contributions in any two age-bands should be the same for all 8414 wards in the country, regardless of their socio-economic characteristics.

B12.2. Principle (i) is quite acceptable, but a fine “judgement” might be needed before (ii) is accepted as a principle. I can find no such “judgement” in RARP 26 or any statistical analysis to show that its implicit adoption might be over-ruling what the data would reveal. (The data on age-band costs at the ward level in 19 age-bands were at hand in the calculation of \( U_{\text{national}} \)) Rather it seems that the RARP 26 investigators were reluctant to accept the product form (what RARP 26 calls a “two-step age-adjustment”) as a way of handling the very different and cost-influential age-profiles of different wards. Part of their remit from DoH had been to investigate “alternative methodologies to replace the age-related components of the existing formulae” (which the DoH steering group may have seen as a form of “age-ism”). The alternatives were investigated but finally rejected in favour of “further investigation”.

B12.3. The multiplier M is given a simple and statistically convenient form that has no prior justification:

\[ M = \begin{align*} 
& \text{Average level of } U/U_{\text{national}} \text{ for the health authority (HA for short)} \\
& + (\text{Coefficient of 1st proxy } \times \text{Deviation of 1st proxy from its HA average}) + . \\
& + (\text{Coefficient of 1st supply variable } \times \text{Deviation of 1st supply variable from its HA average}) + . . . \\
& + \text{Inexplicable residual}.
\end{align*} \]

The dots . . . save paper—they stand for additional contributions (each of them like the products within brackets) from the large number of additional proxy and supply variables involved in adjustment of the coefficients. Such simple expressions (technically known as “linear combinations of adjustable coefficients”) were at the heart of the new theory of “combination of observations” that the mathematical genius of Karl Friedrich Gauss discovered over 200 years ago for use in geodetic surveys. Justification for their simple form depended entirely on the fact that, for Gauss, the quantities corresponding to the proxy deviations here were very small, so that a linear combination could be taken to be a satisfactory first-order approximation to the true relationship even if it were not expressible as a linear combination. Such an assumption cannot be made in the present context since proxies can vary considerably eg in some health authorities the variable “proportion of non-whites”, that plays an important role for the indices, will have been close to 0% in some wards and 100% in others.

B12.4. The adjustment of coefficients (“least squares estimation”) is made for each considered choice of variables from a much larger collection to minimise the sum of the squares of the 8414 differences between \( M \) and the \textit{per capita} ratio \( U/U_{\text{national}} \). Using the term “estimation” to describe the adjustment is somewhat prejudicial: it suggests that there is some scientific entity waiting to be determined. It should always be borne in mind that whatever reality there is in this construction of a funding formula is man-made.

B12.5. RARP 26 reveals that great attention was paid to the DoH remit that the study should propose “a methodology to adjust for unmet need”. The DoH steering group knew, from the what the University of York study found for the previous formula, what the new study might be able to find for the relationship between utilisation and the proportion of non-whites in small areas (such as wards). With a different measure of ethnicity (“proportion not in black ethnic groups”, taken negatively to avoid problems with the logarithm of zero), the York study had found a statistically significant positive coefficient/utilisation goes down (in the formula) as black ethnic proportion goes up. RARP 26’s intermediate “basic model” with ten proxies and eight supply variables duly found a statistically significant “wrong sign” for the coefficient of its measure of ethnicity (as well as for a measure of unemployment). This was interpreted as a “sign” (i.e. indication) of unmet need, especially when three more proxies (indices of morbidity) were added in the finally recommended “model” and the sign remained both “wrong” and statistically significant.
The steps to get from the fitted formula $M$ in B 12.3 to the recommended $I_2$ were:

(i) replacement of the HA averages (in the first line of $M$) by their national average to make a ‘level playing field’ with respect to any supply effect at the HA level that applied equally to all wards in the health authority;

(ii) setting all the supply deviations to zero for the same reason;

(iii) removal of the terms for the two proxies with the “wrong” signs on the grounds that such removal is equivalent to a correction for “unmet need” (favouring populations with higher non-white proportions or higher unemployment).

The analogical derivation of the mental health index $I_2$ has two notable differences.

For $I_2$, the per capita ratio $U/U_{\text{national}}$ to which the formula $M$ was fitted was recognised in RARP 26 as the “indirectly standardised” utilisation. As noted in B 12.1, this ratio is what is needed for consistency with two principles for the construction of any utilisation model. The consistency must have been either unknown to, or rejected by, the RARP 26 team because the variable to which the analogous mental health formula was fitted was the “directly standardised” utilisation whose use can be shown to violate the first (reasonable) principle.

Unlike the finding in B12.5 for the basic acute and maternity model, the basic mental health model fitted to utilisation in 7,982 wards did not deliver a statistically significant coefficient for the “proportion of non-whites” proxy. So, according to the rules of the statistical game being played, there was at that stage no “indication” of possible unmet need. RARP 26 nevertheless introduced a fresh variable (the psycho-social morbidity index) and was able to get the statistically significant “wrong sign” that justified correcting for the supposed unmet need, as was done for $I_1$. Although the resulting very different model was “poorly specified”, it was said to “provide interesting and plausible results”. Such subjective judgements provide the theoretical basis of the mental health index 12 that DoH built into the current formula.

RARP 26 has to appeal to judgements because its statistical methods are in themselves so questionable. Before getting to the stage of least-squares estimation with a specific choice of variables, that choice has been subject to the screening-out of many variables on the grounds of mutual correlation, even before a residual set is subject to the hazards of “forward and backward stepwise selection”. Except when a choice has been subject to the screening-out of many variables on the grounds of mutual correlation, even before a residual set is subject to the hazards of “forward and backward stepwise selection”. Except when a choice has been subject to the screening-out of many variables on the grounds of mutual correlation, even before a residual set is subject to the hazards of “forward and backward stepwise selection”, the consistency must have been either unknown to, or rejected by, the RARP 26 team because the variable to which the analogous mental health formula was fitted was the “directly standardised” utilisation whose use can be shown to violate the first (reasonable) principle.

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Reference


Evidence submitted by Glynden Trollope (Def 13)

The Group is an alliance of user, carer and voluntary sector representatives with first hand experience of mental health services in Hertfordshire. Recently the Group has been instrumental in persuading the Scrutiny Committee of Hertfordshire County Council to refer cuts in Mental Health finance to the Secretary of State.

We suggest that in probing the reasons for NHS deficits the committee should question the following aspects:

1. Why are there delays in implementing plans for transitions from old to new acute hospitals?

2. Why doesn’t the Government provide adequate finance for centrally determined pay awards, Frameworks and other targets? The Government retrieves a significant percentage of pay awards through direct and indirect taxation.

3. Why is there a lack of information, not least through users and close carers, to check value for money in the context of efficacy of treatment and care?

4. Another concern is the equity of fund distribution between different aspects of secondary health services—eg Cancer, Heart and Mental Illness. In respect of mental health are PCT’s adhering to the 15.9% recommended by Professor Louis Appleby? Is it a satisfactory level relative to the incidence of mental illness in the population and the implications for society and the economy?

5. The longstanding bad practice in the NHS of “raiding” healthy budgets to cover up other deficits should be stopped. It is partially responsible for overall financial problems because it delays essential remedial action being taken promptly when over spend is occurring. Where this malpractice takes place it is an abrogation of responsibility for the Government to refuse to intervene and insist that the issues have to be settled locally by executives who are responsible for the bad practice! This lack of governmental response condones unsatisfactory financial management.

There is also serious concern that mental health finances have been and are being undermined as a result of this practice. Moreover percentage cuts in revenue budgets are in perpetuity and diminish the value of subsequent per cent increases in funds. The NHS’s irrational and doctrinaire opposition to ring fencing of finances should be challenged. In many health sectors this would be inappropriate but mental health services are discrete and historical trends and stigma demonstrate that their finances need to be protected.

To exemplify our concern and explain a wider problem we refer to Hertfordshire. In the last financial year Hertfordshire Partnership Trust received £4 million extra but over £5 million was deducted from its revenue. Questioning will reveal the scale of revenue cuts and sacrifice of capital sales’ proceeds required of this and its predecessor Trust over several years. The sale of the Laundry Building at Hill End Hospital in St. Albans is but one example and there is a more recent case involving c £4 million. For further evidence an analysis should be required of the total per cent savings required in 2006–07 of Hertfordshire Partnership Trust compared with Primary and other Trusts in Hertfordshire. It is also important to question why over many years HPT has been expected to achieve 100% of savings required whilst other trusts have only achieved 60%?

6. In analysing accounts it should be noted that some real increases in revenue are being claimed by the authorities when this is not the case. This is when increased revenue is related to transferred services, from other Trusts, which have to be financed!
7. Consideration should also be given to the impact on future mental health budgets of increasing demands for continuing care and the implications of significantly increased requirements for treatment implicit in the proposed amendments to the mental health bill.

The Alliance would be prepared to give oral evidence.

_Glynden Trollope_
Coordinator, The Group

2 June 2006