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NHS Deficits

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, which can be found in HC 73-II. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x (HC 1204–II) for evidence published in June 2006, Ev x (HC 73–II) for evidence published in December 2006.

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Summary

In the last 2 years the NHS has been in overall deficit and there has been an increase in the number of NHS organisations with a deficit. These deficits are not new. There have been hidden underlying deficits for many years, but they were revealed by policy changes which increased transparency, in particular the switch in accounting procedures associated with the introduction of the Resource Accounting and Budgeting (RAB) regime. For example, as a result, it was no longer possible to underspend on capital expenditure and use the money to subsidise current spending.

While there have long been underlying deficits, their size has increased in the last two years. The deficits have many causes. Different witnesses gave different weight to the importance of different factors. Our inquiry has highlighted the role of :

- the funding formula,
- poor central management; and
- poor local management.

Some of the worst deficits can be explained by exceptionally difficult circumstances such as large inherited debts.

The funding formula allocates considerably more money per head to some PCTs than others. This may be related to the scale of health inequalities but it can make financial balance harder to achieve. A number of witnesses argued that there was a correlation between trusts' deficits and the allocation of funding. The Department's Chief Economic Adviser told us that it was necessary to examine the financial position of health economies rather than that of individual trusts. He found a moderate correlation between the needs and age index and deficits in health economies in 2004/05, but denied that this showed that the funding formula had caused the deficits. The Secretary of State told us that "overspending is concentrated in healthier, wealthier parts of the country".

Poor central management has contributed to the deficits. The Government's estimates of the cost of Agenda for Change and the new GP and consultant contracts proved to be hopelessly unrealistic. Government targets, such as the 4-hour A&E target, have been expensive to meet and have had unintended consequences which have imposed additional costs.

Poor local management is also to blame. For all the added costs imposed by the Department of Health, it is undeniable that the NHS has had a lot more money to spend. Surpluses can be found in PCTs and trusts with a low per capita funding. Deficits exist in trusts with a high per capita funding. We had a good deal of evidence of poor financial management; for example of a hospital trust which hired staff without knowing whether it could afford to pay their salaries, and of PCTs which failed to recruit vital members of the financial management team. Nevertheless, poor financial management is not just caused by local managers and boards. The Government has also contributed, for example by repeated changes and the emphasis on meeting targets at short notice. We recommend that the

Department take note of the Secretary of State's admission that our criticism of the practice of shifting the financial goal posts late was legitimate.

The Secretary of State has said that the NHS as a whole will be in surplus by the end of March 2007 and she will take personal responsibility for that. This is being achieved in several ways.

Funds have been transferred to trusts in deficit through top-slicing all PCTs and establishing a contingency fund. Top-slicing is a temporary expedient, but must not become a permanent part of NHS funding. We recommend that a time limit be set on its use. Funds must be returned to the originating bodies as soon as possible and in a planned way so that the organisations can maximise the benefits from delayed spending plans. Continued top-slicing and the establishment of a contingency fund would be an admission by the Department that it accepted that individual trusts would remain in deficit and that it had the ability, and the willingness to "bail them out". It could be seen as undermining the attempt to create a culture of strong local financial management. It would lead to the allocation of resources in an unplanned and ad hoc way. It would also reduce PCT's autonomy and reverse the Department's policy of increasing the proportion of funding directly allocated to PCTs.

Trusts in deficit have put in place recovery plans to clear deficits in a 3- or 5- year period. Unfortunately, many existing recovery plans are unsatisfactory. We are concerned that some plans are encouraging short-term measures that may further destabilise the situation and not be in the best long-term interests of the NHS. The trust in deficit must be responsible for drawing up its recovery plan which should then be agreed with the SHA.

While the NHS may be in overall surplus by the end of March 2007, not all trusts will be in surplus by then and it is unlikely that trusts with the biggest deficits will be able to repay their accumulated deficits in 5 years. It is important that as a first step they achieve 'in-year balance'. Where there is no realistic chance of recovering the deficit over the 3- to 5- year period without severely affecting services, consideration should be given to allowing a longer period to pay off historic deficits.

Trusts are making major savings. The workforce budget and the education and training budget have made the main contribution to reducing deficits. Many posts have been lost, although we have not received the evidence to prove or disprove the high headline figures given prominence by the RCN and BMA. On the other hand, there have been relatively few compulsory redundancies, but the posts lost through retirements and natural turnover have affected patient services. Soft targets such as mental and public health services have also suffered as has funding for voluntary organisations. We believe this to be unacceptable. While the national picture is varied, this has been a bleak year for many newly trained staff.

We welcome the Government's acknowledgement that there have been very large cuts in education and training and that these are having adverse effects on staff morale and development. This could have a significant effect on the quality of the workforce. We were told that these cuts will only last for a short time, but no guarantee was given. Moreover, amalgamation of the training budget with other SHA budgets is likely to lead to more reductions in that budget. The heavy cuts in the training budget are unacceptable. Savings

should not be made disproportionately in areas, such as training, where for structural reasons it is easiest to make them.

Our inquiry has provided a number of lessons which relate to:

- the accounting regime;
- financial management in local NHS organisations;
- the Department of Health.

As presently operating RAB is not a suitable accounting regime to use within the NHS. We recommend that an alternative to, or refinement of, RAB be introduced which retains the necessary accounting and financial disciplines of in-year financial control but allows for limited year-to-year flexibility and gives a suitable time for the recovery of deficits. It is fundamental that the regime chosen does not reduce trusts' income at the same time as requiring them to pay back any deficit owed.

We welcome the steps the Department has taken to increase transparency, but note that this is work in progress. Effective examination of the underlying financial position of an area, and determination of which organisations are struggling, are impossible if deficits are transferred between bodies within health economies as the SHA sees fit. The Department's Chief Economic Adviser told us that analysis had been made of deficits by health economy. The Department should consider examining the accounts of all trusts within a single health economy. The Department's data on this subject should be published as soon as possible.

This inquiry has provided compelling evidence of a failure of financial management. The most basic errors have been made: there are too many examples of poor financial information, inadequate monitoring and an absence of financial control. Finance is important. We recommend that the Government issue a restatement of duties in respect of basic accounting procedures.

There is a need to strengthen the role and position of Finance Directors. Given the pressures that they face in the current environment Boards should assure themselves that the Finance Director is appropriately skilled and competent to give them accurate and impartial advice. Boards must focus on the core tasks of finance, and review the position whereby many Finance Directors are given lead responsibility for non-finance functions.

In recent years the NHS has veered from one priority to the next as the political focus has changed. It has concentrated on meeting targets with too little concern for finance. The new emphasis on finance must not lead to a reduction in the quality and scope of evidence-based clinical care but measures to reduce NHS spending wasted on inappropriate or unproven therapies are to be welcomed and encouraged.

We welcome the Department's commitment to improve forecasting and undertake more local testing of new policies. It must make its calculations explicit and make them widely available well in advance of implementation. If the timescale has to be extended as a result, so be it. New policies must also be widely piloted.

There is concern about the fairness of the funding formula. We do not consider ourselves

qualified to judge whether these concerns are justified. We recommend that the formula be reviewed. Consideration should be given to basing the formula on actual need rather than proxies of need.

We are surprised that it took so long for the unsustainable financial commitments which trusts were undertaking to be recognised. Auditors did not pick up what was happening at an early stage. SHAs failed to monitor the trusts' activities adequately and the Department failed to check the work of SHAs.

1 Introduction

1. Between 2002 and 2006, NHS spending has increased more than at any other time since the NHS's foundation. In 2002/03, the start of the 5-year period covered by the NHS Plan, its spending was £57.2 billion;[1] by the end it will be around £96.2 billion.[2] It will have risen from approximately 7% to 9% of GDP.[3]

2. It was therefore a surprise to find out that in 2004/05 the NHS had a gross deficit of £594 million. By the end of 2005/06 the gross deficit had increased to £1.2 billion with 174 organisations in deficit.[4] In May 2006 we decided to undertake an inquiry into the subject. Witnesses to this inquiry were invited to submit evidence on the following points:

a) the size of the deficits and the savings which each trust has to make in 2006/07;

b) the reasons for the deficits, including:

   i. 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);

   ii. the findings of the 'turnaround' teams, whether these findings are right and whether the turnaround teams have provided value for money; and

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

c) the consequences of the deficits, including:

   i. the effect on care;

   ii. the number of job losses;

   iii. the effects of 'top-slicing', in the current and future years;

d) the period over which financial balance should be achieved.

3. We discuss below our findings relating to:

- the origins and extent of the deficits, and how far they have been revealed by new accounting procedures;
- causes;
- the Government's recovery strategy;

1 Department of Health, Departmental Annual Report 2002/03, Cm 5904

2 Public Expenditure on Health and Personal Social Services 2006, HC 1692–i. These figures are for the NHS and exclude Personal Social Services spending

3 Department of Health, *The NHS Plan: a plan for investment, a plan for reform*, July 2000

4 Department of Health, *Chief Executive's report to the NHS*, June 2006. This figure rose to 179 when the figures were audited: http://www.dh.gov.uk/assetRoot/04/14/04/38/04140438.pdf

- consequences: the effects of the need to make savings on services, jobs, training and patient care;
- lessons.

4. We received 72 submissions and held five oral evidence sessions, hearing from the Secretary of State, officials including the Chief Executive of the NHS, eight chief executives of trusts, three finance directors as well as two former senior officials. We also heard from the Audit Commission, turnaround teams and financial consultants, academics and professional groups. In addition, we commissioned Professor John Appleby of the King's Fund to analyse the unaudited NHS accounts for 2005/06. We wish to thank them and all who submitted evidence, as well as our specialist advisers, Robert Dredge, Sean Boyle and Professor Nick Bosanquet, who worked hard to steer us through the many complexities of the subject.

2 History, background and extent of deficits

5. All NHS organisations have a statutory duty to 'live within their means', yet despite the unprecedented financial investment in the NHS as part of the NHS Plan, the number of NHS bodies in deficit has apparently been growing steadily over the past few years. In 2001/02, around 8% of NHS organisations reported an in-year deficit. This increased to 18% in 2003/04, 28% in 2004/5 (see Figure 1 below) and 31% in 2005/06.[5] In 2005/06, a similar number of NHS and foundation trusts reported a deficit as in the previous year (68 and 11, respectively), but the number of primary care trusts (PCTs) with an overspend had grown from 80 to 106.[6] The 6-month figures for 2006/07 show that 178 organisations overall are in deficit (70 NHS trusts and 108 PCTs).[7]

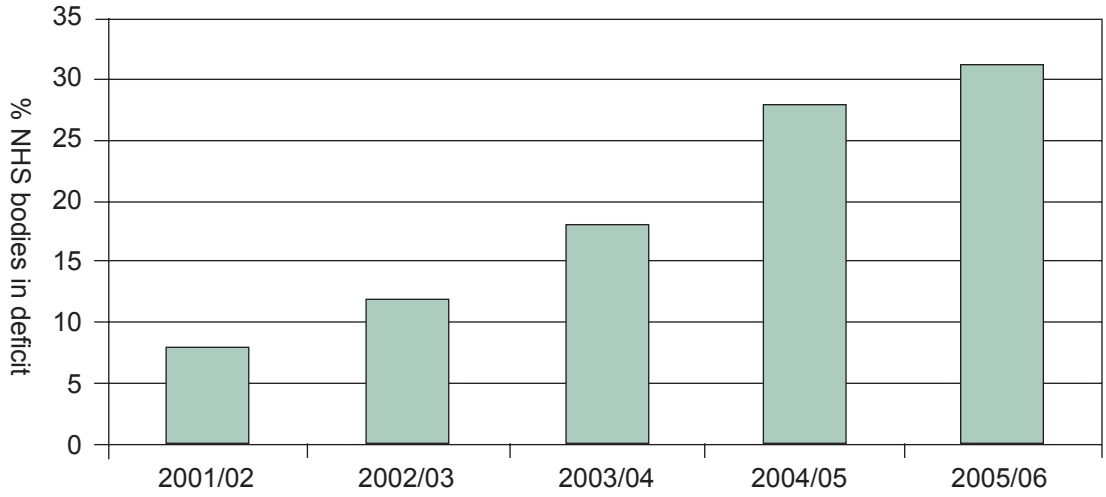

Figure 1: The increase in proportion of NHS bodies with a deficit or overspend

Source: Adapted from NAO analysis of NHS summarised account data and accounts of individual NHS bodies including Foundation Trusts[8]

How deficits arise

> Annual income twenty pounds, annual expenditure nineteen six, result happiness. Annual income twenty pounds, annual expenditure twenty pounds ought and six, result misery. (*Mr Micawber* in 'David Copperfield')

6. The income of PCTs comes primarily from the Department of Health, which allocates over 80% of the NHS budget to PCTs.[9] The remaining 20% is allocated to strategic health authorities (SHAs) and NHS trusts directly as operational or strategic capital, or to fund

5 NAO/Audit Commission, *Financial management in the NHS*, June 2006

6 Public Expenditure on Health and Personal Social Services 2006, HC 1692–i

7 Department of Health, *NHS financial performance Quarter 2 2006–07*, November 2006

8 NAO/Audit Commission, *Financial management in the NHS*, June 2006

9 www.kingsfund.org.uk/resources/briefings/local_variations.html

specific developments, programmes or projects. By far the largest component of this budget is the funding provided to SHAs for workforce development and training.[10]

7. Funding is allocated to PCTs on a per capita basis but is weighted depending on the nature of the population served. According to the Department it uses a complex mathematical formula developed by independent academic researchers and adapted by its resource allocation team to determine the level of funding. The current formula was introduced in 2003 but has been changed slightly for the 2006/07 and 2007/08 allocations.[11] The box below describes the formula in more detail.

8. PCTs commission activity from acute trusts, foundation trusts, care trusts, mental health trusts and other healthcare providers. Thus these trusts receive most of their income from carrying out work for PCTs.

9. Budgets for individual practices or departments within NHS bodies are determined by the local practices of each health body. Each will have an annual budget setting process, often led by their Finance Directors and management team. They are expected to set a budget that will not over-commit their incoming resources.

10 Ev 138 (HC 73-II)

11 Ev 129 (HC 1204-II)

Box A: The funding formula

The funding formula aims to provide resources that reflect local needs for healthcare. Additional funds are allocated to an area with high levels of deprivation, for example. Funding is weighted according to a number of factors, including age, socio-economic variables and indices of morbidity and mortality. Other elements include rates of HIV/AIDS, Personal Medical Services (PMS), prescribing and emergency ambulance cost adjustments. In 2004/05, per capita weighted allocations varied between £860 for individuals in the least deprived areas to £1166 in the most deprived.[12] A Market Forces Factor (MFF) is added to the formula. This allows for the differences between areas of the unavoidable costs of providing health care, such as expenditure on the workforce.

The funding formula generates a target allocation for each PCT. This indicates what is considered the PCT's 'fair share' of the national allocation, based upon the total impact of all of the weighted factors. The PCT's current allocation is then compared to this target and the gap, known as the Distance from Target, determines the level of increased allocation given in any one year. No PCT has a reduced allocation, and all receive a minimum level to cover the cost of inflation. Additional funding, or growth, is allocated in proportion to the PCT's Distance from Target, with those furthest away, ie. the most under-funded, receiving a higher rate of growth than those at or near to Target.

The formula does not directly measure health needs. Instead it uses proxies of socio-economic status and assumptions associated with these variables, based on a series of statistical analyses.[13] Resource Allocation Research Papers (RARPs) are research commissioned by the Department's Advisory Committee on Resource Allocation (ACRA). RARP 26 stated:

> 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.[14]

Recent research on the funding formula is limited.[15] However, some researchers have criticised the funding formula and argued that there is a connection between it and PCTs' levels of deficit. These and other arguments relating to the funding formula will be discussed later in the report (see chapter three).

12 Ev 155 (HC 1204-II)

13 Ev 184 (HC 1204-II)

14 Ev 185 (HC 1204-II)

15 Ev 184 (HC 1204-II)

Definitions

10. Deficits are recorded in several different ways as part of Government accounting procedure, depending on the period of time in question and whether the organisation is an NHS trust, PCT or SHA. The most common terms are:

- **the in-year deficit**, which is used to describe an NHS trust's deficit (if the trust has a surplus, it is described as an 'in-year' surplus);
- **the overall net deficit**, which is the total of in-year deficits and overspends, plus any surpluses, of all NHS organisations; and
- **the cumulative deficit**, which is a trust's previous years' deficits added together.

These and other terms are defined below based on information supplied by the Department.[16]

In-year deficit/surplus

11. Hospital trusts record a final figure to reflect the total income and total expenditure in one year, known as their **in-year deficit** or in-year surplus, and this is reported to the Department.

12. The **gross in-year deficit** reflects only the total deficits recorded by all NHS trusts in one year, and does not include the amount of surplus revenue. In 2005/06, this figure was £674 million deficit. The **net in-year deficit/surplus** reflects the sum of all NHS trusts' deficits *and* surpluses. In 2005/06, this figure was £560 million deficit.

13. Surpluses and deficits are described as under- or overspends among PCTs and SHAs. The **gross overspend** represents the total of all in-year PCT and SHA overspends. In 2005/06 this figure was £603 million. The **net overspend** is the sum of all PCT and SHA in-year under- and overspends. There was underspending by PCTs and SHAs of £651 million. This resulted in a net underspend in 2005/06 of £48 million.

Gross/net deficit

14. The sum of in-year deficits in NHS hospital trusts plus the overspends of all SHAs and PCTs give the overall **gross deficit** figure. This figure does not include any trust surpluses or SHA/PCT underspends. The 2005/06 unaudited NHS accounts reported a gross deficit of £1,277 million.

15. The gross deficit is offset by underspends by PCTs and SHAs, and by surpluses in some NHS trusts. In 2005/06 the overall unaudited **net deficit** for trusts, PCTs and SHAs was £512 million. The table below shows how this figure was reached. After this analysis was provided, the Department released the audited figures, showing slippage[17] of £35 million.

16 Letter from Richard Douglas to Health Committee, 8 September 2006, see Ev 123 (HC 73-II)

17 Delay (planned or unplanned) in the implementation of a programme or budget, thus resulting in a non-recurring release of funds that can be applied to other short-term expenditure or savings

Foundation trusts reported a net deficit of £24 million in 2005/06; the audited figures have yet to be placed before Parliament.

16. The net deficit in 2005/06 was much worse than the 2004/05 net deficit of £221 million, but is lower than the £623 million deficit that the Department predicted for 2005/06 in September 2005. The Quarter 2 accounts show that the position for 2006/07 has deteriorated even over the past 3 months, however (see next section). As the table below shows, the financial positions of PCTs and hospital trusts have continued to deteriorate since September 2005. This has been offset by a larger underspend by the SHAs than was forecast.

	2005–06		**2004–05**
	Unaudited Accounts (£m)	**Forecast Position September 2005 (£m)**	**Audited Accounts (£m)**
PCTs	-476 (£603m deficit/£127m surplus)	-301	-272
NHS Trusts	-560 (£674m deficit/£114m surplus)	-515	-322
SHAs	524	193	373
	-512	**-623**	**-221**
TOTAL (unaudited)	**-512**		
TOTAL (audited)	**-547**		

Table 1: Unaudited and audited net deficits in NHS bodies 2005/06. Audited figure does not include Whipps Cross Hospital trust.

Source: Letter to Health Committee from Richard Douglas, 8 Sept 2006

Cumulative deficit/surplus (accumulated or historic deficit)

17. NHS trusts, PCTs and SHAs record their cumulative deficit on the balance sheet as the **income and expenditure reserve**. It represents the total of all previous deficits and surpluses of the organisation. When the cumulative deficit exceeds 0.5% of the current year turnover, the trust is obliged under the **statutory breakeven duty** to eliminate that debt within a 3- or 5-year period. In 2005/06, the audited sum of all cumulative deficits/surpluses of NHS trusts in England was £547 million deficit. Almost one quarter of NHS trusts, PCTs or SHAs reported a deficit of over 0.5% of their income and, according to the Department, 91 NHS trusts alone have cumulative deficits for the purposes of the breakeven duty that total £1,305 million.[18]

18. A deficit could be defined across a whole health economy, including the accounts of the PCT, acute trust, mental health trust and other providers. Although setting the boundaries of each health economy would present a challenge, for example where a trust serves more than one PCT or vice versa, this would give a picture that is not affected by transfers

between PCTs and trusts and would provide the most balanced picture of an area's financial position. The Department has begun to analyse deficits in this way.

Differences between the audited and unaudited accounts

19. Unaudited accounts are published soon after the end of the financial year. The audited accounts are published in the autumn. The audited end-of-year results from 2004/05 showed a significant difference from the previously reported unaudited figures which were published in June 2005.[19] The unaudited accounts for 2004/05 showed a deficit of £133.9 million, which grew to £251.2 million when the figures were audited. While previous years have shown variance of several million above or below the predicted levels, the 2004/05 figures show a difference of almost eight times that of the previous year (see table below).

Financial Year	Surplus/(deficit) reported at month 12 (£m)	Surplus/(deficit) reported in audited accounts (£m)	Variance (£m)
2001/02	53	71	19
2002/03	70	96	26
2003/04	88	73	(15)
2004/05	(134)	(251)	(117)
2005/06	(512)	(547)	(35)

Table 2: variance between audited and unaudited figures

Source: Department of Health

20. Detailed examination of the variance shows:

- Of 70 PCTs forecasting deficits, 32 improved their positions and many reported surpluses;
- Of 198 PCTs forecasting break-even, 49 ended in deficit;
- Of 61 NHS trusts forecasting deficits, 20 made a surplus; and
- Of 145 NHS trusts forecasting breakeven, 27 ended with a deficit.[20]

The NAO/Audit Commission's report, *Financial management in the NHS*, stated that they were "concerned about the level of audit adjustments required during the 2004/05 audit".[21]

21. Not only is there a difference between the audit and unaudited figures, but the audited figures are also subject to change. When first reported, the audited gross deficit figure for 2005/06 was £1,227 million, with 174 organisations in deficit. The Department later

19 NAO/Audit Commission, *Financial management in the NHS*, June 2006

20 Ev 69 (HC 1204-II)

21 NAO/Audit Commission, *Financial management in the NHS*, June 2006

reported that this figure was £1,312 million gross deficit and that 179 organisations were in deficit that year.[22]

22. The Department stressed that 2004/05 was the first year that there was a significant difference between the unaudited and audited figures for NHS finances. It stated that the reasons for the discrepancies were "differences of opinion between Boards and auditors" on the following:

- Under-estimation of drugs expenditure by PCTs;
- Understatement of the costs of Agenda for Change;
- Expenditure being originally classified as capital and then as revenue.

There were also differences in opinion over the amount of income owed to the organisations by other NHS bodies and how these were being shown in the two organisations' sets of accounts.

23. Some of the problems seem to have been addressed in 2005/06 when the deficit in the audited accounts was £35 million more than in the unaudited accounts.

Which organisations are in deficit?

24. SHA areas in deficit are more common in the south of the country than the north, with those reporting the greatest overspends concentrated in the south-east.[23] Sir Ian Carruthers, then acting Chief Executive of the NHS, confirmed that the four areas of the country in greatest difficulty are Avon, Gloucestershire and Wiltshire; London; the East of England; and Surrey and Sussex.[24]

25. Examination of deficits as a percentage of PCT turnover, however, shows that overspending in 2005/06 was more evenly spread throughout the country.[25] A full list of PCTs, acute trusts and Foundation Trusts in deficit can be found in Annex 1.

Hidden deficits revealed

26. Deficits appear to be a relatively new problem for the NHS, but in fact they have occurred in six of the last 10 fiscal years. Following a period of small surpluses between 2000 and 2004, large deficits have arisen in 2004/05 and 2005/06. The financial position of the NHS since 1996 is shown in the table below.

22 The Quarter 1 report (Department of Health, *NHS financial performance Quarter 1 2006–07*, August 2006) stated that the gross deficit in 2005/06 was 1,227 million; the Quarter 2 report (Department of Health, *NHS financial performance Quarter 2 2006–07*, November 2006) quoted the second figure for 2005/06.

23 Department of Health, *NHS financial performance 2005/06,* Report from the Director General, Finance & Investment. June 2006.

24 Q320

25 See Ev 72 (HC 1204–II) for map of PCTs in deficit and surplus.

	Net surplus/(deficit) (£ million)
1996–97	(460)
1997–98	(121)
1998–99	(18)
1999–2000	(129)
2000–01	112
2001–02	71
2002–03	96
2003–04	73
2004–05	(251)
2005–06	(547)

Table 3: NHS financial position, 1996/97 – 2005/06

27. In fact, even in years with a recorded surplus there were underlying deficits, but they were hidden. They have been brought to light by new policies and procedures, including:

- The devolution of budgets;
- The introduction of Resource Accounting and Budgeting (RAB); and
- The end of brokerage

Devolution of budgets

28. One of the main policy changes that revealed the extent of the deficits came as part of policy changes arising from the implementation of the NHS Plan. The Department committed itself to devolving a greater share of the centrally held budgets to front line organisations.[26] This meant that it reduced the flexibility to withhold and use these budgets to rectify any emerging financial problems. Put simply, the Government held back less money to bail out those trusts in deficit.

Resource Accounting and Budgeting

29. Even more significant has been the application of a new method of accounting. The Government-wide system of Resource Accounting and Budgeting (RAB) was introduced in April 2001 and is a key element of the financial framework of the NHS. It has had two important effects in relation to deficits, namely the end to capital to revenue transfers and the 'double deficit' effect.

26 Department of Health, *The NHS Plan, A plan for investment, A plan for reform*, Cm 4818-I, July 2000

30. Calculations published in the magazine *Public Finance*, and confirmed by the Department, showed that RAB disguised significant amounts of overspending over the past 5 years[27] as Table 4 shows:

	Reported net surplus/(deficit) (£million)	RAB adjustment (£million)	Position without RAB (£million)	Capital to Revenue transfers (£million)	Estimated underlying position (£million)
2001/02	71	+112	(41)	250	(291)
2002/03	96	+71	25	250	(225)
2003/04	73	+96	(23)	318	(341)
2004/05	(251)	+77	(328)	0	(328)
2005/06 (unaudited)	(512)	-117	(395)	0	(395)

Table 4: Effect of RAB on NHS budget reporting; brackets indicate a deficit

Source: Public Finance, 23 June 2006

Thus even though the underlying deficit has increased, it is clear that there have been underlying deficits for several years. The figures in Table 4 show that the NHS has been overspending for the past 5 years. The deficit has grown from £291 million to £395 million.

The end of capital to revenue transfers

31. The introduction of RAB meant that the previously often used device of offsetting overspends on the revenue budget (expenditure on services) by underspending on the capital budget, and netting these off at the aggregate level, was no longer possible. Table 4 shows that in 2001/02 and 2002/03 £250 million of capital underspend was used to cover revenue overspends.[28] In 2003/04 the figure increased to £318 million.[29] From 2004/05 such transfers were no longer possible.[30]

Recovery of financial deficits: the double deficit effect

32. Another effect of RAB is that any hospital trust ending one financial year in deficit is wholly responsible for recovering its financial position. First, the trust has to reduce its spending to match its income. Secondly, the deficit is carried in the balance sheet of the trust and reported as a cumulative (accumulated or historic) deficit, which must be recovered over a 3- to 5-year period. The trust therefore has to make a surplus in future

27 The NHS would have overspent by between £225m and £395m each year since 2001/02

28 Department of Health publication: *A Short Guide to Resource Accounting and Budgeting in the NHS*, issued 4 February 2005. It states at paragraph 11, 'Under RAB HAs and PCTs will have to keep their accrued spending within their resource limits. This is a statutory duty...There will be separate Resource Limits for revenue and capital'.

29 *Public Finance*. 23 June 2006. The article references the figure in the table to Hansard, but does not give a specific fuller reference.

30 RAB was phased in over 3 years to allow the Department and the NHS time to adapt, hence the delay in the effect of RAB on capital to revenue transfers.

years to recover its deficit.[31] This means that once financial balance is lost there is a 'double deficit' effect. The challenges of breaking even with reduced income, let alone generating a surplus, can mean that once an in-year deficit has been incurred the accumulated deficit will quickly worsen.

33. Both under- *and* overspending are carried forward to the next year's revenue allocation. The use of RAB to bring forward surpluses and deficits since 2001/02 has had a marked effect on the way the underlying financial position of the NHS has been understood and reported. The Department's report *NHS financial performance 2005–06* showed the in-year overspend in 2005/06 was exaggerated by £117 million because deficits were carried forward from the previous year. This was because, under RAB, the NHS started the year off with this amount deducted from its revenue allocation, to cover an estimate of the previous year's overspend. Resources were inflated because of underspending during the previous year. *Public Finance* stated:

> The implication is that, although the total NHS overspend for 2005/06 was £512m, only £395m of that was mismanaged, 'overtraded' or otherwise spent by NHS trusts: the remaining £117m was never even allocated and went instead to paying off the previous year's debt.
>
> But for the four years before 2005/06, the RAB carry-over rules meant that the NHS's resources were boosted by reported underspends in the previous year.[32]

34. Although PCTs have their budgets reduced the following year by the amount of the deficit, the deficit amount is not posted on the balance sheet. PCTs therefore do not face the 'double deficit' problems of NHS trusts. A similar system is in place for SHAs. Overspends are very rare on SHAs' directly managed budgets, however, and the impact is minimal as they do not commission or provide any services directly.

Brokerage

35. The end of overt brokerage (the movement of funds between NHS organisations within the same SHA boundary) has also brought to light problems that doubtless existed before but were effectively concealed. Mr Phil Taylor from the Healthcare Financial Management Association (HFMA) outlined how brokerage was used when it was permissible:

> If you gave brokerage to an NHS trust it avoided that problem of the [RAB] double whammy…If a trust was opening a new facility, in the first year or two it is much more expensive when you open a new facility and so you need to pass a little extra bit of funding to that organisation in order to get over that hump. There could be other reasons for moving brokerage round the system, but the intention always was not to make the system less transparent but to oil the wheels to make the NHS able to cope with local difficulties.[33]

31 NAO/Audit Commission, *Financial management in the NHS*, June 2006

32 *Public Finance* 23 June 2006, www.publicfinance.co.uk

33 Q475

The NAO/Audit Commission reported that, although overt brokerage is now not allowed, more opaque kinds of brokerage may still take place.[34] These we discuss below.

Conclusions

36. **In the last 2 years there has been an increase in the number of NHS organisations with a deficit and there has been a total overall deficit. The latter figure, known as the net deficit, was £251 million in 2004/05 and £547 million in 2005/06. The latter figure would have been higher but for a remarkable growth in SHA surpluses. The number of PCTs and trusts in deficit is rising in 2006/07.**

37. **However, the underlying figures tell a somewhat different story from the headline figures. It is difficult to assess how long the NHS has been overspending as deficits were hidden in the past. Deficits were revealed by policy changes which increased transparency, in particular the switch in accounting procedures associated with the introduction of the Resource Accounting and Budgeting (RAB) regime. As a result it was no longer possible to underspend on capital expenditure and use the money to subsidise current spending. In addition, RAB has led to the double deficit problem whereby a trust's income in the current year has both to pay for that year's provision and pay back previous year's deficits. As a result of RAB the in-year deficit for 2005/06 was exaggerated by £117 million. We discuss RAB again in more detail below.**

38. **Nevertheless, while there have long been underlying deficits, their size has increased in the last two years. The Secretary of State has said that the NHS as a whole will be in balance by March 2007 and she will take personal responsibility for that. The Government has started to tackle the problem in earnest, but undoubtedly it will not be an easy task.**

34 NAO/Audit Commission, *Financial management in the NHS*, June 2006. An example of such opaque brokerage could be through adjustments to Service Level Agreements.

3 Causes of deficits

39. In the last chapter we examined the changes in accounting conventions which have revealed underlying deficits. In this chapter we look at central policies and local actions that have contributed to the deficits. We have been able to draw on evidence from the NAO, the Audit Commission and turnaround teams[35] as well as many other organisations including senior officers and Board Members of trusts, both serving and recently retired. The Department has undertaken its own study of the causes of deficits, but unfortunately it had not been completed by the end of our inquiry. Nevertheless, we were informed of some of its preliminary findings.[36]

40. Witnesses agreed that there were many causes of the deficits, but they gave different weight to different factors. Some stressed that trusts in affluent rural areas received an inadequate income and were disproportionately likely to be in deficit.[37] Others emphasised that the largest and most intractable deficits were caused by exceptional circumstances such as very expensive Private Finance Initiative (PFI) projects. Yet others, including the Secretary of State, pointed to the increases in workforce costs arising from higher pay and the growth in the number of people employed by the NHS. Witnesses disputed whether poor central or poor local management was the main cause. We examine the evidence under the following headings:

a) Income: the link between the funding formula and deficits

b) Expenditure, including

   i. trusts with intractable historic problems

   ii. the increase in staff costs

   iii. poor local management

   iv. poor management by central Government both:

   - by imposing additional costs through badly-costed policies; and
   - by hindering good local management.

Incomes: the link between the funding formula and deficits

Concerns about the funding formula

41. There have always been concerns about the funding formula which allocates money to PCTs. Current concerns are considered in more detail in Box B. Some PCTs receive significantly less funding per head than others. Two main types of criticisms of the funding formula are made:

35 Teams of external management consultants sent in to improve organisations' performance

36 By Prof McCormick in the third evidence session, Qq 395, 415–417

37 Eg. Prof Sheena Asthana, Ev 152, Ev 37 (HC 1204–II)

- Specific criticisms, for example that it discriminates excessively against rural and affluent areas and makes inadequate allowance for multi-site locations; and
- Methodological criticisms, in particular that it:

  – purports to allocate funds according to need, but is based on proxies of healthcare need, rather than actual need; and

  – is based on inadequate evidence and subjective decisions about which variables to include.

Box B. Witnesses' views of the failings of the funding formula

Witnesses made several criticisms of the funding formula. These included both specific and methodological failings:

Specific concerns

- There is no component to allocate additional funds for providing health services in rural areas, apart from that relating to ambulance provision. In this respect, the Department of Health's funding differs from local government allocations and from NHS resource allocation in Scotland, Wales and Northern Ireland.[38] Additional costs include transport of patients over larger areas, costs of staff travelling, and the need for smaller, more scattered facilities and better communication technology. The Department told us:

  > Rurality is not explicitly included in the main component parts of the model. However, the researchers were aware of the possible impact of rurality and attempted to tackle the issue by including measures of access cost, including the Access Domain of the Index of Multiple Deprivation (IMD) and measures of distance[39]…The researchers maintained that, "if the supply side variables do reflect differences in access between areas….rural areas will have their different needs adequately reflected in the allocation formula."[40]

- Costs associated with multi-site locations are not considered. The formula largely assumes an average asset mix, which may disadvantage those with large estates or multiple sites, which face larger capital charges. Such trusts have fewer opportunities to benefit from economies of scale and face added costs (both financial and in terms of productive time) of, for example, moving staff and patients between sites. Mr David Law, Chief Executive of West Hertfordshire Hospitals Trust, which reported a deficit of almost £27 million, particularly highlighted the difficulty of operating two A&E departments.[41] This was also mentioned by Turnaround Director Mr Sean Sullivan, who added that a higher number of sites may lead to duplication of services.[42]

- The effects of the market forces factor (MFF) is much disputed. On the one hand, it was argued that it may cause a bias towards urban areas.[43] NHS pay scales are determined nationally and so it was argued that there is no need to weight this element. Professor Sheena Asthana from the University of Plymouth stated:

38 Ev 130 (1204-II)

39 The access domain in the IMD measures the extent to which people have poor geographical access to certain key services, namely post office, large food shops, GP surgery and primary school.

40 Ev 132 (HC 73-II)

41 Q155

42 Q100

43 Ev 152 (HC 1204-II), Q399

> We have a national wage scale in the NHS. In fact what you will find is that your nursing staff in urban areas tend to be on lower grades because there is a higher turnover of nurses, whereas again in rural areas you tend to have nurses on higher grades who are far more expensive and they need to be because they need to work with a degree of autonomy.[44]

On the other hand, the North East London SHA told us that:

> …the Market Forces Factor…is clearly pivotal to London, where the cost of living and the relative attraction of non-NHS employers is substantially higher than any other city in the country…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.[45]

- Age is considered, but witnesses claimed that the funding formula does not weight funding adequately for populations that include a high proportion of older adults. Older individuals are more likely to use health services, with service use rising by 30% between the ages of 65 and 85,[46] yet equal weighting of age to deprivation means that PCTs with older populations often receive less funding that those with younger populations. The NHS Confederation stated that the funding formula may have contributed to deficits in areas with high numbers of elderly inhabitants.

On the other hand the Secretary of State claimed:

> [Age] is not the only cause of variation in health needs, nor is it such a major cause of variation between different areas because the age composition of different populations does not vary as much as, for instance, the incidence of cancer and heart disease and other factors.[47]

- At the same time, not enough weighting may be given to the "additional needs" of specific populations. Dr Peter Carter, Chief Executive of the Central and North West London Mental Health NHS Trust (CNWL), highlighted the importance of adjusting the weighted capitation formula for mental illness scores. Dr Carter claimed that if such weighting is not routinely applied, then inner city mental health services in particular, which attract a very high incidence of mentally ill people, will be disadvantaged.

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44 Q399

45 Ev 90 (HC 1204–II)

46 Ev 154 (HC 1204–II)

47 Q736

48 Ev 184 (HC 1204–II)

49 Ev 155 (HC 1204–II)

50 Ibid

51 Ev 154 (HC 1204–II)

52 Ev 184 (HC 1204–II)

53 Ev 191 (HC 1204–II). Prof Stone told us that only 5 pieces of work evaluating the use of the formula in practice were in existence

54 Ev 191 (HC 1204–II)

Methodological failings

- A major problem with the funding formula, according to several witnesses, is that it is based on indirect measures of healthcare need. Professor Mervyn Stone from University College London, argued that, "Those allocating resources do not have sufficient information to measure need directly."[48] The existing formula is based on current use of health services; it may be measuring not need but the inefficient use of resources in areas with generous allocations. Prof Asthana and Dr Alex Gibson told us:

  > 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…are appropriate.[49]
  >
  > ...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.[50]

- Elements of the funding formula are "poorly evidenced and insensitive to local factors" according to North East London SHA[51], and other witnesses told us that the research and theory underlying the formula is "unclear and inadequate". Little work on the operational use of the current formula exists.[52] The funding formula relies on subjective decisions on the variables that are included and how they are measured, "because its statistical methods are in themselves so questionable".[53] Prof Stone stated that:

  > I am afraid that, once acquainted with the details of what has been done, most statisticians would conclude that [one of the main research papers underpinning the formula] exhibits a naïve belief that its fitted formulae—simple linear combinations of whatever the combination of mechanical variable selection techniques and "judgement" ultimately delivered—can be trusted even as guides in the cutting of a large financial cake.[54]

The judgements made have a direct effect on the level of funds that are allocated to PCTs.

Relationship between PCT deficits and the funding formula

42. We heard evidence that the difficulties with the different aspects of the formula and the lack of underlying evidence outlined above (see Box B) make it more likely that some types of trusts will have a deficit.[55]

43. A comparative study of the 29 PCTs reporting the greatest deficit and the 29 reporting the greatest surplus showed a relationship between deficits and the funding formula. The work, undertaken by researchers from Suffolk West PCT,[56] showed marked differences between the characteristics of the PCTs in each group. Per capita funding varied by £123 on average between the two. Other differences included:

55 Ev 152 (HC 1204-II), Ev 183 (HC 1204-II)

56 Affiliated with Cambridge and East Anglia Universities. BMC Health Services Research 2006, 6: 64.

a) Regional variation: those in deficit tended to be in the East of England and a significant proportion (10 out of 29) formed part of Birmingham and the Black Country SHA or Greater Manchester SHA;

b) Population density: the populations of PCTs in deficit were nearly seven times less dense than those PCTs reporting a surplus;

c) Deprivation: most of the PCTs in surplus served deprived communities, with almost half being spearhead PCTs[57] while only one of those in deficit was in this position;

d) Population growth: PCTs in deficit had 2.7 times the level of population growth compared to PCTs in surplus (13.37 versus 4.94%, respectively);

e) Working conditions: staff in deficit PCTs reported greater levels of work pressure and extra hours compared to their counterparts in surplus PCTs; and

f) Staff numbers: numbers of dispensing GPs were higher in deficit areas than those in surplus.

44. It was suggested that the funding formula may have contributed to deficits in areas with older populations. The NHS Confederation told us:

> The focus of deficits in areas that have relatively affluent but elderly populations… 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.[58]

Relationship between deficits and funding growth

45. Prof Asthana argued that there was a link between the level of growth in funding and deficits. She showed that by the end of 2004/05, only four of the 60 PCTs with the greatest funding increase between 2003/04 and 2004/05 were in deficit while 34 of the 60 PCTs with the smallest funding increase were in deficit. The Healthcare Commission stated that almost one-third of the PCTs with the lowest levels of growth are projecting a deficit:

> 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.[59]

46. The Commission added that the distribution of the trusts in greatest difficulty suggests that external rather than local factors contributed to deficits:

57 PCTs with high levels of deprivation which receive additional funding to address their problems.

58 Ev 85 (HC 1204-II)

59 Ev 57 (HC 1204-II)

> 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.[60]

47. Mr Andy McKeon from the Audit Commission agreed that the funding formula had contributed to the deficits problem, but saw the contribution as modest:

> …in terms of PCTs, we found that, yes, there was a statistically significant (ie. a true) relationship between the level of resources available to an organisation and whether it was in deficit, but that accounted for less than 10%—I think it was actually about 7%—in the variation of performance. So, it may well be a factor in a number of cases but it is not the only factor in those cases.[61]

Deprivation and deficits

48. Prof Asthana also claimed that there was an inverse relationship between deficits and high levels of deprivation, which relates to the funding formula.[62] She argued that the likelihood of deficits in affluent areas suggested that either wealthier groups use healthcare services more than is necessary (according to their healthcare needs, as determined by the Department) or that inadequate levels of funding are provided for these areas. Some argue that affluent areas tend to be in deficit because wealthier people demand more healthcare services.[63] However, Prof Asthana found that the average service use in deprived areas is significantly greater than that in less deprived areas, for a range of measures (see table below).

	PCT Deprivation, IMD2004, by quintiles						
	Most Deprived	2nd	3rd	4th	Least Deprived		Overall Average
Finished Consultant Episodes *per capita*	0.31	0.29	0.28	0.26	0.25	**	0.28
Hospital Admissions *per capita*	0.28	0.26	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

Table 5. Hospital Episode Statistics, 2004/05

** *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*

60 Ev 58 (HC 1204-II)

61 Q455

62 Four of the 60 PCTs in the most deprived areas reported a deficit at the end of 2004/05 compared to 36 of the 60 PCTs in the wealthiest areas. Ev 153 (HC 1204-II)

63 Ev 154 (HC 1204-II)

49. Witnesses predicted that the situation would worsen as funding was shifted from more affluent rural areas to deprived urban locations.[64]

The Department's view

50. In the evidence session of 20 July, the Department of Health denied any link between deficits and the funding formula. Although Sir Ian Carruthers conceded that the formula "does not suit anybody when you get down to it, no formula ever does,"[65] he stated bluntly:

> There is no relationship between deficit size and resources allocated.[66]

Mr Richard Douglas, Director General of Finance and Investment at the Department added:

> There is nothing that demonstrates any significant link between the amount of funding per head of population and the deficit in an organisation. You can look across the whole range of PCTs, look at their deficits, look at the funding per head, look at the amount of growth they had and you cannot come to a significant link between those two things.[67]

Other witnesses agreed. For example, the BMA denied that there was any correlation between deficits and PCTs' distance from resource allocation target.[68]

51. On the other hand, in a later evidence session, following further research, Professor Barry McCormick, the Chief Economic Adviser at the Department of Health, gave us a slightly different point of view. He claimed that PCT deficits were not the relevant measure. In view of the fact that deficits can be shifted around health economies it was necessary to examine the finances of all bodies in order to determine the underlying position of the area:

> The problem we have got with just looking at PCT deficits is that in some parts of the country these deficits and local agreements have caused the deficits to lie on the PCT side of the accounts and sometimes they have caused them to lie on the acute trust side of the accounts, so an appropriate way, if we are to get a proper picture of whether an area has problems or not, is to bring together the accounts of the trust in the area with the PCT in the area and see them in a unified fashion.[69]

His view was shared by senior officers in trusts (see Box C below). Nevertheless, it would be a remarkable coincidence if there were no relationship between deficits and health economies but a strong relationship between deficits and PCTs.

64 Q422

65 Q335

66 Q285

67 Q324

68 Ev 29 (HC 1204-II)

69 Q415

Box C: Deficits within a single health economy

The interaction of trusts within a health economy is crucial to the development of deficits. We heard that it was common for an acute trust to report a deficit while the neighbouring PCT was in surplus.

We were told that funds were transferred around single health economies, with the knowledge of the SHA. Witnesses described the process as "a mechanism" employed by SHAs so that not all the organisations in an area are in deficit:

> **Chairman**: …the Department's chief economist told us that the recorded deficits do not reflect reality: sometimes they sit on the PCT side and sometimes on the acute trust side. Basically, they were saying it is rather arbitrary. Do you agree with that comment?...
>
> **Mr John Rostill**: Yes, I think it is correct. It is a mechanism. In Worcestershire the debt, for a long time, sat with the acute trust, with the agreement of the Strategic Health Authority, so in that year we overspent by a considerable amount and the other health organisations in Worcestershire broke even. This year, as a result of the top-slicing, most of the debt, I think, will actually be with the primary care trust and they will overspend, as I think will the Mental Health Partnership, and, if our plans go well, we will actually balance.[70]

Mr Rostill later added:

> Basically, the SHA did not want all the health organisations in Worcestershire to show a deficit, and it was agreed, just before I arrived there, that the debt would actually lie with the trust.[71]

This was supported by the Audit Commission's findings in its review of failing organisations. Its report stated:

> Some of the NHS organisations attributed their deficit to the actions for their SHA in parking responsibility for a health community's financial problem with an individual organisation for convenience, rather than on the merits of the case. Some organisations may be right in this view.[72]

52. Having analysed the financial position of health economies, Prof McCormick told us that in 2003/04, the year when the resource model was last changed, there was no correlation between the needs and age index and where deficits occurred, suggesting that the funding formula had no impact on deficits. In 2004/05 there was a moderate correlation. We do not know the position for 2005/06. He told us:

70 Q531

71 Q533

72 Audit Commission, *Learning the lessons from financial failure in the NHS*, July 2006

> When we [bring together trust and PCT accounts from the same area], what we find for 2003/04 is no relationship at all between the age/needs index and the deficits of an area… When we do it for 2004/05, we do find a relationship in that we find in the less needy areas a slightly greater tendency for deficits to arise. It is not a strong tendency, but there is a slight tendency in the evidence.[73]

53. While there was a moderate correlation in 2004/05, Prof McCormick denied that it was caused by the funding formula: the health economies in deficit had had increases in spending:

> I do not personally believe that [the funding formula] is responsible for driving the deficits, but it seems to be the back on which the present concern which many people have about the formula is being driven. I do not believe that link is actually that well established.[74]

He added:

> if you look at the growth of allocations to PCTs between 2003/04 and 2004/05 and match them against the deficits in PCTs in 2004/05, you do not find any correlation.[75]

54. Subsequently, the Secretary of State told us that it was "right and fair that places with better health needs get greater funding". She added that "it is true that the overspending is concentrated in healthier, wealthier parts of the country".[76]

Expenditure

Intractable historic problems

55. A few trusts face intractable historic problems, as Sir Ian Carruthers acknowledged:

> If you look at them over time [some trusts in deficit] are the same organisations that cannot escape from their histories.[77]

56. Large scale inherited debts have caused problems for some trusts. West Hertfordshire had a significant gap between income and expenditure in healthcare from before the trust was formed, in 2000.[78]

57. A number of organisations have suffered significantly because of particularly costly PFI deals. There have been some well-publicised cases, such as Queen Elizabeth Hospital in Woolwich, Norfolk & Norwich and Barnet & Chase Farm trusts. Amicus cited an accountant's report on Queen Elizabeth Hospital:

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73 Q415

74 Q393

75 Q416

76 Q726

77 Q273

78 Ev 142 (HC 1204-II)

> [The report] 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. [79]

58. Elsewhere, structural problems and multi-site trusts, such as those in Surrey & Sussex and West Hertfordshire, have caused particularly high operational costs.[80] In other areas, the independent sector treatment centre (ISTC) programme has caused costs to increase.[81]

59. Mr Philip Davidson from KPMG summarised the situation:

> There are going to be situations where organisations, when run at their most efficient, may nevertheless not be able to reach a full turnaround position, recurring surplus or at least no deficit and paying off their accumulated deficit. There will be situations where that occurs and those situations may well be as a result of local conditions.[82]

Staff costs

60. Most of the increase in spending in the NHS in recent years has gone to pay for higher staff costs. This year, staff costs will account for 56% of the increase in funding.[83] Staff numbers have significantly increased as the following table shows.

Staff	1997	2001	2005	% increase since 1997
Consultants	21,474	25,782	31,993	48.98%
Registrars	11,909	13,220	18,006	51.20%
GPs	29,389	30,685	35,302	20.12%
Qualified nurses	318,856	350,381	404,161	26.75%
Allied health professionals	45,022	51,316	61,082	35.67%
Ambulance staff	14,941	14,855	18,117	21.26%
Managers and senior managers	22,173	27,424	39,391	77.65%
Administrative and clerical staff	160,479	184,229	233,174	45.30%

Table 6. Staff numbers since 1997 (head count)

61. Since 1997, there has been an increase of 77.65% in numbers of managers and senior staff. Administrative and clerical staff numbers have risen by 45%.[84] In 2000, the NHS Plan announced 7,500 more consultants, 2,000 more GPs, 20,000 extra nurses and 6,500 extra allied health professionals.[85] The increases seen far exceed those set down in the NHS Plan,

79 Ev 15 (HC 1204-II)

80 Ev 141 (HC 1204-II), Ev 160 (HC 1204-II)

81 Q175

82 Q145

83 Public Expenditure on Health and Personal Social Services 2006, HC 1692–i

84 Uncorrected transcript of oral evidence taken before the Health Committee on 23 November 2006, HC 94–i, Q22

85 Department of Health, *The NHS Plan: a plan for investment, a plan for reform*, July 2000

however. The number of GPs, for example, has risen from 30,685 to 35,302 and qualified nurses from 350,381 to 404,161 since the Plan's introduction. The Secretary of State told us that the target for hospital doctors was for 74,590 by 2007. [86] By 2004 over 78,000 hospital doctors were employed and by 2005 this figure was over 82,000. She told us:

> The reality is that the NHS has spent more of the growth money on additional staffing than was planned …That is why some individual organisations around the country are now having to make some very difficult decisions on their staff, including in some cases redundancy.[87]

62. The NHS is therefore employing more doctors than it intended to by 2007. Very much the same is true for nurses.[88] Pay rises too have made a major contribution to the increase in staffing costs. For example, of the 56% additional spending on staff in 2005/06, 47% was due to pay increases.[89]

Poor local management

63. According to some witnesses, local NHS organisations are to blame for spending without due regard to what they could afford. Sir Ian Carruthers commented:

> If you want my personal view on this… I believe that the financial problems are a symptom of the managerial actions.[90]

The NAO/Audit Commission report stated:

> 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…some NHS bodies have financial management and governance arrangements which mean that…they have coped better than others.[91]

64. It was claimed that the most basic problem has been the recruitment of staff with too little thought for the financial consequences. Mr Taylor from the HFMA told us:

> …some NHS Employers' figures that were out last week…said the NHS had recruited an additional 268,000 staff over the last 6 years. Perhaps some organisations recruited too many too quickly. [92]

65. Mr David Nicholson, the newly appointed NHS Chief Executive, explained that there appeared to have been "no linkage between the reporting of the overall financial position

86 See Ev 136 (HC 73-II). These figures are based on projections for the 2002 Spending Review.

87 Q743

88 Q742

89 Public Expenditure on Health and Personal Social Services 2006, HC 1692–i

90 Q284

91 NAO/Audit Commission, *Financial management in the NHS*, June 2006

92 Q525

with the 'upward trajectory' of recruiting staff that it could not afford and by using non-recurring money to balance the in-year position".[93]

66. The NAO, Audit Commission and local organisations such as Overview and Scrutiny Committees noted significant failings in local management including:

- Poor accounting and financial management
- Inadequate leadership and loss of management control;
- Lack of expertise and focus ('corporate management') at Board level; and
- Lack of engagement with clinicians.[94]

Poor accounting and financial management

67. Mr Antony Sumara, the former Chief Executive of University Hospital of North Staffordshire NHS Trust, told us: "poor financial systems, poor financial reporting, poor financial management all contributed to the problem [of deficits]".[95] The Secretary of State was clear that improvements were necessary:

> It comes back to individual organisations not necessarily understanding their true financial position.[96]

Commenting on the large difference between the audited and unaudited figures of trusts in 2004/05, Mr Douglas acknowledged failures of financial management:

> I just would not have expected the scale of last year. In terms of the overall improvements in financial management, there are clearly issues for us on that.[97]

68. Key aspects of good financial management include skilled finance directors and accurate financial reporting. While the best are excellent, too many are poor. In a survey of Chief Executives, published in the *Health Service Journal* earlier this year,[98] 39% of respondents believed that the calibre of finance directors had been a major cause of the deficits. Surprisingly, many have other functions in addition to their finance role, which cannot assist financial management.[99]

69. Dr Bill Moyes of Monitor stressed the need for effective and timely financial reporting to the Board to ensure financial control:

> Our experience in the foundation trusts that have got into problems is that mostly they have lost control of cost. They do not have the information to marry up activity

93 Q799

94 NAO/Audit Commission, *Financial management in the NHS*, June 2006, Audit Commission, *Learning the lessons from financial failure in the NHS*. July 2006, Ev 67, Ev 128 (HC 1204-II)

95 Q221

96 Q788

97 Q290

98 *Health Service Journal*, 19 January 2006

99 Audit Commission, *Learning the Lessons from Financial Failure in the NHS*, July 2006

> and cost, to understand where to cut cost, where to try and increase income and so on.[100]

According to Dr Moyes, the Foundation Trust accounting regime is vital since it makes deficits clear to the Boards and its monitoring system:

> …flags up problems faster than in the generality of the NHS in a way which boards cannot ignore; boards cannot pretend they do not have problems. [101]

Lack of leadership and loss of management control

70. The loss of control in some trusts is truly appalling. Mr Martyn Everett, Director of Recovery at Kensington and Chelsea PCT, which had a deficit of £22 million in 2005/06, informed us that:

> There was a complete breakdown in financial control in Kensington and Chelsea and poor management to the extent that deficits were being run up that the primary care trust did not realise were happening. Basically action could not be taken or was not taken because they were not aware that they had a problem.[102]

71. Elsewhere trusts did not consider whether they could afford to pay staff before recruiting them. The Secretary of State told us:

> North Staffordshire as well as the Royal Cornwall—and there will be others—took on significant numbers of staff last year at the point where the scale of their financial problems was really starting to become very visible to everybody.[103]

72. The need for effective leadership to prevent this sort of thing from happening was highlighted by many witnesses.[104] For example, West Hertfordshire cited a lack of leadership as one of the contributors to its deficit.[105] It is very important at the most basic level to have someone prepared to say no.

73. A loss of control is inevitable when organisations lack the appropriate staff. We were told that not all trusts have permanent finance directors in place.[106] The Secretary of State told us that part of the reason for reconfiguration was that some PCTs had been unable to recruit finance directors and were sometimes forced to share management teams.[107] She admitted, however, that not all reconfigured PCTs had the necessary senior staff in place either:

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100 Q281

101 Q279

102 Q99

103 Q788

104 Eg. Q381 [Dr Bill Moyes], Q120 [Mr Martyn Everett], Q221 [Mr Peter Law]

105 Ev 142 (HC 1204-II)

106 Audit Commission, *Learning the Lessons from Financial Failure in the NHS*, July 2006

107 Q708

> The Primary Care Trust boards have largely been appointed—although that is not quite complete in every case where there has been a reorganisation—with chief executives in place, putting their management teams in place. Inevitably that takes time. There are still some—and I do not have the exact numbers—who do not yet have permanent directors of finance in place.[108]

74. Dr Carter from Central and North West London mental health trust pointed out the need for strong leadership from the Board:

> 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.[109]

Dr Moyes told us:

> There have also been failures at Board level. Other trusts have failed to adopt some of the best practice to be seen in Foundation Trusts.[110]

A particular problem has been the failure to recruit non-executive Board members with relevant financial expertise.

Engagement with non-financial staff

75. The Audit Commission informed us that clinical staff's lack of engagement with financial matters also contributed to a lack of financial control. This view was echoed by witnesses. Mr Sumara said:

> If you are going to draw out themes as to why organisations get into this sort of state, the levels of clinical engagement and openness are critical… The way to get some of these problems sorted out is to get the clinicians involved in the decisions, get the PCTs to help support what you are doing, the GPs particularly, get them involved in what you are trying to do.[111]

Mr Simon Pleydell, Chief Executive of South Tees Hospitals Trust, which has a deficit of over £21 million, commented:

> The board leadership is important, but it is the staff in the organisations that need to understand what it is that needs to be achieved. Most of them—and they have said this to me personally—do not like being in a financially difficult position because everybody talks about money and not the quality of care which is being delivered.[112]

76. Evidence from Advanced Medical Solutions, a research and manufacturing company of non-pharmaceutical medical supplies, stated that, "there is a disconnection between

108 Q709

109 Ev 34 (HC 1204-II)

110 Q343

111 Q216

112 Q221

clinical decision-makers and budget holders within the NHS".[113] This lack of responsibility for budgets, and of awareness of the need for cost efficiency among staff who prescribe or order supplies, may lead to excessive spending.

Poor central management by the Department of Health

77. The Healthcare Commission told us that a deficit is "not directly correlated with a low star rating".[114] If trusts with deficits can achieve good results as measured by the Commission, they are clearly well-managed to some degree. This suggests that poor local management cannot be blamed across the board for financial failure.

78. Several witnesses argued that the Department bore a heavy responsibility for the deficits, both because its policies had increased the costs which trusts have to fund and because it was in itself a cause of poor local management.[115]

79. The survey of Chief Executives, published in the *Health Service Journal,*[116] showed that many respondents blamed central policies for the lack of financial balance in the NHS. The survey included the following findings:

- 99% said Agenda for Change and the consultant and GP contracts were not costed effectively by the Department and that this had a significant impact on the financial status of the NHS;
- 67% said the NHS would not be facing such severe financial problems if it were not for "inflexible government targets";
- 66% said the policy of introducing more and more private providers had destabilised parts of the NHS.

Other witnesses expressed similar views and added a number of other Government decisions which had contributed to financial imbalances, including PFIs, ISTCs, PCT reconfiguration and Payment by Results.[117] In some cases these decisions had been made at the end of the preceding financial year and amounted to a significant shifting of the goal posts for trusts to achieve.[118] The Secretary of State accepted this as a legitimate criticism.[119]

Badly-costed work contracts

80. Three major new working contracts have been introduced in the last two years: Agenda for Change, and the GP and consultant contracts. While the pay increases were unsurprisingly welcomed by staff, they cost the NHS significantly more than was predicted

113 Ev 10 (HC 1204-II)

114 Ev 56 (HC 1204-II)

115 Eg. Qq171, 175

116 *Health Service Journal*, 19 January 2006

117 See the following sections for details

118 Qq586-594

119 Q711

(£220, £250 and £90 million more, respectively in 2005/06[120]). The total of this extra spend is similar to that of the total net deficit of the NHS. The projected figures for 2006/07 are £394 million for Agenda for Change and £48 million for the consultants contract.[121]

81. The new contracts have affected some organisations particularly badly. Mr Sumara, formerly of University Hospital of North Staffordshire, explained that a teaching trust such as his spends more on consultants; as a result the new consultant contract would cost it more than a non-teaching trust:

> The two biggest pressures for us of something like £4.5 million excess cost have been on the consultants' contract and Agenda for Change issues…[and] we have a much higher ratio of consultants to activity than other organisations…so that would be an extra cost.[122]

Government Targets

82. The Government has imposed many central targets designed to speed up patients' access to healthcare services over the past few years. The pressure to meet these targets has, it is claimed, led to significant increases in expenditure.[123] Mr John Rostill, Chief Executive of Worcestershire Acute Trust, told us:

> The National Health Service plan predicted and encouraged the growth of front-line staff—doctors, nurses, allied health professionals—to meet what were patient-oriented targets but were very ambitious…[meeting targets meant the] necessity of taking on additional staff.[124]

Four hour A&E target

83. The 4-hour waiting time target for patients attending A&E has been expensive to implement and has involved the diversion of funds from other areas. Mr John McIvor, Chief Executive of Rotherham PCT, said:

> The achievement of the final 2% on the A&E target was a very, very costly bit to achieve and that money had to be found from elsewhere.[125]

For example, additional staff have had to be in place to ensure this very demanding target can be met.

84. The A&E target has also had a number of adverse indirect effects with consequences for costs. The numbers of patients presenting to A&E has grown. The A&E target may have contributed to this growth, along with other factors (see Figure 2 below). Mr Ken Cunningham, the ex-Chief Executive of Surrey and Sussex Hospitals Trust, told us:

120 Qq294–297 [Richard Douglas]

121 Department of Health, *Road-testing PbR,* 2006

122 Q187

123 Q24

124 Q550

125 Q47

> There is still an increase in the number of people presenting at A&E. I do not think the acuity of disease has increased, people are not sicker than they were, but the threshold for entry seems to have dropped. [126]

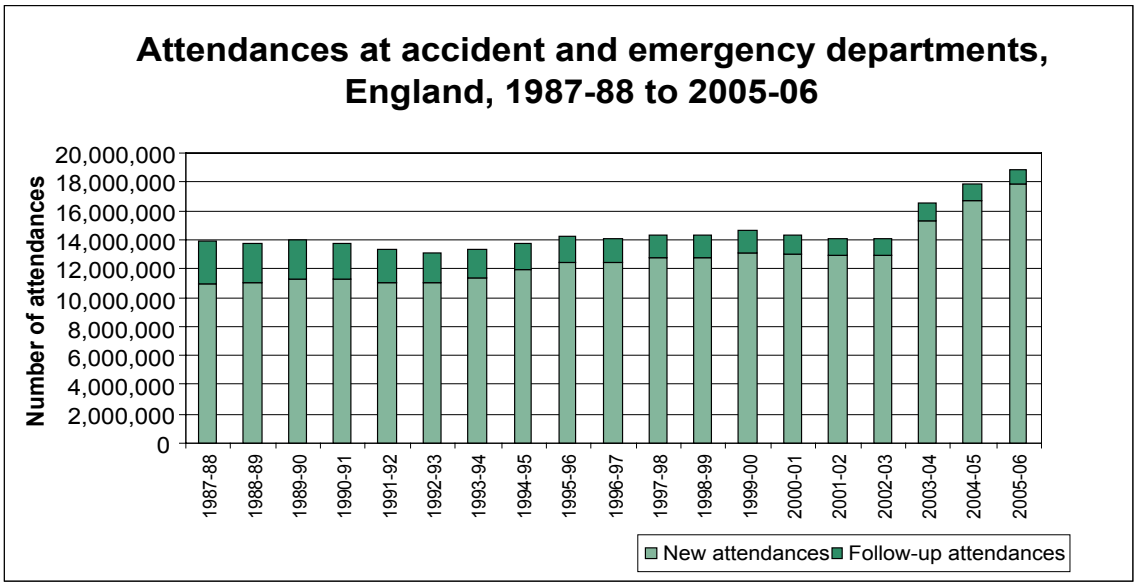

Figure 2. Attendances at A&E departments, England, 1987–88 to 2005–06

Source: Department of Health form KH09, QMAE.
Note: walk-in centres were included from 2003/04. The increase will be partly due to this factor.

85. Meeting the target may also have led to an increase in admissions to hospital via A&E which has affected trusts' ability to meet waiting list targets. This in turn affects expenditure. Mr Brian Shipley, Finance Director at Southend Hospitals Trust told us:

> …at the beginning of the year, an increase in non-elective admissions …meant that we were behind our elective targets and in doing that, having to put on additional theatre lists, outpatient sessions or whatever we had to do; you actually have to look at the financial consequences of that. [127]

Waiting time targets

86. Waiting time targets, in particular the maximum 18-week wait from initial presentation to the start of treatment and the two-week referral target for suspected cancer, have also forced trusts to take a variety of costly measures, including cutting times for imaging and other diagnostic procedures.[128] Mr Andrew Kenworthy, Chief Executive of Kensington and Chelsea PCT told us that waiting time targets were, "a major driver of additional cost pressures and expenditure for primary care trusts".[129]

126 Q247

127 Q17

128 Ev 110 (HC 1204-II)

129 Q189

Private Finance Initiative and Independent Sector Treatment Centres

87. PFI projects can also adversely affect trusts' finances. They may increase the level of fixed costs in a trust at the same time as other Government policies, such as Payment by Results and Patient Choice, mean that the trust's income is more uncertain. Some bad deals have been agreed in the past. Mr Rostill from Worcestershire Acute Trust told the Committee that the inflexibility of the PFI contract was a serious flaw, and that the basis of the contract in his area—90% occupancy—was a mistake:

> You will accept that I am biased, but it does seem to me that the contract is in favour of PFI partners rather than us … Where I sit, my hands seem to be tied much more than had this been an NHS funded hospital.[130]

88. However, while a small number of PFI schemes have had a major impact on deficits (see above), the general picture is different. The NAO and Audit Commission found that not all trusts with PFI projects were in deficit and there was only a slightly higher incidence of deficits amongst bodies with PFI schemes. They warned though that "the relatively small number of NHS trusts currently operating PFI schemes means that purely statistical comparisons should be treated with caution". [131]

89. Where ISTCs have created over-capacity in a local health economy they have inevitably deprived the local hospital trusts of income. Amicus cited the contract signed by PCTs in Trent and South Yorkshire for services from the Partnership Health Group Ltd. It cost £13.4 million to carry out work worth £10.1 million at NHS rates.[132] Witnesses representing trusts in deficit gave other specific examples of the financial impact of ISTCs in their areas:

> **Mr Sumara**: It potentially has a £1.5 million problem for me. Burton Hospital has an ISTC about to open. The PCTs have been—for want of a better phrase—encouraged to divert some of their activity to that hospital. The loss of income amounts to just over £1 million.
>
> **Mr Law**: We have a very substantial ISTC proposed on the Hemel site which will be run by Clinicentre. That creates substantial risks for the organisation. We shall lose around £15 million of income. [133]

90. PCTs suffer too because they have to pay for procedures at ISTCs regardless of whether patients use them. The BMA told us:

> 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. [134]

130 Q582

131 NAO and Audit Commission, *Financial Management in the NHS*, June 2006

132 Ev 16 (HC 1204-II)

133 Q175

134 Ev 30 (HC 1204-II)

PCT reconfiguration

91. Another factor which has affected finances in 2005/06 is PCT reconfiguration. Several witnesses thought that the new, larger PCTs would benefit the NHS overall in the long-term.[135] They would be better able to negotiate favourable terms than their predecessors. The Turnaround Director Mr Sullivan told us:

> From my viewpoint, given the lessons that are being learned fairly sharply at the moment, I would expect those [reconfigured] PCTs to perform to a higher level within the next year to 18 months.[136]

92. However, the situation is different in the short term. In our report on *PCT Reconfiguration*, we doubted that the Department would achieve the savings of £250 million which it clamed would result from the reorganisation.[137] Costs associated with reconfiguration, including those incurred by changing sites, closing offices and redundancy payments, are now blamed for the deterioration of the overall NHS position in the second quarter of 2006/07.[138] The new NHS Chief Executive Mr David Nicholson told us that redundancies alone will cost about £325 million this year.[139]

Payment by Results (PbR)

93. The Department argued that PbR will bring several advantages; for example, it will encourage staff to "understand their businesses much better".[140] Those providers with above average costs will make a loss on each procedure; those with lower than average costs will gain. Southend Foundation Trust attributed most of its planned surplus of £5.2 million in 2006/07 to PbR. [141]

94. On the other hand, witnesses pointed out that PbR was an additional hurdle that would increasingly be a source of financial instability.[142] The system can have a major impact on finances. The tariff for 2006/07 was increased by 1.5% after building in a 2.5% efficiency requirement.[143] This has impacted on PCTs' budgets. Mr McIvor, from Rotherham PCT, stated:

> The volatility around PbR is very, very high. A 1% variation in PbR for us is a £3.5 million shift in our budget and that is quite significant.[144]

95. We were also told about problems with the coding of procedures under PbR. Mr Cunningham, formerly of Surrey and Sussex Hospitals Trust, argued that because of

135 Eg. Qq 110–112 [Mr Everett, Mr Sullivan], Q535, Q540 [Mr Rostill, Mr Ridley]

136 Q115

137 Second Report of the Health Committee 2005–2006, *Changes to Primary Care Trusts*, HC 646

138 Department of Health, *NHS financial performance Quarter 2 2006–07*, November 2006

139 Uncorrected transcript of oral evidence taken before the Health Committee on 23 November 2006, HC 94–i, Q40

140 Q338

141 Q21

142 Qq15,16

143 Ev 143 (HC 73-II)

144 Q15

inaccurate coding, 'artificial inflation' might occur, which could benefit either the provider or the purchaser. He stated that hospital trusts were now paid on the basis of the coded activity but:

> … if the primary coding can be adjusted or inflated in any way then it will change radically the costs that that particular procedure attracts, and because there is medical terminology around these codes they have to be accurately interpreted, and I know that having examined some coding in some trusts recently there is the opportunity for misinterpretation, if I can call it that, and I think that could be an area that needs some clarification and some scrutiny.[145]

96. South East Hertfordshire PCT and Royston, Buntingford and Bishop's Stortford PCT stated that PbR might 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.[146]

97. Sir Ian Carruthers, then acting Chief Executive of the NHS, agreed that there could be "distortions" in the coding of procedures but he "was not overly concerned on that particular issue".[147] He did not say why.

98. The system depends on accurate reference costs and an accurate national tariff, but those originally set by the Department for use from April 2006 were introduced late (on 31 January 2006). They were then found to be inaccurate and had to be withdrawn (on 22 February) and then republished on 17 March. These inaccuracies may already have contributed to the accrual of deficits in some areas in the current financial year and may continue to do so.

99. There remains concern that some aspects of the tariff still fail to reflect differing levels of complexity in what is nominally the same procedure. Some of these costs remain controversial, for instance:

- there is no increase in the tariff for some paediatrics work, which has caused children's hospitals problems (Great Ormond Street, for instance reported a shortfall of £22 million);[148]
- a dual and single heart bypass attract the same payment.[149]

100. While PbR has probably not had a major effect on finances yet, it has added to instability in the system. There are concerns that it will increasingly affect finances in the future.

145 Q254

146 Ev 123 (HC 1204-II)

147 Q339

148 Ev 38 (HC 1204-II)

149 Ev 44 (HC 1204-II)

The Department's view

101. On the other hand, while acknowledging that costs had risen because of its policies, the Department argued that the rise in funding over the past few years should have meant that trusts were able to cope with additional costs. For example, Sir Ian Carruthers denied any link between the new working contracts and the development of deficits:

> It is a fact that the general practitioner contract cost more than we estimated. It is also a fact there have been record levels of growth and people have been receiving 9% or more… and it is also a fact to say that none of these individual things when you look at all of them can explain the actual positions very often in local organisations.[150]

Government's contribution to local management problems

102. Not only has the Government added to costs but it is also believed that it bears some responsibility for poor management locally. For example, trusts had been instructed to meet waiting list and other targets at all costs. As Mr Keith Ford from Avon, Gloucestershire and Wiltshire SHA told us:

> A&E performance was measured weekly and when it dipped, it was measured daily and I had a daily phone call. You respond, not just to what people say is important but how frequently and how hard they measure you on it.[151]

103. Mr Shipley from Southend University Hospital told us that until recently the Government gave less emphasis to the importance of financial management.[152] The Department may also bear some responsibility for failures of leadership at board level. The NHS Confederation stated that there has been a recent down-playing of the role of the Board, with more credence given to "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.[153]

104. We were told of the consequences of the repeated change initiated by the Department:

> The NHS changes its processes and procedures, often at relatively short notice, because of information that becomes available, in this case often towards the end of the financial year, and, clearly, just as there is pressure on the systems now, there is a great deal of media coverage of what the eventual public deficit was going to be.[154]

The Patient and Public Involvement (PPI) Forum of Hull and East Yorkshire Hospital Trust pointed out the constantly changing financial requirements:

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150 Q276

151 Q23

152 Q23

153 Ev 85 (HC 1204-II)

154 Q590

> 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.[155]

105. As a result, rather than take time to plan rationally how to meet the targets cost-effectively, organisations rushed into making the changes which often meant employing more staff than they could afford. Dr Jillian Pritchard from St Peter's Hospital in Surrey pertinently asked:

> Why the obsession with "modernisation", "reform", "change". These are not synonymous with good or improved practice.[156]

Conclusions

106. **The increases in the underlying deficits incurred by PCTs and hospital trusts have many causes. Different witnesses gave different weight to the importance of different factors. In addition to the effects of the changing accounting procedures associated with the introduction of RAB which were discussed in the last chapter, our inquiry highlighted the contribution of the funding formula, the effect of Government policies, poor management by the Department of Health and poor local financial management. Some of the worst deficits can be explained by exceptionally difficult circumstances such as large inherited debts.**

107. **The funding formula allocates considerably more money per head to some PCTs than others. This may be related to the scale of health inequalities but it can make financial balance harder to achieve. A number of witnesses argued that there was a correlation between trusts' deficits and the allocation of funding. The Department's Chief Economic Adviser told us that it was necessary to examine the financial position of health economies rather than that of individual trusts. He found a moderate correlation between the needs and age index and deficits in health economies in 2004/05 but denied that this showed that the funding formula had caused the deficits. The Secretary of State told us that overspending was concentrated in the "healthier, wealthier parts of the country".**

108. **Poor central management has contributed to the deficits. The Government's estimates of the cost of Agenda for Change and the new GP and consultant contracts proved to be hopelessly unrealistic. Government targets, such as the 4-hour A&E target, have been expensive to meet and have had unintended consequences which have imposed additional costs. PFI schemes and ISTCs have also added to costs. We recommend that the Department takes note of the Secretary of State's admission that our criticism of the practice of shifting the goal posts late was legitimate.**

109. **Poor local management is also to blame. For all the added costs imposed by the Department of Health, it is undeniable that the NHS has had a lot more money to**

155 Ev 59 (HC 1204-II)

156 Ev 181 (HC 1204-II)

spend. Surpluses can be found in PCTs and trusts with a low per capita funding. Deficits exist in trusts with high per capita funding. We had a good deal of evidence of poor financial management, for example of a hospital trust which hired staff without knowing whether it could afford to pay their salaries, and of PCTs which failed to recruit vital members of the financial management team. Nevertheless, poor financial management is not just caused by local managers and boards. The Government has also contributed, for example by repeated changes and the emphasis on meeting targets at short notice.

4 The recovery programme

110. In November 2005, the Secretary of State for Health said that deficits were due to "overspending, sometimes for several years, or poor financial management, or poor organisation of clinical services".[157] The Government claimed that the NHS would have tackled these problems and regained financial balance by the end of 2006/07.

111. In order to pay off existing deficits and prevent future deficits, a number of actions have been taken, either centrally or by SHAs. These include:

- finding funds from other parts of the NHS through top-slicing and the use of a contingency fund
- the clearance of deficits through recovery plans with the assistance of turnaround teams;
- making savings, largely from the workforce and training budgets; and
- making improvements to accounting procedures and poor local and central management.

We discuss the savings and the improvements which need to be made in the following chapters. Here we consider top-slicing, contingency funds and the clearance of the deficits.

Funding deficits from other parts of the NHS

112. The Department stated:

> 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.[158]

The deficits have had to be covered by funds from trusts in balance through 'top-slicing' (see glossary) and by the development of a contingency fund or buffer zone.

Top slicing

113. In 2005/06 every PCT was top-sliced, including those with deficits. According to Sir Ian Carruthers, the top-slice varies from 0.5% to 3%.[159]

114. The practice of top-slicing trusts that are performing well to support those that are regarded as performing poorly is doubtless very annoying for well-managed trusts. The NHS Confederation stated:

157 HC Deb, 15 Nov 2005, Col 850

158 Ev 4 (HC 1204-II)

159 Q368

> It is demoralising to clinicians and staff who have worked hard to achieve savings to then be asked to deliver more to provide support to other organisations which have not always been managed as stringently.[160]

115. There was also criticism of the way top-slicing had been implemented, for example of the Department's failure to explain where and when top-slicing would take place. Mr Ford, Director of Finance at Avon, Gloucestershire and Wiltshire SHA told us:

> There are some lessons to be learned and if there is to be a top-slice for 2007/08, we need to get it out in the public domain a lot earlier.[161]

116. The NHS Confederation and some other witnesses agreed, however, that for all the trouble that top-slicing caused, it was necessary. Mr Taylor of the HFMA stated:

> Universally, we want to get out of that situation, so, although top slicing might not be thought to be an ideal way forward, if this year's top slice can sort out the problem, such that we can return to financial balance, then on the whole I think we see it positively.[162]

Mr Everett, from Kensington and Chelsea PCT, admitted that the top-slice had negatively affected the PCT's provision of services, but that the move would pay off later on:

> Undoubtedly the fact that we have been top-sliced means that we are doing things that we would not have done otherwise, but the view is that we are maintaining core services and that whilst there will be some difficulty in the short term, getting the PCT back into surplus will mean that there is much more money to be invested into primary care.[163]

117. Moreover, top-slicing has advantages over the previous system of brokerage. Whereas in the past there was no guarantee that funds removed through brokerage would be returned, now trusts are assured that their top-sliced funds will be returned. We were a little sceptical, but the Secretary of State attempted to reassure us:

> What we are now doing as part of this far more transparent system is asking the Strategic Health Authority in each region to manage the financial situation in that region. Where that involves top-slicing that is a postponement, if you like, of spending that would have taken place this year but done on the basis that the organisations contributing to the -slice will get those resources back. They will get them back as far as possible within the 3-year allocations period.[164]

118. **Top-slicing is a temporary expedient, but it must not become a permanent part of NHS funding. We recommend that a time limit be set on its use. We note the Secretary of State's intention to return top-sliced funds at an early date. Funds must be returned**

160 Ev 86 (HC 1204-II)

161 Q88

162 Q513

163 Q129

164 Q837

to the originating bodies as soon as possible and in a planned way so that the organisations can maximise the benefits from delayed spending plans.

Contingency funds

119. The SHAs plan to create a "contingency budget" against PCT and trust deficits which is to be lodged centrally with the NHS Bank and which has been taken from the amalgamated SHA budget. The report, *NHS financial performance Quarter 1 2006–07*, stated:

> The SHAs have undertaken to deliver savings by the better targeting and management of resources using their local knowledge. They will spend £5.5b on these services and have so far set aside a saving of a further £350m which has been used to create a contingency fund.[165]

SHAs have recently indicated that they can find another £100 million savings so the total contingency fund should be £450 million.[166]

120. Mr Douglas spoke of the need to develop surpluses as a buffer to future NHS spending.[167] The Audit Commission's *Review of the NHS financial management and accounting regime* recommended that arrangements of this kind be made permanent. They call the fund they wish to see established a 'national buffer'.[168]

121. The contingency fund or buffer would be used to support trusts which were in deficit; if not used, however, the money would be returned to local NHS bodies the following year. The Audit Commission sees it as protecting the Department and allowing trusts to operate more easily. It would also protect NHS trusts from the effects of RAB. The Commission added that a buffer would be necessary in any case as the number of Foundation Trusts increases, so that the Department can cover any deficit incurred.

122. **We note the plans to establish a 'buffer' or permanent contingency fund. We have serious concerns. The establishment of the fund would be an admission by the Department that it accepted that individual trusts would remain in deficit and that it had the ability, and the willingness to "bail them out". It could be seen as undermining the attempt to create a culture of strong local financial management. It would lead to the allocation of resources in an unplanned and ad hoc way. It would also reduce the proportion of funding allocated directly to PCTs. This goes against the Government's policy of giving more power and autonomy to local organisations.**

165 Department of Health, *NHS financial performance Quarter 1 2006–07*, August 2006

166 Q804

167 Q314

168 Audit Commission, *Review of the NHS financial management and accounting regime, A report to the Secretary of State for Health*, July 2006

Clearance of deficits

Are the Government's proposals achievable?

123. The Department intends that the deficits should be cleared quickly. Its plans are that by the end of March 2007:

- The NHS as a whole will be in balance (although three of the 10 SHAs will not be);[169]
- Most individual NHS organisations will be in "run-rate balance".[170] This means that bodies do not spend more money than they receive each month;
- Many individual NHS organisations will be in 'in-year' balance;

Based on individual agreements between trusts and SHAs, all accumulated deficits are to be cleared within a 3-year or, exceptionally, a 5-year period.[171]

124. Mr Douglas outlined the improvements in the NHS financial position expected over the next few months:

> We aim to eliminate the £500 million so we get to zero for the system as a whole. In all the organisations who have had financial problems we expect to see improvement by the end of this year and we aim to be in a position where almost all of those organisations are in monthly balance.[172]

125. Some of these targets seem achievable, but witnesses had doubts about others.[173] First, it is likely that the NHS as a whole will be in surplus by April 2007. Reductions in spending by SHAs should ensure that this target is met. In contrast, many individual trusts will not be in balance. In fact, if the pattern observed between the first and second quarter of 2006/07 continues, the number of trusts in deficit may increase; it is not clear when they are expected to be in 'in-year' balance. Clearing accumulated deficits in 3 or even 5 years will be difficult for a number of trusts.

126. Some witnesses were optimistic. Mr Taylor from the HFMA described the proposals as a "short, sharp year of correction," following which trusts would be back in financial balance.[174]

127. Other witnesses were more sceptical. Inflexible costs present a barrier. The fixed unit costs of PFI hospitals and ISTCs, for example, are a severe burden. Mr Cunningham stated:

> Where a trust has a deficit of, let's say, more than 8% or 9%, getting up to 10% [of turnover]…it is practically impossible to maintain the range of services that these trusts need to maintain and to deliver that sort of reduction in expenditure.…Given

169 East of England, London and the South East Coast. Ev 4 (HC 1204-II)

170 Q700

171 NAO/Audit Commission, *Financial Management in the NHS*, June 2006

172 Q363

173 Qq 145, 147, 264

174 Q517

> the extent of fixed costs or semi-fixed cost that are very difficult to move within a hospital trust I cannot see that you could eliminate 8%, 10%, 12% of cost in one or two years; it is just not deliverable.[175]

128. Efficiency savings add to the difficulty. The HFMA stated that efficiency savings set by the Government at 2.5% would be, "extremely challenging" as a result of deficits.[176] The organisation added:

> For organisations starting the year in balance this is a significant saving to find. But organisations carrying forward a deficit face a far stiffer challenge. First they must address their underlying overspend—ensuring they live within their means. However they also need to plan to make a surplus to offset their earlier deficits—so enabling them to meet their statutory duty to break even.
>
> … According to our members, savings targets of 4%–5% in acute trusts are typical and in some organisations the targets are even more challenging.[177]

129. The quick turnaround has been made even more difficult by additional requirements made of trusts by the Department. For example, the changes to the Purchaser Parity Adjustment, the sudden increase in the expected level of efficiency savings and adjustment to the Payment by Results tariff towards the end of the financial year were all cited as contributing to deficits. Many trusts did not have time to adjust.[178] In Worcestershire, for instance, these costs alone added £17 million to the existing deficit of £20 million.[179] In South East Hertfordshire, the introduction of PbR and removal of Purchaser Parity Adjustment meant the PCT needed to find an extra £9.2 million to provide the same level of service as the previous year.[180]

130. Some trusts have deficits of extreme difficulty, including:

Organisation Name	Unaudited Position	Audited Position	Annual Turnover	% Deficit
Surrey and Sussex Healthcare NHS Trust	-40,834	-40,281	143,720	-28.00%
South Tees Hospitals NHS Trust	-21,395	-21,395	318,143	-6.70%
West Hertfordshire Hospitals NHS Trust	-28,284	-26,785	209,199	-12.80%
Queen Elizabeth Hospital	-19,199	-19,289	132,983	-14.50%
Hillingdon PCT	-36,506	-36,148	284,584	-12.70%

Table 7. NHS organisations in extreme difficulty

175 Q264

176 Ev 143 (HC 73-II)

177 Ibid

178 Qq585–589. [John Rostill]. Ev 161

179 Q594

180 Ev 125 (HC 1204-II)

Source: Public Expenditure Questionnaire 2006.

131. Witnesses doubted whether such organisations can recover in the time scale set.[181] The NAO/Audit Commission report, *Financial management in the NHS*, warned:

> A number of Trusts have expressed concerns to us that once financial balance has been lost, the resultant cut in income under the RAB regime makes recovery doubly difficult.[182]

Mr Taylor from the HFMA echoed this view: "once an NHS organisation gets into deficit, it is very difficult for it to get out of deficit."[183]

132. The Secretary of State agreed that not every trust would have eliminated its deficit within 5 years, but would not say what would happen if organisations failed to break even after this time. According to Mr Ken Cunningham, in such situations the Department will have to decide whether to grant exceptional levels of funding or close hospitals.[184]

133. **The Department plans to be in overall surplus by the end of March 2007. However, not all trusts will be in surplus by then and it is unlikely that trusts with the biggest deficits will be able to repay their accumulated deficits in 5 years. Such trusts should be responsible for drawing up a recovery plan which is agreed by the SHA. It is important that as a first step they achieve 'in-year' balance. Where there is no realistic chance of recovering the deficit over the 3- to 5-year period without severely affecting local services, consideration should be given to allowing a longer period to pay off historic deficits.**

Recovery

The use of turnaround teams

134. In November 2005 private sector firms were appointed to assist trusts in deficit. The accountancy firm KPMG carried out a brief initial examination in 62 organisations—28 PCTs and 34 NHS Trusts[185] and followed this with a second phase of assessments of another 36 organisations.[186]

135. The National Programme Office (NPO) for turnaround was then established by the Department in February 2006 "to provide coordination, review, monitoring and scrutiny of all turnaround projects".[187] The NPO produces a weekly report to the Turnaround Task Force on progress.

181 Q264

182 National Audit Office/Audit Commission, *Financial Management in the NHS*, June 2006

183 Q506

184 Q268

185 This cost £1,493,500 (ex. VAT and expenses). Ev 7 (HC 1204-II)

186 This cost £1,092,400. Ev 7 (HC 1204-II)

187 At a cost of an average £177,000 per month. Ev 4–7 (HC 1204-II)

136. Private sector turnaround directors were appointed to each of the SHA regions in England. With the NPO, the directors coordinate and monitor activity in their area and ensure that, where necessary, organisations receive targeted external support.

137. The trusts with the biggest deficits were required to appoint dedicated turnaround teams, issue clearer guidance on financial reporting and provide training for financial managers.[188] All of the PCTs and trusts deemed to require targeted support now have it in place. Further organisations are being monitored for inclusion in the programmes, including the 21 organisations outside of the turnaround programme that have reported large deficits in 2005/06.[189]

138. Up to September 2006, over £7 million had been spent on Turnaround Directors in 31 NHS bodies. We were told that trusts will spend £22.1 million on "external turnaround support between Jan 06 and March 07".[190]

139. We received mixed evidence regarding the effectiveness of turnaround teams. The teams themselves and the Department thought them value for money despite the high cost.[191] Some witnesses, including Mr Rostill from Worcestershire Acute Trust, were somewhat disparaging about their effectiveness, and keen not to have a team directly involved in the financial management of his organisation.[192] Others reported that turnaround teams had made a positive contribution. Mr Law from West Hertfordshire NHS Trust stated:

> I think they have made a significant contribution for us. We delivered £4.5 million of savings last year; we have a programme of £15 million this year. We would have struggled, because of the issues around organisational capacity…to produce that without their input. There is a good rate of return on the investment we have made. They have brought a fresh perspective into the NHS and by and large have been enormously helpful.[193]

Mr Sumara added that the support of turnaround teams was valuable in the short-term and had benefited his organisation financially:

> They have saved me more money than they have cost, put simply, quite considerably more money, particularly on the procurement end of the business…Going back to this thing about capacity, while you have the organisation in that sort of turmoil people needed additional support and expertise and they have been good at providing expertise.[194]

188 BBC News online: news.bbc.co.uk/1/hi/health/4821682.stm

189 We were told this in June 2006. NAO/Audit Commission, *NHS Financial Performance 2005-06*, June 2006, DH *Financial Turnaround in the NHS*, January 2006 and Ev 1 (HC 1204–II). Turnaround teams are now present in a 143 organisations compared to 52 in December 2005 (*HSJ*, 16 November 2006).

190 Uncorrected transcript of oral evidence taken before the Health Committee 23 November 2006, HC 94–i, Q89

191 Ev 4, Ev 75 and Ev 102 (HC 1204–II)

192 Qq 625–626

193 Q225

194 Q227

140. The Audit Commission stated that turnaround directors offered "few new ideas" but were effective project managers and good at "posing tough questions and holding the line".[195] Mr Nicholson agreed:

> One of the things turnaround has brought to the system as a whole, certainly in the places where it has worked well, is a much greater rigour, a much clearer programme and project management approach and some reasonably good ideas from the external world to enable us to make progress.[196]

141. **£22 million is to be spent on turnaround teams between January 2006 and March 2007. There are mixed views as to whether they provide value for money, but on balance our witnesses thought they played a useful role. That they have been necessary is a sad reflection on the quality of much management in the NHS over many years.**

Recovery plans

142. Trusts in deficit have produced recovery plans which could bring considerable advantages. For example, Mr Everett told us:

> If you were looking at the plan as a whole, a big element of it is removing excess capacity and improving efficiency.[197]

143. However, according to the NAO and Audit Commission who examined the plans, many were deficient:

> While some bodies' financial recovery plans have been successfully designed and delivered, others have been based on unrealistic assumptions or short-term measures.[198]

Moreover, most NHS Trusts and PCTs had recovery plans to address the causes of their individual deficits but that these plans were sometimes inadequate and were often not being fully delivered in practice. Only 13% of PCTs and 21% of acute trusts had plans which in June 2006 the NAO/Audit Commission agreed were comprehensive and deliverable. Recurring weaknesses in the plans included that they:

- were viewed as the responsibility of finance director/department;
- did not address the underlying causes of the problem;
- made unrealistic assumptions or overly ambitious savings plans;
- were not agreed with all relevant staff/departments;
- were not updated and progress not monitored.[199]

195 Ev 27 (HC 1204-II)

196 Q822

197 Q142

198 NAO/Audit Commission, *Financial Management in the NHS*, June 2006

199 Ibid

144. We were told that too often instead of sensible decisions arising from well-considered plans, we are getting short term reactions such as paying creditors late "as a policy aimed at alleviating short-term financial pressures, not through administrative shortcomings".[200] Dr Peter Carter stated "short term crisis decisions are being made which will have negative long-term impacts on patient care".[201]

145. There are also concerns that some recovery plans are seeking too rapid a recovery. The requirement to break even on in-year budgets this year, and break even overall in the next 3 to 5 years, increases the risk that organisations will take actions that limit spending in the short term but lack long-term strategic vision.

146. An additional and important aspect of the issue is that it is unclear whether deficits have been accurately located. They have been placed in the formal accounts of one body, but this may be a matter of (bad) luck or expediency, caused by the inconsistent application of RAB or SHA policies on where deficits should lie. It may be better to allocate the deficit to the relevant local health economy rather than an individual PCT or hospital trust, and economy-wide plans to recover the balance should be the new focus of SHA and Department of Health attention.

147. Many existing recovery plans are unsatisfactory. The trust in deficit must be responsible for drawing them up. They should be agreed with the SHA. To state the obvious, plans must ensure that savings are based on long-term not short-term considerations and have minimal effects on clinical services.

200 Ev 54 (HC 1204-II)

201 Ev 34 (HC 1204-II)

5 Consequences of deficits

148. While not every trust has to be in balance by the end of the 2006/07 financial year, trusts with deficits have to take steps to make significant savings and trusts in balance have been 'top-sliced'. This has had consequences for many aspects of the NHS, its staff and patients. The main foci for savings, which we discuss below, are:

- Services;
- The workforce; and
- Education and training.

We also consider the implications for patient care.

Savings made through changes to services

Services commissioned by PCTs

149. PCTs have made savings through a variety of measures, but 'soft targets' such as funding for voluntary organisations and for mental health and public health services have been particularly affected. According to the Royal College of Nursing (RCN), "funding which is not ring-fenced is being used to achieve deficit recovery targets".[202]

Voluntary organisations

150. The funding of voluntary organisations has been affected by deficits. Mr Everett told us that:

> …there are elements of [Kensington and Chelsea's] plan where we are cutting back on our support for voluntary organisations which, if it were not for the top-slice we probably would not do. [203]

Hospital chaplaincies

151. Among the small, soft targets affected by cuts are hospital chaplaincies. We were told that one trust's Board plans to decrease the chaplaincy levels by 70% in order to make necessary savings.[204] This will affect the non-medical yet important care patients and their friends and families receive in hospital. The Hospital Chaplaincies Council of the Church of England informed us:

> All of this means that patients are inevitably suffering. Relatives and members of staff are not receiving support at crucial times. In the present circumstances there will soon be a time when a patient requires the support of a chaplain at his/her last hours

202 Ev 113 (HC 1204-II)

203 Q142

204 Ev 147 (HC 73-II)

> and no chaplain will be on call, or by the time a chaplain races from one site to another it will be too late.[205]

Mental health

152. Mental health services appear to have been particularly targeted. The Royal College of Psychiatrists reported cuts of £16.5 million in planned funding to 11 mental health trusts.[206] The charity Rethink suggested that over £30 million had been cut from services in 30 different areas of England.[207] A survey of mental health trust Finance Directors showed that, in 2006/07, 63% of trusts have been asked to reduce spending plans. Of these, 83% said that deficits were the main reason.[208] According to the Royal College:

> These cuts are not to do with the inefficiency or non-effectiveness of the mental health services but are being used to subsidise other parts of the health service going into overspend.[209]

153. We received evidence from a number of mental health trusts which have had to make savings. Dr Ros Keeton, Chief Executive of Worcestershire Mental Health Partnership Trust, told the Committee that her organisation had a 5% reduction in commissioning from the PCT.[210] Cuts may be greater in some areas. The Hertfordshire Partnership Trust, for example, has to make 5% savings across all services, but has chosen to cut psychological services by 11%. A direct access referral service will close, although patients are part way through their courses of treatment.[211] The Royal College of Psychiatrists stated that Southwark PCT has asked for a reduction in mental health services of 7.2%.[212]

154. Many submissions pointed out that the cuts mean a significant step back in the provision of mental health services. Dr Carter from CNWL told us:

> 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.[213]

205 Ev 147 (HC 73-II)

206 Ev 120 (HC 1204-II)

207 Ev 103 (HC 1204-II)

208 The Sainsbury Centre for Mental Health. *Under Pressure: The finances of Mental Health Trusts in 2006*. July 2006

209 Ev 120 (HC 1204-II)

210 Q637

211 Ev 17 (HC 1204-II)

212 Ev 120 (HC 1204-II)

213 Ev 35 (HC 1204-II)

Public health

155. The White Paper *Choosing Health* encouraged spending on public health programmes.[214] There are concerns that the White Paper's aspirations are now being undermined by the need to make savings.[215] North East London SHA stated:

> 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.[216]

156. The same organisation added that funding will be cut for other public health programmes, such as smoking cessation, sexual health clinics, the provision of school nursing and the development of the public health workforce.

Savings made by acute trusts

157. The main savings made by hospital trusts are through reductions in employment levels and services. Reductions in employment and the effects on patient care are discussed below. Where large savings and reductions in the workforce have had to be made, some organisations have reorganised their services. At Worcestershire acute trust, for example, all hospital births, neo-natal care and the special baby care unit have been moved to a single site at the Worcestershire Royal Hospital.[217] The acute trust stated that, "service reconfiguration is essential"[218] but added that this will not be enough to combat the problem:

> …the Trust Board has recognised that it will not be able to take the final steps to achieve recurrent financial balance without even more radical action. This will involve a comprehensive review of services across the three sites and serious questions about their sustainability.[219]

In some places acute hospitals may have to be merged or reconfigured to make the necessary savings. In an interview with *The Guardian*, Mr Nicholson said that there would be up to 60 reconfigurations of NHS services. A&E departments, paediatrics and maternity services would be affected.[220]

214 Department of Health, *Choosing Health: Making Choices Easier*, Cm 6374, November 2004

215 Ev 113 (HC 1204-II)

216 Ev 90 (HC 1204-II)

217 *Birmingham Post*, 4 December 2006

218 Ev 152 (HC 73-II)

219 Ibid

220 Letter from Mr Nicholson to MPs, November 2006 and *The Guardian*, 13 September 2006

The workforce

Redundancies and posts lost

158. As we have seen, most of the rapid increase in expenditure has been for staff costs arising from pay rises and the increase in the number of staff in post.[221] Reductions in the levels of staffing are now bound to occur as organisations seek to reduce their expenditure. The HFMA explained:

> The NHS spends up to 70% of its money on staff and it would be reasonable to expect 70% of the required savings to come from the staff budget…given the amount of expenditure tied up in staff costs, it is inevitable that in some organisations compulsory job losses may be needed.[222]

159. The BMA estimated that jobs lost as a result of redundancy or natural wastage totalled over 11,000.[223] The Royal College of Nursing stated in October 2006 that 19,000 posts were at risk. [224] Their estimates of cuts to NHS staff and services included:

- Mid Yorkshire Hospitals Trusts to cut 222 posts from a range of services;
- 1,200 posts and 186 beds to be cut after the merger of two Nottingham hospitals;
- East and North Hertfordshire NHS Trust, West Hertfordshire NHS Trust and City Hospitals Sunderland Foundation Trust each to cut up to 500 hospital posts (subsequently the Chief Executive of West Hertfordshire Trust told us that around 750 posts would be lost[225]);
- Oxford Radcliffe NHS Trust to lose 600 posts;
- PCTs in Buckinghamshire to reduce staff in almost all community services, including almost 50 district nursing posts.

160. A survey by the Royal College of Midwives found that 33% of managers surveyed reported that their maternity budget had been cut, 25% that numbers of staff had been reduced with half of these trusts operating a recruitment freeze and 25% that senior midwives' posts were being replaced by junior posts.[226]

161. Macmillan told us that specialist services are particularly likely to be cut:

> 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

221 Public Expenditure on Health and Personal Social Services 2006, HC 1692–i

222 Ev 143 (HC 73-II)

223 Ev 30 (HC 1204-II)

224 Ev 151 (HC 73-II)

225 Q219

226 Ev 105 (HC 1204-II)

> redundancy…PCTs and hospital trusts are reneging on written agreements, negatively affecting posts and services that Macmillan has supported financially.[227]

Breakthrough Breast Cancer gave similar evidence.[228] A survey of PCTs by the Association of Breast Surgery in June 2006 found that 66% said that breast care nurse posts were threatened by redundancy, not replacing retirees or requiring specialist nurses to return to general duties. The charity commented:

> A reduction in the numbers of specialist breast care nurses will make achieving Government targets for breast cancer treatment, including the 31 day and 62 day waits, more difficult. In addition, it will limit breast a unit's ability to meet the two week wait for all women referred by their GP by 2008, a commitment made by the Government in 2005.[229]

162. The Department admitted that redundancies will take place. Sir Ian Carruthers told us:

> It is actually difficult at a national level to draw conclusions on the manpower reductions because, in some cases, they are notices of consultation, in others they are reductions in posts, they are not necessarily reductions in people; they are about reducing agency costs, introducing vacancy freezes and, in very few cases, are about compulsory redundancies… it is not as simple as adding [the figures] all up, but reductions there will be.[230]

163. However, the Department accused the media of 'talking up' the number of job reductions likely to occur.[231] As the Secretary of State pointed out, the figures referred to by the BMA and RCN are not compulsory redundancies. Natural turnover and recruitment freezes account for many of the posts lost. Some of the lost jobs include notional posts to which no one has ever been appointed.[232]

164. The Department does not record the number of posts lost although it keeps records of redundancies and produces regular statements of non-agency staff in post.[233] It has also examined some of the announcements of lost jobs and in every case found them to be exaggerated. For example, the Secretary of State told us that in North Staffordshire:

> The headline figure was over 1,000 job losses. They started consulting on a very large number of redundancies. They are ending up not only with fewer jobs lost but far fewer redundancies than the number they consulted on. As we look at the organisations with the biggest headline figures, we can see that they are ending up in a very different and lower position than the headlines.[234]

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227 Ev 77 (HC 1204-II)

228 Ev 136 (HC 73-II)

229 Ev 136 (HC 73-II)

230 Q351

231 Q351 and 354

232 Q745

233 Q746

234 Q769

165. The Department announced in October 2006 that 903 compulsory redundancies were made in the NHS in the first half of this financial year.[235] Approximately 25% of the jobs or posts lost were clinical positions[236] (see Annex 2 for the number of redundancies per SHA).

Future employment and recruitment difficulties

Employment prospects for newly qualified staff

166. An additional problem is the effect of the reduction in available jobs on newly qualified staff and those staff in training. A survey by the Council of Deans showed that 80% of nursing students who qualified in summer 2006 had been unable to find jobs in the months preceding graduation. This compares with 30% in 2005.[237] More recent figures show that only 55% of newly qualified nurses, 58% of midwives and 15–20% of physiotherapists have found posts to date.[238]

167. The Chartered Society of Physiotherapy informed us that "unprecedented numbers of newly qualified physiotherapy graduates [were] unable to find employment…in the NHS".[239] A survey conducted by the society showed that large numbers have been unable to find jobs:

> 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…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.[240]

168. Those looking for training posts are also affected. Dr Jonathan Fielden from the BMA added that around 9,000 doctors were currently unable to find a training post.[241]

169. On the other hand, Sir Ian Carruthers denied that newly qualified staff would have problems finding jobs:

> …the workforce is reaching a plateau, is stable and is not going to grow, but I think it remains to be seen whether the claim that you have made that people coming out of training will not have jobs is true.[242]

Subsequently, the Secretary of State told us:

235 Q746

236 Ev 30 (HC 1204-II)

237 Ev 138 (HC 73-II)

238 Figures from October 2006. Unpublished evidence from the Council of Deans

239 Ev 39 (HC 1204-II)

240 Ibid

241 Q665

242 Q354

> Just as some trusts have taken on staff over the last year or so that they could not afford, some trusts have also commissioned training places but now find they cannot afford to employ the graduates from those training places…
>
> It is very difficult this year at a point where obviously we have some organisations making compulsory redundancies and clearly they are not in a position to take on newly qualified staff.[243]

She also had the following exchange with Dr Naysmith:

> **Dr Naysmith**: Have you any idea at the moment what proportion of nurses, midwives and physiotherapists have found jobs this year compared with last year?
>
> **Ms Hewitt**: It varies very considerably. In London, where there is a much higher turnover of staff, it is much easier for newly qualified staff in all of those professions to get jobs. There are other parts of the country where it is very difficult. In the East Midlands, for instance, although I think there are 49 newly qualified physiotherapists, the overall number is fairly small but a very high proportion of them, certainly a month ago, had not found a job.[244]

170. Current graduates entered their training programmes in September 2003 and the numbers able to enter these programmes were determined earlier that year. In February 2003 the Department of Health issued a press release that announced funding allocations for workforce development and stated:

> More than 8,000 extra training places for nurses, midwives, therapists and healthcare scientists will be funded from a record £3.4 billion investment in the NHS workforce announced today…[245]

171. According to the Council of Deans, NHS trusts had little or no input on numbers of places commissioned except for discussion with educational institutions of how to provide placements for learning in practice for the students.[246] The high numbers of students now qualifying are the result of the Department of Health's policies.

Recruitment in future

172. There are concerns that the difficulties in finding jobs will affect recruitment in the future. Professor Anne Marie Rafferty of the Florence Nightingale School of Nursing, told us how demoralising the present situation was:

> We have worked extremely hard to work in concert and very collaboratively with our NHS partners over the last few years. It is quite demoralising for all staff concerned, not just within the [Higher Education Institutions] but also the NHS and, of course, the future generations of students, and our reliance on the delivery plans that have

243 Q780

244 Qq781–782

245 Department of Health press release 2003/0067, *Record funding for thousands more training places announced*, 17 February 2003, available at www.dh.gov.uk

246 Ev 142 (HC 73-II)

> been set out in the NHS Plan, particularly in the community, I think is severely under threat.[247]

Given the state of morale and the difficulty newly qualified students have in finding a job, recruitment is bound to be affected.

173. However, the Secretary of State denied that this was a problem. Potential clinicians were still coming forward to train:

> …training places for nurses are higher than they have ever been before and applications for nurse training places are certainly higher than they have been for a very long time. The return to nursing campaign that the NHS ran some years ago was also enormously successful in bringing nurses back who had simply left that career.[248]

Education and training

174. The Department of Health spends over £3.5 billion each year on education. Most of the money is raised from the Multi-Professional Education and Training (MPET) levy, which is paid by SHAs. The MPET comprises three main elements:

- SIFT (Service Increment for Teaching, £800 million) for medical and dental undergraduate education within the NHS;
- MADEL (Medical and Dental Education Levy, £1,400 million) for medical and dental postgraduate education. Most of this budget is spent on junior doctors' posts;
- NMET (Non-Medical Education and Training, £1,300 million) for nursing and allied health professional education.[249]

175. Funding for MPET (included in the workforce budget) constitutes the greatest proportion of SHAs' total spend (see Table 8 below):

Central budget bundle	England (£000)
Workforce (mainly training)	3,734,249
Quality and outcomes framework	978,500
Clinical Excellence Awards	170,000
Remaining central budgets	1,226,885
Total	6,109,624
Reduction	650,000 (10.64%)
Total	5,459,634

Table 8

Source: Board papers from East Midlands SHA of 28th September 2006[250]

247 Q665

248 Q781

249 Department of Health. Letter from John Bacon to SHA Chief Executives, *Funding for Education and Training 2005/06*, 7 October 2005

Cuts in the training budget

176. The MPET budget was previously identified as a separate budget held by the SHA and, as such, was ring-fenced. As late as autumn 2005 the Department was reminding SHAs that MPET funds were only to be used for educational and workforce purposes.[251] This did not stop the funds being used to remedy local deficits. The Council of Deans stated that, although brokerage between the MPET budget and SHA budgets occurred in recent years, the problem has now become more serious. The ring-fencing has been increasingly notional over the last two years.[252]

177. As the table above shows there has been a 10% reduction in SHA spending.[253] The reduction in the MPET seems to have been higher as the workforce budget contributed 29% (£150.5 million) of the total amount of underspending by SHAs in 2005/06.[254]

178. The Council of Deans stressed that SHA Boards had "clear understanding" that the SHA needed to underspend on MPET to reduce overall levels of deficit.[255] The Council provided specific examples: the following is taken from Avon, Gloucestershire and Wiltshire SHA board papers:

> The [workforce budget] has taken significant measures to achieve £7.8m, which has contributed to the overall [Avon Gloucestershire and Wiltshire] wide financial position.

and

> …the SHA set the WDC a savings total of £10m to contribute to achieving a balanced [local delivery plan] and to avoid cost-shifting to the service. This meant further reductions in education commissions had to be made.[256]

179. The Secretary of State confirmed that savings were being made by SHAs from the education and training budget:

> [Savings are] certainly involving a reduction in the training and education budget this year. That is difficult and certainly unpopular…That is certainly part of how they are creating that contingency.[257]

180. Mr John Sargent—former Chief Executive of the Greater Manchester Workforce Development Confederation summed up the effect of deficits on workforce planning:

> The financial pressures in the last two years have driven many managers to address short term financial savings as a very high priority agenda item. This means that they

250 Ev 138 (HC 73-II)

251 Professor Charles Easmon, personal communication

252 Ev 138 (HC 73-II)

253 It is not clear when this reduction occurred. The Council of Deans estimated August/September 2006

254 Ev 138 (HC 73-II)

255 Ibid

256 Ibid

257 Q803

> have had little time or enthusiasm for workforce development initiatives—even when such initiatives would deliver large and sustainable financial savings in the medium and long term.[258]

Link between training budgets and deficits

181. Sir Ian Carruthers admitted that there was a correlation between deficits and reduced spending on training.[259] There has been great variation in the amounts cut from the training budgets of different SHAs, with those in areas of greater deficit losing more from this budget. In Cumbria and Lancashire SHA only £2,000 out of total expenditure of £33 million was underspent on training; in Hampshire and the Isle of Wight SHA, a £20 million underspend on workforce development was recorded and the total underspend was £4.4 million.[260] In this area a small total SHA surplus has only been possible because of a massive reduction in the training budget.[261] The Council of Deans argued that there was also a clear link between areas with large reductions in the numbers of students able to commence courses and the reported level of projected deficits of individual SHAs:

> This leads us to believe that there is an immediate danger of funding distributed by the DH for education and training purposes within the MPET budget being used for other purposes by the SHA.[262]

There is no doubt that SHAs have had to make savings from their budgets to help offset deficits in the overall SHA health economy.

Effects of cuts on training courses and students

182. There is inevitably concern about the cuts in the training budget of SHAs. South West London SHA stated that it would not be providing funding for continuing professional development, healthcare assistant secondments, second registration students, enrolled nurse conversion or National Vocational Qualifications.[263]

183. Reductions in the training budget have a direct effect on the numbers of students of allied health services able to start training programmes. In a letter from the Council of Deans to Lord Warner, made available to the Committee, the Council highlighted concerns regarding student numbers:

> There would appear to be an average reduction of commissions for new students for this year of around 10%. However, in some of the current SHA areas, much more drastic reductions are being imposed of up to 30% and in one case 40%.[264]

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258 Written evidence from Mr John Sargent, *Workforce Planning*, (WP 94) [unprinted]

259 Q254

260 Ev 138 (HC 73-II)

261 If savings had not been made in the education and training budget, the SHA would have reported a significant overspend.

262 Ibid

263 Letter from South West London SHA, 28 April 2006 provided to the Health Committee by UNISON, 6 June 2006

264 Letter from the Council of Deans to Lord Warner re MPET budget

184. Most cuts in the MPET budget appear to come from the Non-Medical Education and Training (NMET) budget which is the budget for training nurses and allied health professionals. For instance, Thames Valley and Avon reported that the "bulk of the underspend is from the NMET budget" and Avon, Gloucestershire and Wiltshire reported that the change in the medical and dental budgets was 2.04% while that for NMET was 6.28%.[265]

The future

185. SHAs now have more control over MPET funding through the amalgamation of the MPET budget with other centrally distributed budgets since the start of 2006/07. The document *NHS financial performance 2006–07 Quarter 1*, published on 11 August, referred to central budgets as now including:

- Specific public health programmes;
- Medical education;
- Non-medical clinical training;
- GP performance reimbursement;
- Clinical excellence awards;
- Services such as walk-in centres, out of hours services and NHS direct.[266]

186. The Council of Deans believes that the amalgamation of these budgets will allow far greater 'raiding' of the training budget to take place.[267]

187. The Council of Deans expects SHAs to try to make further savings from education and training budgets during this financial year:

> One SHA sent an email to Trusts and Universities on Friday 20 October 2006, which starts: "I wanted to let you know prior to formal notification early next week that the SHA needs to reduce by a further £13m, this year's MPET allocation".[268]

The Council added that senior figures in SHAs and deaneries had been warned that other training budgets for 2006/07 were likely to be cut by 10%.[269]

188. The £450 million "contingency budget" planned by SHAs has been taken from the amalgamated budget of £5,459.6 million. The Council of Deans argued that the contingency fund is likely to increase and the absence of any ring-fencing of education and

265 Ev 138 (HC 73-II)

266 Department of Health, *NHS financial performance 2006–07 Quarter 1*, August 2006

267 Ev 138 – 142 (HC 73-II)

268 Ibid

269 Ibid

training budgets makes it even more likely that these funds will be used to reduce deficits in other parts of the health economy.[270]

189. Cuts in the training and education budgets affect the adequacy of workforce planning for the future, particularly if the continue for more than a short period. The cuts are also a threat to higher educational establishments that have expanded their programmes. This has far-reaching effects for allied healthcare staff as well as doctors and nurses.

190. It is uncertain how long the reduction in the training budget will last or whether there will be a permanent reduction to provide a contingency fund. The Secretary of State told us:

> [Cutting the education and training budget] is a very difficult decision and it is not one that you could sustain long term. If you repeat reductions in training and education year in, year out, sooner or later you find yourself with an absolute shortage of the skilled people on whom the NHS completely depends.[271]

However, she did not indicate how long the cuts in the training programme would continue.

Patient care

191. According to the NAO/Audit Commission's report, "managing and recovering significant deficits can have a major impact on a body's ability to deliver services and meet performance targets".[272] Mr McIvor (Chief Executive of Rotherham PCT) told us

> There is no way I could sit here and say we have lost £9 million and that has had no effect on patient services.[273]

Many other witnesses, for example Dr Keeton of Worcestershire Mental Health Trust, had a similar story to tell. Dr Carter of CNWL told us that a reduction in the availability of community-based care beds was likely to lead to bed-blocking. In the long-term, this would incur greater costs as trusts would be forced to place patients in more expensive non-NHS facilities.[274]

192. The Royal College of Psychiatrists stressed that cuts now could endanger the progress made in mental health services in recent years:

> 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 5 years and return us to the

270 Ibid

271 Q805

272 NAO/Audit Commission, *Financial Management in the NHS*, June 2006

273 Q86

274 Ev 35 (HC 1204-II)

> massive inefficiencies and risks of depending too much on hospital beds…Taking away a 5% margin… will be catastrophic for mental health.[275]

We were also told:

> 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…standards and patients' recovery are definitely under threat. *(anonymous physiotherapist)*[276]

193. It is likely that deficits will also impact on services provided by social care bodies. The County Councils Network cited funding withdrawals ranging from £20,000 to £1.8 million, and affecting domiciliary care, day services, transport, meals services and residential and nursing home placements. Those with moderate needs are likely to be most affected: in Wiltshire, the county council decided it had to focus on funding services for those whose needs are substantial or critical. In Hampshire, care will only be given to those with critical care needs.[277]

194. Not only will services be affected, but also patient care. Senior NHS officials warned us of the consequences:

> There will be a number of areas where we are reducing services and that will impact on patient care[278]

195. While most of the reduction in medical staff has occurred through a reduction in posts or natural wastage rather than redundancy, this still, we were told, has a serious effect on patient care.[279] Research led by Prof Rafferty of Kings College London argued that the fewer the nurses on hospital wards, the greater the likelihood of death or complications. In a large-scale survey of hospital trusts in England where patient to nurse ratios varied from 6.9 to 14.3, Prof Rafferty found that wards with lower nurse to patient ratios had a higher patient mortality rate.[280] Prof Rafferty told us:

> When we surveyed 30 trusts within the NHS we discovered that, in fact, the worst-staffed trusts had a 26% higher risk of mortality and, therefore, the impact of reducing nurse-staffing levels on patient care can be very profound.[281]

196. Other research, commissioned by the RCN, showed that higher nurse:patient ratios were associated with lower incidence of respiratory, wound and urinary tract infections, patient falls, pressures sores and medication errors. Better patient experience and perception of healthcare were associated with higher numbers of nursing staff.[282]

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275 Ev 120 (HC 1204-II)

276 Ev 40 (HC 1204-II)

277 Ev 47 (HC 1204-II)

278 Q206 [Mr Kenworthy, Chief Executive of Kensington and Chelsea PCT]

279 Ev 107 (HC 1204-II)

280 Kings College London, Press Release 136/06 *Care and nursing numbers link*, 24 October 2006

281 Q651

282 Ev 115 (HC 1204-II)

197. In contrast, the Government, while acknowledging that services would be affected, argued that there was expected to be minimal impact on patient care. The Secretary of State pointed out that there were massive opportunities for increased efficiency as the report by the NHS Institute for Innovation and Improvement had shown:

> The NHS is not everywhere as efficient in its use of staff as it needs to be, it is more than possible for hospitals—for instance, by doing more day care surgery—to give patients better care with better outcomes and fewer staff.[283]

Dr Keeton agreed that changes in working patterns and procedures had resulted from the need to limit spending and some of these, such as decreasing the number of inpatient beds by treating patients at home and reducing rates of delayed discharges, increase efficiency and may be preferable for patients.[284]

198. The Secretary of State added:

> On those key aspects of patient care that we have been targeting and measuring over some years, we are continuing to see patient care sustained or continuing to improve despite the financial difficulties. We would expect that to remain the case throughout this financial year. That is a real tribute to the staff because in no way do I underestimate the difficulties that have been caused to staff by the need to sort out these financial problems.[285]

Conclusions

199. **Savings from the workforce budget and the education and training budget have made the major contribution to reducing deficits. Many posts have been lost, although we have not received the evidence to prove or disprove the high headline figures given prominence by the RCN and BMA. On the other hand, there have been relatively few compulsory redundancies. While the national picture is varied, this has been a bleak year for many newly trained staff.**

200. **We welcome the Government's acknowledgement that there have been very large cuts in education and training and that these are having adverse effects on staff morale and development. We were told that these cuts will only last for a short time, but no guarantee was given.**

201. **In the best case, the need to make savings can lead to the more rational organisation of services; in the other circumstances as in Worcestershire or Hertfordshire the effect on services can be severe. Although there have been few redundancies the posts lost by retirement and natural turnover have affected patient services. Soft targets such as mental health and public health services have also suffered as has funding for voluntary organisations. We believe this to be unacceptable.**

283 Q775

284 Q639

285 Q773

6 Lessons

202. As a result of changing accounting procedures and Government attempts to increase transparency, long-standing deficits have been revealed. The poor state of local and central financial management has also been brought to light.[286] In the last 5 years the NHS has received the largest ever growth in funding. Unfortunately, largely because of large increases in the number of staff employed combined with large pay rises, the rise in spending has exceeded the unparalleled rise in income.

203. There are evidently lessons for workforce planning. These we will tackle in our report on the subject which we intend to publish early next year. We consider other lessons below in relation to the need for changes to:

- accounting procedures;
- local financial management, and
- central Government management

Changes to accounting procedures

204. In its *Review of the NHS financial management and accounting regime*, published in July 2006, the Audit Commission found several aspects of the NHS accounting regime unsatisfactory and recommended changes, including:

- An end to the use of RAB within the NHS;
- Greater transparency and better financial reporting; and
- The introduction of a failure strategy.

Our examination of these proposals drew both on witnesses evidence and the study of the 2005/06 unaudited accounts which we commissioned Prof Appleby to undertake. We note that the Department has begun to make improvements and we examine what more needs to be done.

RAB

205. As we have seen, RAB has been widely criticised, in particular the

- 'double deficit' effect; and
- inconsistent application by SHAs.

206. The Government is aware of problems with RAB and asked the Audit Commission to examine the system and make recommendations on its use within the NHS. The Commission recommended that RAB should not be applied to the NHS as it is

286 See Chapter 2

"incompatible" with trusts' financial regime.[287] While the system may be suitable for Whitehall departments as an encouragement to limit spending, it is not appropriate for hospitals, which may have to spend extra in a single year (for example to provide new facilities), and less the following year to compensate. Under RAB, the organisation would suffer as the debt accumulated. Instead, the Audit Commission argued that trusts should use an accounting system which emphasises cash and liquidity and allows borrowing for investment and working capital.[288]

207. The review also recommended that any elements of an organisation's deficit which have resulted from RAB adjustments should be eliminated through provision of cash-backed income.[289] Where such funding would come from was not clear, however.[290]

208. RAB could be modified in a way that retains the necessary accounting and financial disciplines of in-year financial control, but allows for limited year-to-year flexibility and gives a suitable time period for the recovery of deficits. Allowing a degree of year-to-year flexibility within, for example, a 3-year period, as long as the organisation is in balance at the end of it, would address many of the problems currently associated with RAB. In exceptional circumstances a longer period may be necessary to recover the largest deficits. Organisations must be held responsible, and the processes should discourage the accumulation of such deficits.

209. The full impact of the RAB rules is confused by suggestions that RAB is being applied inconsistently between SHAs. According to the NAO/Audit Commission report, SHAs normally pass on the increase or decrease in resources that results from a deficit or surplus to the trust responsible, but SHAs may have applied this system differently across the country. This may stem from a lack of understanding of RAB and its implications. The NAO/Audit Commission report stated:

> We have concerns that RAB is not applied consistently to local bodies, and that its effects on their financial performance are not sufficiently transparent.[291]

210. **We agree that as presently operating RAB is not a suitable accounting regime to use within the NHS. The requirement that a hospital trust pay back a deficit while operating on reduced income is inappropriate for a healthcare service and in some cases impossible to achieve. We recommend that an alternative to, or refinement of, RAB be introduced. It is fundamental that the regime chosen does not reduce trusts' income at the same time as requiring them to pay back any deficit owed.**

287 Audit Commission, *Review of the NHS financial management and accounting regime*, July 2006

288 Ibid

289 An allocation of resources made to an organisation that is supported by the actual cash, in the appropriate accounting period to pay, for the intended programme of spend. It differs from an agreement to commit resources in one accounting period in the knowledge that cash to actually make payments for these commitments may not be available until a future period

290 Audit Commission, *Review of the NHS financial management and accounting regime*, July 2006

291 NAO/Audit Commission, *Financial Management in the NHS*, June 2006

Greater transparency

211. The Department has introduced greater transparency into the NHS. RAB has meant that the revenue account can no longer be subsidised by the capital account. Whereas previously brokerage systems allowed funds to be shifted around the NHS invisibly, now top-slicing makes it apparent where the transfers are.[292] The Secretary of State told us of the Department's achievement:

> We are creating a transparent system where the Primary Care Trusts, as commissioners, have statutory responsibility for the entire NHS budget for their area. They are responsible for deciding, with GPs, through practice-based commissioning, where that money will be spent, as are the patients, through patient choice. Hospitals then receive money reflecting the activity they are undertaking and in line with the contracts they hold with commissioners, and where the spending sits where it is incurred and deficits, if there was overspending, also sit where they are incurred.[293]

She added:

> by removing brokerage we have removed one of the major sources of lack of transparency; a problem that has given rise to organisations believing they were in financial balance when they were in nothing of the kind[294]

Mr Nicholson told us:

> It is true that in the past it was a matter for local judgement about where the final year end positions were, where you put brokerage, where money was moved around the system. Not only was it done in different places in different ways, but there were different results that came out of it.[295]

212. While significant progress has been made, some forms of brokerage have not entirely disappeared. As we have seen, funds are regularly transferred around single health economies, with the knowledge of the SHA. Brokerage may be disguised, for example, through adjustments to Service Level Agreements (SLAs); this was a significant cause of the variance between the audited and unaudited figures in 2004/05.[296] The Department admitted that there was also evidence of "inappropriate adjustments and/or omissions" in 125 organisations' accounts for 2004/05.[297] The true financial position of individual NHS organisations is less clear than the overall figure for England.

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292 Qq 838, 703

293 Q707

294 Q705

295 Q703

296 NAO/Audit Commission, *Financial Management in the NHS*, June 2006

297 For example, Scarborough and North East Yorkshire NHS Trust reclassified previously purchased medical instruments as stock and fixed assets in order to reduce its in-year spending level. Other inappropriate adjustments were also reported by the auditor. See NAO/Audit Commission, *Financial Management in the NHS*, June 2006, p 52 for more details.

213. Prof Barry McCormick, the Department's Chief Economic Adviser, told us that it was necessary to examine the finances of all local bodies in order to determine the underlying position of that region. He told us that the Department is working on analysis incorporating health economy-wide data, although he could not say when it would be published.

214. **We welcome the steps the Department has taken to increase transparency, but note that this is work in progress. Effective examination of the underlying financial position of an area, and determination of which organisations are struggling, are impossible if deficits are transferred between bodies within health economies as the SHA sees fit. The Department's Chief Economic Adviser told us that analysis had been made of deficits by health economy. The Department should consider examining the accounts of all trusts within a single health economy. The Department's data on this subject should be published as soon as possible.**

215. There also needs to be more transparency about the amount of support, planned or otherwise, received by failing trusts. Prof Appleby's analysis of the unaudited 2005/06 accounts showed that a significant amount of planned and unplanned support was given to trusts during the last financial year. Some trusts received 'planned support' that was not detailed, or included in the accounts, at the start of the year. At what point, and why, this support was given was not clear.[298] **We recommend that planned support be detailed in the published monitoring returns at the beginning of the financial year. Any unplanned support that is received should be identified separately and explained.**

Failure strategy

216. Many organisations which have reported large deficits in the last two years have been struggling for a long time and have accumulated substantial debts.[299] At present the NHS does not have a formal failure strategy. The Audit Commission proposed that systems designed to identify organisations in crisis early should be put in place as part of standard financial reporting procedure. Specific "trigger points" should be determined which, once reached, would serve to notify the SHA and Department of the problem. Early identification of trusts that are in financial trouble would allow early intervention to avoid organisations falling into greater amounts of debt.[300]

217. **We are surprised that the NHS has no formal failure strategy. There must be a clearly defined and understood policy, and course of actions, to deal with organisations which have failed financially We recommend that the Department establishes a failure strategy which included measures to identify organisations in difficulty at an early stage. Once a given threshold or "trigger" is reached, the Department should intervene quickly to avoid the accumulation of a larger deficit. Recovery plans, as we have stated earlier, should be prepared by the organisation in difficulty and agreed with the SHA.**

298 Ev 156 (HC 73-II)

299 Eg. West Hertfordshire, Surrey and Sussex Trusts

300 Audit Commission, *Review of the NHS financial management and accounting regime*, July 2006

Local financial management

218. Basic financial management has been poor in too many trusts. A variety of measures to improve the situation have been proposed, including.

- Getting the basic financial management system right; and
- Improving engagement of clinical staff and Board members in financial matters.

Improvements to the accounting regime

219. Some organisations' problems have arisen through the most basic failings of financial management, which we described in chapter 3, including poor quality financial information, inadequate monitoring and a loss of control.

220. The Department has put in place strategies to improve the situation. It has sought to reduce the discrepancy between the unaudited and audited figures. Accounting guidance, including that issued to NHS bodies on request of end of year financial data, has been reviewed and tightened and the Department now meets regularly with the Audit Commission in an attempt to identify any concerns early on.[301] The Department has also emphasised the responsibility of SHA finance directors for maintaining high standards of accounting practice. In addition, it now requires finance directors to attend training programmes to improve financial management within NHS organisations.[302]

221. There are a few signs of change. There were fewer discrepancies between the audited and unaudited accounts in 2005/06 than in the previous year, which suggests that the standard of financial reporting has improved, but it is too earlier to see the extent of any improvement.

222. **This inquiry has provided compelling evidence of a failure of financial management. The most basic errors have been made: there are too many examples of poor financial information, inadequate monitoring and an absence of financial control. Finance is important. We recommend that the Government issue a restatement of duties in respect of basic accounting procedures.**

223. **There is a need to strengthen the role and position of Finance Directors. Given the pressures that they face in the current environment, Boards should assure themselves that the Finance Director is appropriately skilled and competent to give them accurate and impartial advice. Boards must focus on the core tasks of finance, and review the position whereby many Finance Directors are given lead responsibility for non-finance functions.**

224. **In recent years the NHS has veered from one priority to the next as the political focus has changed. It has concentrated on meeting targets with too little concern for finance. The new emphasis on finance must not lead to a reduction in the quality and scope of evidence-based clinical care but measures to reduce NHS spending wasted on inappropriate or unproven therapies are to be welcomed and encouraged.**

301 Ev 3 (HC 1204-II)

302 Ibid

Engagement and communication between staff

225. Too often accounting is seen as the responsibility of Finance Directors and their Department alone. The NAO/Audit Commission's report stressed that there should be closer communication between finance and other staff, particularly clinicians. It recommended that clear accountability and 'ownership' of budgets be introduced throughout organisations: managers and other staff responsible for budgets should be given the skills needed to carry out their role.[303]

226. Engagement with clinical staff has several advantages. It can improve organisations' financial position as Kevin Ellis from Price Waterhouse Cooper informed us:

> If people understand what the size of the prize is and how their individual actions can contribute to making the savings, you get far more engagement. We are seeing in the turnaround situations that I have been involved in that there is probably less connectivity at the start of the process certainly between the clinicians and the finance functions.[304]

227. Mr Steve Phoenix, Chief Executive of Adur, Arun and Worthing PCT, said that in the future, the NHS will need:

> …much more financially savvy clinicians, doctors and nurses and we shall need to make sure that our finance staff at whatever level have a skill set which responds to that and that will be a challenge for the finance function as it will for other parts of management as well.[305]

228. **An organisation's budget is not solely the responsibility of the Finance Department. Trusts must make staff in other departments, including clinical staff, aware that they have responsibilities too. All budget-holding staff, managers and Department heads should receive training in financial management appropriate to their position. However, it has to be recognised that spending decisions are often taken by clinicians who are not budget holders. They too need to recognise their financial responsibilities and trusts need to build management and budget structures that fully incorporate clinicians in their governance processes.**

229. Boards too need to pay close attention to finances and ensure that they have non-executive members with financial expertise relevant to the NHS. **Boards should include non-executive members with relevant financial expertise.**

Lessons for the Department

230. The Department is much to blame for the failings this inquiry has highlighted. There are several lessons relating to:

- The costing and piloting of policies;

303 NAO/Audit Commission, *Financial Management in the NHS*, July 2006

304 Q116

305 Q58

- The funding formula;
- Where and how the cuts have fallen, particularly in relation to the training budget; and
- Inadequate financial monitoring.

Costing and piloting of policies

231. The Department has a poor track record in forecasting the cost of its policies. As we have seen in chapter 3, it grossly underestimated the cost of the changes arising from Agenda for Change and the new consultant and GP contract, with serious consequences. Similarly it seems to have failed to realise how expensive meeting the 4-hour A&E target would be. No global figure is available for just how much it has cost the NHS to meet this target but it has been high and even higher if the unintended consequences are taken into account such as increases in the number of people attending A&E. Similar inaccuracies occurred in other policies such as the Payment by Results tariff which was issued and then had to be withdrawn.

232. A number of explanations have been put forward for the failure to cost accurately the pay deals. North East London SHA blamed limitations in the cost data used by the Department.[306] Representatives from the Department agreed that mistakes had been made in the prediction of these costs.[307] Mr Douglas attributed the errors to the complexity of the subject and the high number of people involved in the negotiation system rather than data limitations. He stated:

> What you have to recognise on the pay contracts is these are complex negotiations of staff contracts for about a million people across the NHS. They are going to be implemented in different ways across different parts of the country. Although we will always aim to get the figures precisely right we will not, they are too complicated for that.[308]

233. The biggest mistake and one that must be rectified was the failure to discuss publicly what the contract would cost. We applaud the new NHS Chief Executive for recognising this simple truth. He told us

> I think that transparency is very important. It has not always been as well done as it could have been in the past. Once you have got that transparency, you have got the chance of getting it more right. Things like, for example, the consultant contract where assumptions were made about the number of sessions we would get with consultants and assumptions were made about how many consultants would be available 24 hours a day to come into hospitals. A set of assumptions were made that were not tested with the NHS in a rigorous way and hopefully this transparency will help that quite a lot.[309]

306 Ev 87 (HC 1204-II)

307 Q275

308 Q287

309 Uncorrected transcript of oral evidence taken before the Health Committee on 23 November 2006, HC 94–i Q9

234. Better piloting would also help. There was, as far as we know, no piloting of the consultant or GP contract or of the 4-hour A&E target. More effective piloting of PbR could have avoided the adjustment to the tariff, which has been disruptive for many bodies. We heard calls for more piloting from several witnesses:

> 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. (RCN)
>
> 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. (RCN[310])
>
> 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. (Amicus[311])
>
> 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. (Socialist Health Association[312])

235. The Department agreed that there should be more local testing.

> **Dr Howard Stoate:** Do you believe that there should have been more piloting of the PbR system before it was rolled out nationally?
>
> **Sir Ian Carruthers:** It is a retrospective question. The fact is that that view (ie. the need to have pilots) was not felt to be appropriate at the time. I would support that view. Where I think we could do more is to do more local testing, as we have done actually with the tariff in the last few months.[313]

236. **We welcome the Department's commitment to improve forecasting and undertake more local testing of new policies. It must make its calculations explicit and make them widely available well in advance of implementation. If the timescale has to be extended as a result, so be it. New policies must be widely piloted.**

The funding formula

237. We have discussed earlier concerns about the funding formula. It has been criticised for not taking adequate account of a range of factors. Witnesses argued that the formula is biased against people in affluent rural areas in favour of those in deprived urban areas. There are also doubts as to whether the formula is based on needs rather than the differing

310 Ev 107 (HC 1204-II)

311 Ev 15 (HC 1204-II)

312 Ev 121 (HC 1204-II)

313 Q237

cost of providing care.[314] More information would therefore need to be gathered. Basing the funding formula on actual need rather than proxies of need would require substantial work, but could mean more appropriate allocation of funds.

238. **There is concern about the fairness of the funding formula. We do not consider ourselves qualified to judge whether these concerns are justified. We recommend that the formula be reviewed. Consideration should be given to basing the formula on actual need rather than proxies of need.**

Cuts and the training budget

239. As we have seen, the cuts necessitated by efforts to recover the deficits have fallen on soft targets such as voluntary organisations, hospital chaplaincies and mental health and public health. Training has been particularly badly affected. There is concern that this has happened not because these are the sensible places to cut but because they are the easiest. It is hard to believe that the training budget would have been cut so much had it not been under the control of SHAs. As we have seen the situation is likely to get worse. The Council of Deans expects SHAs to try to make further savings from education and training budgets during this financial year.[315]

240. **The Department can give no guarantee as to when the cuts in training might come to an end. Moreover, amalgamation of the training budget with other SHA budgets is likely to lead to more reductions in that budget. The heavy cuts in the training budget are unacceptable. Savings should not be made disproportionately in areas, such as training, where for structural reasons it is easiest to make them.**

Monitoring

241. During this inquiry the Department has rightly been critical of the state of financial management in some trusts. Commitments were undertaken which could not be sustained in the long term. Local trusts are audited. They are monitored by SHAs and are required to comply with Financial Directions set by the Department of Health. Why did none of these organisations see what was happening?

242. The Audit Commission supervises the auditing of trusts' accounts. Some are audited by their own in-house auditors, the District Audit, others by private sector auditors appointed by the Commission. It looks as if they woke up to the problem late in the day—when the deficits began to be revealed. The Commission has the power to issue a Public Interest Report in cases where there has been a failure in the financial management of NHS bodies. In 2003/04 it issued one such report, and in 2004/05, four. Since June 2005, over 40 have been issued.[316]

243. Monitoring should have been undertaken by the SHAs which might at least have compared actual recruitment with predictions in the NHS Plan. They evidently failed in

314 Following the Acheson Report in 1998, one if the objectives of the formula has been to "contribute to the reduction in avoidable health inequalities". See Ev 128 (HC 1204-II)

315 See Chapter 4

316 See Audit Commission website: www.audit-commission.gov.uk/pir/index.asp

their basic duties. If they did, the Department must be to blame for not ensuring the SHAs were doing their job. However the auditors would have examined the systems of financial and manpower control as part of their routine audit processes. These would have indicated the rising trends in staffing and expenditure before the full extent of the deficits emerged.

244. **We are surprised that it took so long for the unsustainable financial commitments which trusts were undertaking to be recognised. Auditors did not pick up what was happening at an early stage. SHAs failed to monitor the trusts activities adequately and the Department failed to check the work of SHAs.**

Conclusions

245. **This inquiry has exposed the full extent of the long running deficit in the revenue budget of the NHS. Trusts' deficits, which were previously hidden, have come to light because of technical accounting changes largely arising from the introduction of RAB. We have investigated the causes of these deficits. A few deficits relate to intractable historic problems, many are associated with the extraordinary growth in staff costs arising from pay rises and the large increase in staff numbers. The pay rises have far exceeded the Department's estimates and the numbers of new staff are far higher even than the figures proposed in the NHS Plan. The growth in staff costs points to serious underlying failures in the financial management of the NHS, which have occurred at all levels of the organisation, from the Department of Health to PCTs.**

246. **The Department of Health has begun to tackle the deficits. However, we are concerned that some current policies are encouraging short-term measures that may further destabilise the situation and not be in the best long-term interests of the NHS.**

Conclusions and recommendations

1. In the last 2 years there has been an increase in the number of NHS organisations with a deficit and there has been a total overall deficit. The latter figure, known as the net deficit, was £251 million in 2004/05 and £547 million in 2005/06. The latter figure would have been higher but for a remarkable growth in SHA surpluses. The number of PCTs and trusts in deficit is rising in 2006/07. (Paragraph 36)

2. However, the underlying figures tell a somewhat different story from the headline figures. It is difficult to assess how long the NHS has been overspending as deficits were hidden in the past. Deficits were revealed by policy changes which increased transparency, in particular the switch in accounting procedures associated with the introduction of the Resource Accounting and Budgeting (RAB) regime. As a result it was no longer possible to underspend on capital expenditure and use the money to subsidise current spending. In addition, RAB has led to the double deficit problem whereby a trust's income in the current year has both to pay for that year's provision and pay back previous year's deficits. As a result of RAB the in-year deficit for 2005/06 was exaggerated by £117 million. (Paragraph 37)

3. Nevertheless, while there have long been underlying deficits, their size has increased in the last two years. The Secretary of State has said that the NHS as a whole will be in balance by March 2007 and she will take personal responsibility for that. The Government has started to tackle the problem in earnest, but undoubtedly it will not be an easy task. (Paragraph 38)

4. The increases in the underlying deficits incurred by PCTs and hospital trusts have many causes. Different witnesses gave different weight to the importance of different factors. In addition to the effects of the changing accounting procedures associated with the introduction of RAB which were discussed in the last chapter, our inquiry highlighted the contribution of the funding formula, the effect of Government policies, poor management by the Department of Health and poor local financial management. Some of the worst deficits can be explained by exceptionally difficult circumstances such as large inherited debts. (Paragraph 106)

5. The funding formula allocates considerably more money per head to some PCTs than others. This may be related to the scale of health inequalities but it can make financial balance harder to achieve. A number of witnesses argued that there was a correlation between trusts' deficits and the allocation of funding. The Department's Chief Economic Adviser told us that it was necessary to examine the financial position of health economies rather than that of individual trusts. He found a moderate correlation between the needs and age index and deficits in health economies in 2004/05 but denied that this showed that the funding formula had caused the deficits. The Secretary of State told us that overspending was concentrated in the "healthier, wealthier parts of the country". (Paragraph 107)

6. Poor central management has contributed to the deficits. The Government's estimates of the cost of Agenda for Change and the new GP and consultant contracts proved to be hopelessly unrealistic. Government targets, such as the 4-hour A&E target, have been expensive to meet and have had unintended consequences which have imposed additional costs. PFI schemes and ISTCs have also added to costs. We recommend that the Department takes note of the Secretary of State's admission that our criticism of the practice of shifting the goal posts late was legitimate. (Paragraph 108)

7. Poor local management is also to blame. For all the added costs imposed by the Department of Health, it is undeniable that the NHS has had a lot more money to spend. Surpluses can be found in PCTs and trusts with a low per capita funding. Deficits exist in trusts with high per capita funding. We had a good deal of evidence of poor financial management, for example of a hospital trust which hired staff without knowing whether it could afford to pay their salaries, and of PCTs which failed to recruit vital members of the financial management team. Nevertheless, poor financial management is not just caused by local managers and boards. The Government has also contributed, for example by repeated changes and the emphasis on meeting targets at short notice. (Paragraph 109)

8. Top-slicing is a temporary expedient, but it must not become a permanent part of NHS funding. We recommend that a time limit be set on its use. We note the Secretary of State's intention to return top-sliced funds at an early date. Funds must be returned to the originating bodies as soon as possible and in a planned way so that the organisations can maximise the benefits from delayed spending plans. (Paragraph 118)

9. We note the plans to establish a 'buffer' or permanent contingency fund. We have serious concerns. The establishment of the fund would be an admission by the Department that it accepted that individual trusts would remain in deficit and that it had the ability, and the willingness to "bail them out". It could be seen as undermining the attempt to create a culture of strong local financial management. It would lead to the allocation of resources in an unplanned and ad hoc way. It would also reduce the proportion of funding allocated directly to PCTs. This goes against the Government's policy of giving more power and autonomy to local organisations. (Paragraph 122)

10. The Department plans to be in overall surplus by the end of March 2007. However, not all trusts will be in surplus by then and it is unlikely that trusts with the biggest deficits will be able to repay their accumulated deficits in 5 years. Such trusts should be responsible for drawing up a recovery plan which is agreed by the SHA. It is important that as a first step they achieve 'in-year' balance. Where there is no realistic chance of recovering the deficit over the 3- to 5-year period without severely affecting local services, consideration should be given to allowing a longer period to pay off historic deficits. (Paragraph 133)

11. £22 million is to be spent on turnaround teams between January 2006 and March 2007. There are mixed views as to whether they provide value for money, but on balance our witnesses thought they played a useful role. That they have been necessary is a sad reflection on the quality of much management in the NHS over many years. (Paragraph 141)

12. Savings from the workforce budget and the education and training budget have made the major contribution to reducing deficits. Many posts have been lost, although we have not received the evidence to prove or disprove the high headline figures given prominence by the RCN and BMA. On the other hand, there have been relatively few compulsory redundancies. While the national picture is varied, this has been a bleak year for many newly trained staff. (Paragraph 199)

13. We welcome the Government's acknowledgement that there have been very large cuts in education and training and that these are having adverse effects on staff morale and development. We were told that these cuts will only last for a short time, but no guarantee was given. (Paragraph 200)

14. In the best case, the need to make savings can lead to the more rational organisation of services; in the other circumstances as in Worcestershire or Hertfordshire the effect on services can be severe. Although there have been few redundancies the posts lost by retirement and natural turnover have affected patient services. Soft targets such as mental health and public health services have also suffered as has funding for voluntary organisations. We believe this to be unacceptable. (Paragraph 201)

15. We agree that as presently operating RAB is not a suitable accounting regime to use within the NHS. The requirement that a hospital trust pay back a deficit while operating on reduced income is inappropriate for a healthcare service and in some cases impossible to achieve. We recommend that an alternative to, or refinement of, RAB be introduced. It is fundamental that the regime chosen does not reduce trusts' income at the same time as requiring them to pay back any deficit owed. (Paragraph 210)

16. We welcome the steps the Department has taken to increase transparency, but note that this is work in progress. Effective examination of the underlying financial position of an area, and determination of which organisations are struggling, are impossible if deficits are transferred between bodies within health economies as the SHA sees fit. The Department's Chief Economic Adviser told us that analysis had been made of deficits by health economy. The Department should consider examining the accounts of all trusts within a single health economy. The Department's data on this subject should be published as soon as possible. (Paragraph 214)

17. We recommend that planned support be detailed in the published monitoring returns at the beginning of the financial year. Any unplanned support that is received should be identified separately and explained. (Paragraph 215)

18. We are surprised that the NHS has no formal failure strategy. There must be a clearly defined and understood policy, and course of actions, to deal with organisations which have failed financially We recommend that the Department establishes a failure strategy which included measures to identify organisations in difficulty at an early stage. Once a given threshold or "trigger" is reached, the Department should intervene quickly to avoid the accumulation of a larger deficit. Recovery plans, as we have stated earlier, should be prepared by the organisation in difficulty and agreed with the SHA. (Paragraph 217)

19. This inquiry has provided compelling evidence of a failure of financial management. The most basic errors have been made: there are too many examples of poor financial information, inadequate monitoring and an absence of financial control. Finance is important. We recommend that the Government issue a restatement of duties in respect of basic accounting procedures. (Paragraph 222)

20. There is a need to strengthen the role and position of Finance Directors. Given the pressures that they face in the current environment, Boards should assure themselves that the Finance Director is appropriately skilled and competent to give them accurate and impartial advice. Boards must focus on the core tasks of finance, and review the position whereby many Finance Directors are given lead responsibility for non-finance functions. (Paragraph 223)

21. In recent years the NHS has veered from one priority to the next as the political focus has changed. It has concentrated on meeting targets with too little concern for finance. The new emphasis on finance must not lead to a reduction in the quality and scope of evidence-based clinical care but measures to reduce NHS spending wasted on inappropriate or unproven therapies are to be welcomed and encouraged. (Paragraph 224)

22. An organisation's budget is not solely the responsibility of the Finance Department. Trusts must make staff in other departments, including clinical staff, aware that they have responsibilities too. All budget-holding staff, managers and Department heads should receive training in financial management appropriate to their position. However, it has to be recognised that spending decisions are often taken by clinicians who are not budget holders. They too need to recognise their financial responsibilities and trusts need to build management and budget structures that fully incorporate clinicians in their governance processes. (Paragraph 228)

23. Boards should include non-executive members with relevant financial expertise. (Paragraph 229)

24. We welcome the Department's commitment to improve forecasting and undertake more local testing of new policies. It must make its calculations explicit and make them widely available well in advance of implementation. If the timescale has to be extended as a result, so be it. New policies must be widely piloted. (Paragraph 236)

25. There is concern about the fairness of the funding formula. We do not consider ourselves qualified to judge whether these concerns are justified. We recommend that the formula be reviewed. Consideration should be given to basing the formula on actual need rather than proxies of need. (Paragraph 238)

26. The Department can give no guarantee as to when the cuts in training might come to an end. Moreover, amalgamation of the training budget with other SHA budgets is likely to lead to more reductions in that budget. The heavy cuts in the training budget are unacceptable. Savings should not be made disproportionately in areas, such as training, where for structural reasons it is easiest to make them. (Paragraph 240)

27. We are surprised that it took so long for the unsustainable financial commitments which trusts were undertaking to be recognised. Auditors did not pick up what was happening at an early stage. SHAs failed to monitor the trusts activities adequately and the Department failed to check the work of SHAs. (Paragraph 244)

28. This enquiry has exposed the full extent of the long running deficit in the revenue budget of the NHS. Trusts' deficits, which were previously hidden, have come to light because of technical accounting changes largely arising from the introduction of RAB. We have investigated the causes of these deficits. A few deficits relate to intractable historic problems, many are associated with the extraordinary growth in staff costs arsing from pay rises and the large increase in staff numbers. The pay rises have far exceeded the Department's estimates and the numbers of new staff are far higher even than the figures proposed in the NHS Plan. The growth in staff costs points to serious underlying failures in the financial management of the NHS, which have occurred at all levels of the organisation, from the Department of Health to PCTs. (Paragraph 245)

29. The Department of Health has begun to tackle the deficits. However, we are concerned that some current policies are encouraging short term measures that may further destabilise the situation and not be in the best long term interests of the NHS. (Paragraph 246)

Glossary

ACRA	Advisory Committee on Resource Allocation (Department of Health)
AGW	Avon, Gloucestershire and Wiltshire
BMA	British Medical Association
HFMA	Healthcare Financial Management Association
ISTC	Independent Sector Treatment Centre
MADEL	Medical and Dental Education Levy
MFF	Market Forces Factor
MPET	Multi-Professional Education and Training
NAO	National Audit Office
NMET	Non-Medical Education and Training
NPO	National Programme Office
PbR	Payment by Results
PCT	Primary Care Trust
PFI	Private Finance Initiative
PMS	Personal Medical Services
PPA	Purchaser Parity Adjustment
PWC	Price Waterhouse Coopers
RAB	Resource Accounting and Budgeting
RARP	Resource Allocation Research Papers
RCN	Royal College of Nursing
SHA	Strategic Health Authority
SIFT	Service Increment for Teaching
SLA	Service Level Agreements
STI	Sexually transmitted infection
WDC	Workforce Development Confederation

Top-slicing—the removal of a certain proportion of an organisation's income to support the overall financial position.

Annex 1 NHS organisations in deficit (2005/06)

Organsiation Name	Type of Organisation	Unaudited Position	Audited Position	Annual Turnover	% Deficit
ASHFORD AND ST PETER'S HOSPITALS	NHS TRUST	-7,560	-7,560	169,011	-4.50%
AVON AMBULANCE SERVICE	NHS TRUST	-947	-947	25,667	-3.70%
AVON & WILTSHIRE MENTAL HEALTH PARTNERSHIP	NHS TRUST	-2,789	-2,790	163,745	-1.70%
BARKING, HAVERING & REDBRIDGE HOSPITALS	NHS TRUST	-16,009	-16,009	334,815	-4.80%
BARNET AND CHASE FARM HOSPITALS	NHS TRUST	-8,994	-8,994	252,054	-3.60%
BEDFORD HOSPITALS	NHS TRUST	-11,887	-11,887	101,379	-11.70%
BRIGHTON & SUSSEX UNIVERSITY HOSPITALS	NHS TRUST	-11,290	-11,290	309,281	-3.70%
BROMLEY HOSPITALS	NHS TRUST	-15,765	-15,765	153,492	-10.30%
BUCKINGHAMSHIRE MENTAL HEALTH	NHS TRUST	-461	-461	50,380	-0.90%
DARTFORD AND GRAVESHAM	NHS TRUST	-3,470	-4,436	101,927	-4.40%
DEVON PARTNERSHIP	NHS TRUST	-1,720	-1,720	90,144	-1.90%
EAST AND NORTH HERFORDSHIRE	NHS TRUST	-22,380	-22,379	246,307	-9.10%
EAST KENT HOSPITALS	NHS TRUST	-2,606	-2,606	352,455	-0.70%
EAST SUSSEX HOSPITALS	NHS TRUST	-4,864	-4,864	223,811	-2.20%
ESSEX RIVERS HEALTHCARE	NHS TRUST	-1,439	-1,439	158,922	-0.90%
GEORGE ELIOT HOSPITAL	NHS TRUST	-7,294	-7,294	83,064	-8.80%
GLOUCESTERSHIRE AMBULANCE SERVICES	NHS TRUST	-488	-474	18,578	-2.60%
GLOUCESTERSHIRE PARTNERSHIP	NHS TRUST	-1,319	-1,363	83,481	-1.60%
GOOD HOPE HOSPITAL	NHS TRUST	-5,972	-5,972	113,492	-5.30%
HAMMERSMITH HOSPITALS	NHS TRUST	-18,484	-18,484	430,614	-4.30%
HEATHERWOOD & WEXHAM PARK HOSPITALS	NHS TRUST	-3,691	-3,691	166,656	-2.20%
HINCHINGBROOKE HEALTH CARE	NHS TRUST	-6,535	-7,752	72,763	-10.70%
HULL AND EAST YORKSHIRE HOSPITALS	NHS TRUST	-12,268	-12,267	334,253	-3.70%
IPSWICH HOSPITALS	NHS TRUST	-11,905	-16,735	163,532	-10.20%
MAYDAY HEALTHCARE	NHS TRUST	-5,847	-5,847	161,102	-3.60%
MID ESSEX HOSPITAL SERVICES	NHS TRUST	1,003	-11,202	176,929	-6.30%
MID YOKSHIRE HOSPITALS	NHS TRUST	-14,589	-14,589	300,603	-4.90%
MORECAMBE BAY HOSPITALS	NHS TRUST	-6,357	-6,357	195,801	-3.20%
NORTH MIDDLESEX UNIVERSITY HOSPITAL	NHS TRUST	-8,166	-8,166	133,587	-6.10%
NORTH TEES AND HARTLEPOOL	NHS TRUST	-12,812	-12,812	178,147	-7.20%
NORTH WEST LONDON HOSPITALS	NHS TRUST	-24,064	-24,064	271,946	-8.80%
NORTHAMPTON GENERAL HOSPITAL	NHS TRUST	-2,907	-2,907	164,673	-1.80%
NORTHERN DEVON HEALTHCARE	NHS TRUST	-7,961	-7,961	77,056	-10.30%
OXFORD RADCLIFFE HOSPITAL	NHS TRUST	-19,409	-19,409	474,983	-4.10%
PLYMOUTH HOSPITALS	NHS TRUST	-1,932	-1,932	291,403	-0.70%
PRINCESS ALEXANDRA HOSPITAL	NHS TRUST	-5,857	-5,857	123,514	-4.70%
QUEEN ELIZABETH HOSPITAL	NHS TRUST	-19,199	-19,289	132,983	-14.50%
QUEEN ELIZABETH HOSPITAL KING'S LYNN	NHS TRUST	-10,986	-10,986	99,230	-11.10%

Organsiation Name	Type of Organisation	Unaudited Position	Audited Position	Annual Turnover	% Deficit
QUEEN MARY'S SIDCUP	NHS TRUST	-19,692	-19,750	89,392	-22.10%
ROYAL CORNWALL HOSPITALS	NHS TRUST	-15,687	-15,687	238,999	-6.60%
ROYAL FREE HAMPSTEAD	NHS TRUST	-4,845	-4,845	374,892	-1.30%
ROYAL UNITED HOSPITAL BATH	NHS TRUST	-7,338	-7,339	166,012	-4.40%
ROYAL WOLVERHAMPTON HOSPITAL	NHS TRUST	-9,423	-9,423	222,570	-4.20%
SANDWELL & WEST BIRMINGHAM HOSPITALS	NHS TRUST	-5,737	-5,726	313,388	-1.80%
SCARBOROUGH AND NE YORKS	NHS TRUST	-7,292	-8,961	95,155	-9.40%
SHREWSBURY AND TELFORD HOSPITAL	NHS TRUST	-12,142	-12,142	189,152	-6.40%
SOUTH TEES HOSPITALS	NHS TRUST	-21,395	-21,395	318,143	-6.70%
SOUTH WARWICKSHIRE GENERAL HOSPITALS	NHS TRUST	-13,827	-13,845	85,080	-16.30%
SOUTHAMPTON UNIVERSITY HOSPITALS	NHS TRUST	-12,927	-12,927	368,932	-3.50%
ST GEORGE'S HEALTHCARE	NHS TRUST	-33,569	-33,569	336,896	-10.00%
SURREY AND SUSSEX HEALTHCARE	NHS TRUST	-40,834	-40,281	143,720	-28.00%
SWINDON AND MARLBOROUGH	NHS TRUST	-835	-835	157,556	-0.50%
THE LEWISHAM HOSPITAL	NHS TRUST	-8,805	-8,805	149,017	-5.90%
THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	NHS TRUST	6	-462	71,035	-0.70%
THE ROYAL WEST SUSSEX	NHS TRUST	-13,394	-13,298	98,279	-13.50%
UNITED LINCOLNSHIRE HOSPITALS	NHS TRUST	-15,145	-15,043	289,429	-5.20%
UNIVERSITY HOPSITALS OF NORTH STAFFORDSHIRE	NHS TRUST	-14,985	-15,059	299,619	-5.00%
WEST DOREST GENERAL HOSPITALS	NHS TRUST	-998	-1,082	108,896	-1.00%
WEST HERTFORDSHIRE HOSPITALS	NHS TRUST	-28,284	-26,785	209,199	-12.80%
WEST KENT NHS AND SOCIAL CARE	NHS TRUST	-210	-888	121,455	-0.70%
WEST MIDDLESEX UNIVERSITY	NHS TRUST	-9,024	-9,024	103,117	-8.80%
WEST MIDLANDS AMBULANCE	NHS TRUST	-2,860	-2,629	66,155	-4.00%
WEST SUFFOLH HOSPITALS	NHS TRUST	-11,833	-12,995	98,022	-13.30%
WEST YORKSHIRE AMBULANCE SERVICE	NHS TRUST	-279	-279	67,289	-0.40%
WESTON AREA HEALTH	NHS TRUST	-6,989	-6,989	68,162	-10.30%
WHIPPS CROSS UNIVERSITY HOSPITAL	NHS TRUST	-15,602	-15,811	182,367	-8.70%
WINCHESTER & EASTLEIGH HEALTHCARE	NHS TRUST	-3,045	-3,048	120,956	-2.50%
WORCESTERSHIRE ACUTE HOSPITALS	NHS TRUST	-4,975	-4,952	246,068	-2.00%
WORCESTERSHIRE MENTAL HEALTH PARTNERSHIP	NHS TRUST	-1,585	-1,830	59,694	-3.10%
WORTHING AND SOUTHLAND HOSPITALS	NHS TRUST	-10,623	-10,863	138,976	-7.80%
BEDFORDSHIRE HEARTLANDS	PCT	-20,925	-20,865	232,844	-9.00%
BEXLEY CARE	PCT	-7,730	-7,713	236,325	-3.30%
BILLERICAY, BRENTWOOD AND WICKFORD	PCT	-1,386	-3,291	155,509	-2.10%
BLACKWATER VALLEY AND HART	PCT	-8,252	-8,252	177,876	-4.60%
BRACKNELL FOREST	PCT	-1,836	-1,802	99,407	-1.80%
BROADLAND	PCT	-8,763	-9,222	121,414	-7.60%
BURNTWOOD, LICHFIELD AND TAMWORTH	PCT	-4,243	-4,618	159,495	-2.90%
CAMBRIDGE CITY	PCT	-13,678	-13,894	139,434	-10.00%
CANTERBURY AND COASTAL	PCT	-490	-476	194,603	-0.20%
CENTRAL SUFFOLK	PCT	-765	-765	101,868	-0.80%
CHARNWOOD AND NW LEICESTERSHIRE	PCT	-2,517	-2,505	243,538	-1.00%
CHELMSFORD	PCT	-13,070	-13,070	118,469	-11.00%
CHERWELL VALE	PCT	-3,395	-3,373	121,596	-2.80%
CHESHIRE WEST	PCT	-16,468	-16,469	206,042	-8.00%
CHILTERN AND SOUTH BUCKS	PCT	-5,970	-5,982	149,671	-4.00%

Organsiation Name	Type of Organisation	Unaudited Position	Audited Position	Annual Turnover	% Deficit
COLCHESTER	PCT	-4,395	-4,539	170,131	-2.70%
COTSWOLD AND VALE	PCT	-6,779	-6,788	214,172	-3.20%
COVENTRY TEACHING	PCT	-2,900	-3,794	433,005	-0.90%
CRAVEN, HARROGATE & RURAL DISTRICT	PCT	-2,000	-1,988	231,970	-0.90%
DACORUM	PCT	-5,656	-5,656	150,137	-3.80%
DARLINGTON	PCT	-1,275	-1,436	132,767	-1.10%
DARTFORD, GRAVESHAM & SWANLEY	PCT	-4,316	-4,306	258,587	-1.70%
DAVENTRY AND SOUTH NORTHAMPTONSHIRE	PCT	-4,595	-4,632	100,969	-4.60%
DERBYSHIRE DALES & SOUTH DERBYSHIRE	PCT	-2,778	-2,778	97,481	-2.80%
DERWENTSIDE	PCT	-916	-916	117,579	-0.80%
DURHAM	PCT	-2,914	-2,914	182,501	-1.60%
EAST ELMBRIDGE AND MID SURREY	PCT	-5,789	-5,786	321,535	-1.80%
EAST LINCOLNSHIRE	PCT	-7,482	-7,482	323,794	-2.30%
EASTBOURNE DOWNS	PCT	-7,168	-7,168	224,736	-3.20%
GREAT YARMOUTH	PCT	-1,836	-1,389	122,721	-1.10%
GUILDFORD AND WAVERLEY	PCT	-2,037	-2,027	272,895	-0.70%
HAMBLETON AND RICHMONDSHIRE	PCT	-4,505	-4,505	121,205	-3.70%
HARLOW	PCT	-615	-615	101,876	-0.60%
HARROW	PCT	-9,372	-9,369	233,872	-4.00%
HARTLEPOOL	PCT	-5,984	-5,984	124,164	-4.80%
HERTSMERE	PCT	-9,353	-9,375	102,105	-9.20%
HIGH PEAK AND DALES	PCT	-1,991	-1,991	120,952	-1.60%
HILLINGDON	PCT	-36,506	-36,148	284,584	-12.70%
HINCKLEY AND BOSWORTH	PCT	-4,936	-4,936	97,989	-5.00%
HORSHAM AND CHANCTONBURY	PCT	-590	-589	115,431	-0.50%
HOUNSLOW	PCT	-10,254	-10,249	272,129	-3.80%
HUDDERSFIELD CENTRAL	PCT	-3,553	-3,553	161,968	-2.20%
IPSWICH	PCT	-8,007	-8,007	153,679	-5.20%
ISLE OFWIGHT	PCT	-6,555	-6,555	177,772	-3.70%
KENNET AND NORTH WILTSHIRE	PCT	-12,612	-12,612	204,861	-6.20%
KENSINGTON AND CHELSEA	PCT	-22,052	-21,748	282,628	-7.70%
KINGSTON	PCT	-7,916	-9,608	194,951	-4.90%
LEICESTER CITY WEST	PCT	-5,129	-4,999	168,034	-3.00%
LUTON	PCT	-8,689	-8,689	204,100	-4.30%
MALDON AND SOUTH CHELMSFORD	PCT	-2,659	-2,659	77,887	-3.40%
MEDWAY	PCT	-2,398	-2,343	284,138	-0.80%
MID DEVON	PCT	-2,383	-2,383	121,747	-2.00%
MID-SUSSEX	PCT	-1,949	-4,902	147,312	-3.30%
MILTON KEYNES	PCT	-2,347	-2,332	245,066	-1.00%
NEWBURY AND COMMUNITY	PCT	0	-1,487	103,254	-1.40%
NEWCASTLE-UNDER-LYME	PCT	-1,392	-1,392	123,758	-1.10%
NORTH AND EAST CORNWALL	PCT	-2,876	-2,877	190,487	-1.50%
NORTH BIRMINGHAM	PCT	-3,999	-3,999	198,588	-2.00%
NORTH EAST OXFORDSHIRE	PCT	-573	-579	73,855	-0.80%
NORTH HAMPSHIRE	PCT	-4,375	-4,372	195,696	-2.20%
NORTH HERTFORDSHIRE & STEVENAGE	PCT	-6,728	-6,728	196,566	-3.40%
NORTH LINCOLNSHIRE	PCT	-1,005	-1,005	180,332	-0.60%
NORTH NORFOLK	PCT	-12,219	-12,219	117,030	-10.40%
NORTH SOMERSET	PCT	-4,213	-4,232	213,950	-2.00%
NORTH STOKE	PCT	-8,487	-8,487	173,666	-4.90%
NORTHAMPTON	PCT	-4,243	-4,364	239,396	-1.80%
NORTHAMPTONSHIRE HEARTLANDS	PCT	-1,967	-1,967	311,283	-0.60%
NORWICH	PCT	-1,336	-1,357	161,302	-0.80%

Organsiation Name	Type of Organisation	Unaudited Position	Audited Position	Annual Turnover	% Deficit
OLDBURY AND SMETHWICK	PCT	-3,647	-3,653	134,694	-2.70%
ROWLEY REGIS AND TIPTON	PCT	-1,301	-1,300	108,846	-1.20%
ROYSTON, BUNTINGFORD & BISHOP'S STORTFORD	PCT	-4,318	-4,318	76,700	-5.60%
RUGBY	PCT	0	-956	101,392	-0.90%
SCARBOROUGH, WHITBY AND RYEDALE	PCT	-5,932	-5,932	193,517	-3.10%
SEDGEFIELD	PCT	-3,723	-3,723	120,892	-3.10%
SELBY AND YORK	PCT	-23,651	-23,651	300,805	-7.90%
SLOUGH	PCT	-3,159	-3,177	136,238	-2.30%
SOUTH CAMBRIDGESHIRE	PCT	-6,137	-5,987	112,070	-5.30%
SOUTH EAST HERTFORDSHIRE	PCT	-812	-812	178,796	-0.50%
SOUTH HUDDERSFIELD	PCT	-2,772	-2,772	91,826	-3.00%
SOUTH LEICESTERSHIRE	PCT	-8,500	-10,785	152,310	-7.10%
SOUTH WEST KENT	PCT	-5,855	-6,446	188,542	-3.40%
SOUTH WEST OXFORDSHIRE	PCT	-2,834	-2,888	195,616	-1.50%
SOUTH WESTERN STAFFORDSHIRE	PCT	-4,911	-4,953	190,266	-2.60%
SOUTH WILTSHIRE	PCT	-5,846	-5,821	136,230	-4.30%
SOUTHERN NORFOLK	PCT	-10,506	-10,957	216,186	-5.10%
SOUTHPORT AND FORMBY	PCT	-6,200	-6,216	149,603	-4.20%
ST ALBANS AND HARPENDEN	PCT	-5,754	-5,755	128,578	-4.50%
STAFFORDSHIRE MOORLANDS	PCT	-4,893	-4,892	119,655	-4.10%
SUFFOLK COASTAL	PCT	-5,167	-5,167	106,518	-4.90%
SUFFOLK WEST	PCT	-11,460	-11,460	234,059	-4.90%
SUSSEX DOWNS AND WEALD	PCT	-3,994	-4,006	162,825	-2.50%
SUTTON AND MERTON	PCT	-6,708	-6,708	446,703	-1.50%
SWALE	PCT	-3,307	-3,305	112,442	-2.90%
UTTLESFORD	PCT	-1,457	-1,457	97,685	-1.50%
VALE OF AYLESBURY	PCT	-8,470	-8,770	193,809	-4.50%
WALTHAM FOREST	PCT	-1,962	-1,848	301,099	-0.60%
WANDSWORTH	PCT	-8,935	-8,963	363,193	-2.50%
WATFORD AND THREE RIVERS	PCT	-3,764	-3,764	190,792	-2.00%
WAVENEY	PCT	-3,133	-3,133	154,074	-2.00%
WELWYN HATFIELD	PCT	-643	-643	116,396	-0.60%
WEST GLOUCESTERSHIRE	PCT	-3,863	-3,865	262,066	-1.50%
WEST NORFOLK	PCT	-813	-813	165,377	-0.50%
WESTWILTSHIRE	PCT	-9,735	-9,735	121,767	-8.00%
WINDSOR, ASCOT AND MAIDNEHEAD	PCT	-2,182	-2,174	166,219	-1.30%
WITHAM, BRAINTREE & HALSTEAD CARE	PCT	-5,156	-5,156	134,703	-3.80%
WOKINGHAM	PCT	0	-462	137,998	-0.30%
WYCOMBE	PCT	-3,188	-3,125	142,058	-2.20%
YORKSHIRE WOLDS AND COAST	PCT	-11,540	-11,498	165,144	-7.00%
BARNSLEY HOSPITAL	NHS FOUNDATION TRUST	-100			
DERBY HOSPITALS	NHS FOUNDATION TRUST	-400			
GATESHEAD HEALTH	NHS FOUNDATION TRUST	-400			
HOMERTON UNIVERSITY HOSPITAL	NHS FOUNDATION TRUST	-600			
PETEBROROUGH & STAMFORD HOSPITALS	NHS FOUNDATION TRUST	-1,000			
THE ROTHERHAM	NHS FOUNDATION TRUST	-1,600			

Organsiation Name	Type of Organisation	Unaudited Position	Audited Position	Annual Turnover	% Deficit
LANCASHIRE TEACHING HOSPITALS	NHS FOUNDATION TRUST	-2,800			
BRADFORD TEACHING HOSPITALS	NHS FOUNDATION TRUST	-2,800			
UNIVERSITY HOSPITAL BIRMINGHAM	NHS FOUNDATION TRUST	-3,500			
CITY HOSPITALS SUNDERLAND	NHS FOUNDATION TRUST	-4,700			
UNIVERSITY COLLEGE LONDON	NHS FOUNDATION TRUST	-35,900			

All figures are in thousands

Annex 2

Proposed job losses as of October 2006

Strategic Health Authority	Total post losses proposed since January 2006
South West	1,766
South Central	1,877
South East Coast	1,255
London	3,164
West Midlands	2,974
East Midlands	360
East of England	3,275
North West	1,215
North East	1,274
Yorkshire and the Humber	1,865
NHS Direct	460
TOTAL	**19,485**

Source: RCN

Actual job losses as of September 2006

Strategic Health Authority	Number of staff employed as at 30 September 2005	Compulsory redundancies for clinical staff(1)	Compulsory redundancies for non clinical staff(1)	Total compulsory redundancies(1)
East Midlands	105,887	0	4	4
East of England	129,746	34	88	122
London	210,599	56	243	299
North East	77,857	2	17	19
North West	203,456	4	17	21
South Central	93,114	12	48	60
South East Coast	102,325	7	57	64
South West	133,923	0	119	119
West Midlands	144,189	50	137	187
Yorkshire and Humber	144,149	2	6	8
Special Health Authorities	20,785	*	*	*
England	1,366,030	167	736	903

Source: Department of Health (compulsory redundancies as of 30 September 2006)
Staff in post data from the Information Centre workforce censuses
Redundancy data from DH redundancy survey

Notes:

(1) Redundancies notified as at 30 September 2006 in the 2006/07 financial year—does not include NHS foundation trusts

* Redundancy Information was not collected from special health authorities

Formal minutes

Thursday 7 December 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess	Dr Doug Naysmith
Charlotte Atkins	Mike Penning
Jim Dowd	Dr Howard Stoate
Sandra Gidley	Dr Richard Taylor
Anne Milton	

The Committee considered the draft Report [NHS Deficits], proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 246 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Annexes read and agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 14 December at 9.30 am

Witnesses

Thursday 22 June 2006

Page

Thursday 20 July 2006

Thursday 19 October 2006

Thursday 2 November 2006

Tuesday 21 November 2006

Written evidence in Volume II (HC 73–II)

Written evidence in Volume II (HC 1204–II)

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)