House of Commons
Health Committee

NHS Deficits

First Report of Session 2006–07

Volume II

Oral and written evidence

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The Health Committee

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

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Footnotes

In the footnotes of the Report, references to oral evidence are indicated by ‘Q’ followed by the question number, which can be found in this volume. 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 this volume.
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Brian Shipley, Director of Finance, Southend University Hospital NHS Foundation Trust, **Steve Phoenix**, Chief Executive, Adur, Arun and Worthing PCT, John McIvor, Chief Executive, Rotherham PCT, and Keith Ford, Director of Finance, Avon, Gloucestershire and Wiltshire SHA

Philip Davidson, partner in Restructuring Advisory Group, KPMG, Kevin Ellis, partner in PWC Business Recovery Services, Sean Sullivan, Turnaround Director, Essex, Bedfordshire and Hertfordshire, and Martyn Everett, Director of Recovery, Kensington and Chelsea PCT

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David Law, Chief Executive, West Hertfordshire Hospitals NHS Trust, Antony Sumara, Chief Executive, University Hospital of North Staffordshire NHS Trust, Simon Pleydell, Chief Executive, South Tees Hospitals NHS Trust, and Andrew Kenworthy, Chief Executive, Kensington and Chelsea PCT

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Ken Cunningham, Former Chief Executive, Surrey and Sussex Hospital Trust

Sir Ian Carruthers OBE, Acting Chief Executive of the NHS and Richard Douglas, Director of Finance and Investment, Department of Health, and Dr Bill Moyes, Executive Chairman, Monitor

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Professor Sheena Asthana, University of Plymouth, Professor Mervyn Stone, University College London, and Professor Barry McCormick, Chief Economic Adviser, Department of Health

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Thursday 2 November 2006

John Rostill, Chief Executive, Worcestershire Acute Hospitals NHS Trust, Dr Ros Keeton, Chief Executive, Worcestershire Mental Health Partnership NHS Trust, and Mike Ridley, Formerly Chief Executive, South Worcestershire PCT

Dr Jonathan Fielden, Chair of the Central Consultants and Specialists Committee, British Medical Association, Professor Anne Marie Rafferty, Head of the Florence Nightingale School of Nursing and Midwifery and Paul Turner, Executive Officer, Council of Deans and Heads of UK University Faculties for Nursing and Health Professions

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Rt Hon Patricia Hewitt, a Member of the House, Secretary of State for Health, David Nicholson, NHS Chief Executive, and Richard Douglas, Finance Director, Department of Health

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Oral evidence

Taken before the Health Committee

on Thursday 22 June 2006

Members present:

Mr Kevin Barron, in the Chair

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

Witnesses: Mr Brian Shipley, Director of Finance, Southend University Hospital NHS Foundation Trust, Mr Steve Phoenix, Chief Executive, Adur, Arun and Worthing PCT, Mr John McIvor, Chief Executive, Rotherham PCT and Mr Keith Ford, Director of Finance, Avon, Gloucestershire and Wiltshire SHA, gave evidence.

Q1 Chairman: Good morning. May I welcome you to what is our first session in the Health Committee’s inquiry into NHS deficits? May I for the sake of the record ask you to introduce yourselves and the organisations you come from?

Mr Shipley: I am Brian Shipley, Finance Director at Southend Hospital.
Mr Phoenix: Steve Phoenix, Chief Executive, Adur, Arun and Worthing Primary Care Trust.
Mr McIvor: John McIvor, Chief Executive of Rotherham Primary Care Trust.
Mr Ford: Keith Ford, Finance Director of Avon, Gloucestershire and Wiltshire Strategic Health Authority.

Q2 Chairman: Thank you very much. May I first of all just ask a question about the issue of regional trends to you Mr Ford? Why are health economies in surplus all in the north of the country?

Mr McIvor: I am not sure I know the answer to that question Chairman.

Q3 Chairman: You do not know?

Mr McIvor: I could speculate, but I do not know.

Q4 Chairman: No studies have been done as far as you are concerned?

Mr McIvor: I do not think that it is that the funding formula particularly favours my PCT. We are below capitation still. From the funding formulas which I have seen over my years in the NHS it is as fair as anything else around, but it has not actually meant that we move into a surplus position because of excess funding in any way, shape or form.

Q5 Chairman: It is just the SHA pattern that people are looking at. There are two PCTs in front of us, Mr Phoenix and Mr McIvor. Is the funding formula used to allocate resources to PCTs fair? Does it accurately reflect local needs and costs? Is the main reason you have done so well the fact that the funding formula favours your particular PCT?

Mr McIvor: I do not think that it is that the funding formula particularly favours my PCT. We are below capitation still. From the funding formulas which I have seen over my years in the NHS it is as fair as anything else around, but it has not actually meant that we move into a surplus position because of excess funding in any way, shape or form.

Mr Phoenix: The formula does not favour or disfavour us; we are over capitation, although in the past my part of the world has been judged to be under capitation. It is clear that small changes in the formula can quite significantly affect the way that resources are allocated: whether it is fair or not, I do not know.

Q6 Chairman: May I ask Mr Shipley and Mr Ford why you think the largest acute trusts are more likely to be in deficit?

Mr Shipley: Again that is a very good question. I have worked now in two acute trusts, both in completely different circumstances. Southend is in a part of the world where its relationships with its two local PCTs is very good, it comes from a situation with good financial management, but has a low asset base, so that is an advantage. My previous trust was Dartford and Gravesham which was a PFI hospital. I am not saying anything about PFI generally, but that did carry a high level of cost. You do get completely different circumstances which are unique to organisations, but I do not think the size of the hospital is relevant to the size of the deficit because, for example, Dartford had more financial difficulties than Southend does and was smaller.

Mr Ford: I agree with Brian. I am not aware that there is a size relationship. In my part of the world in particular it is primary care trusts which are the biggest problem areas in terms of deficits. There are two large trusts in Bristol that had big financial problems in 2001-02 and 2002-03 and they dug
themselves out of that and both delivered a surplus last year. It is not something I would correlate with the size of acute trusts.

**Q7 Chairman:** How will the rationalisation of primary care trusts and strategic health authorities affect the ability of your health economy to resolve its financial difficulties?

**Mr Ford:** It will make it worse in the short term. The turbulence associated with people changing boundaries, changing jobs, the loss of what is called corporate memory as you hand it over is bound to be a key issue. I was not at Southend when they moved off the Rochford site. If you go back into Southend’s history, it has always managed its financial affairs. I should say it is easier to do that now all are on one site, but, as David probably knows, we have a number of issues at our hospital site that we need to manage for the future. I do think it is an advantage.

**Q8 Chairman:** Does anybody have any proof?

**Mr Ford:** I would agree with what Keith has just said. In the short term, it will cause a lot of turmoil in the system, I do think where small PCTs are coming together and they particularly face one larger community trust, it is going to be much better to have a large PCT rather than having perhaps three or four negotiating what they are going to negotiate first, so that will be beneficial. When it comes to the SHAs, a good strong performance management at that level is what we have been lacking and that is what we really do need now and that should be improved.

**Mr Phoenix:** I agree with Keith. Although for me the issue is not so much about the structure of PCTs per se, it is the degree to which we shall be able effectively to implement aspects of the system reform agenda and particularly to engage GPs in practice-based commissioning, that is likely to be the tool which will significantly affect the way in which resources are deployed and that will be much more important than the size and geography and structure of PCTs.

**Mr Shipley:** In my part of the world we shall not see a lot of change. Both our PCTs in South East Essex have been working very closely together for a long while and have had joint appointments. Clearly the role of the PCTs and the SHA will change, but I hope that our working relationship with the combined PCT will carry on improving.

**Q9 Mike Penning:** May I take Mr Shipley up on a few things? You said that the size of the trust was not relevant to your efficiency, but you have massively downsized the size of your estate over the years; perhaps even slightly before your time when you sold off most of the Rochford Hospital and sold it for development and housing et cetera. My colleague is the MP for Southend West but I know the area very well myself. Did that have a significant effect on the fact that you are basically operating one site. What seemed a wonderful decision at the time, saving money and all the rest of it, in reality was not too clever.

**Q10 Mike Penning:** A massive disadvantage for the people living in Rochford or Rayleigh or Great Wakering, the areas where you closed the hospital.

**Mr Shipley:** Yes, clearly and you have to have and we are going through the process now of agreeing a travel plan, because the hospital site is very congested and parking is difficult. We are looking at what other opportunities we have, maybe to move some of our outpatient services off site, but you have to manage your asset base. That is an important message and it gives you an opportunity, being all on one site, for better communication and better efficiency.

**Mr Amess:** May I just say that while the decision was taking place about Rochford of course I was MP for Basildon where we were going through another programme, a so-called rationalisation and I stopped the closure of the A&E unit, I stopped the removal of the baby care unit, et cetera, but that was when I was MP for Basildon. I should simply say that the decision about Rochford has gone round full circle and now you have a traffic jam in the hospital site itself and everyone is squashed on the one site. What seemed a wonderful decision at the time, saving money and all the rest of it, in reality was not too clever.

**Q11 Dr Taylor:** Turning to national pressures, as you have probably realised, we have you four gentlemen together because you seemed to have coped with the national pressures and we want to know really how you have done it. When you think of the reorganisations, we are on the 28th or 29th reorganisation. I think it was Niall Dickson who said that to produce Agenda for Change, consultants’ contracts, GPs’ contracts, the pharmacy contract all at the same time was total complete madness. How have you as successful organisations coped with all these changes?

**Mr Shipley:** A good question. You have to manage your workforce; you have to have good relationships. So the consultants’ contract in a way was perhaps an opportunity for consultants to feel that they ought to be paid what they are worth or what they were, but you have to have some control over their job diary and we clearly have that. We do pay a maximum of 12 what are called Programmed Activities (PAs), so we do not pay as much to some of our consultants as other organisations that I am aware of. The other thing with Agenda for Change is that Southend was perhaps in a bit of a unique position because it had local terms and conditions prior to Agenda for Change and although we have implemented part of Agenda for Change in terms of the banding, now that we have achieved foundation status, we are going back to local terms and conditions again, because one of the inherent
problems with Agenda for Change is built-in increments for staff who may not have received them before; they might have been on a spot point. You do have to look at your own individual circumstances and you have put a fair number of controls in place as well as have a look at flexibility, but it certainly added to our cost base.

Q12 Dr Taylor: But you have tied the consultants’ contract down to a maximum of 12, have you?
Mr Shipley: A maximum of 12, yes.
Mr Phoenix: I should say that we have coped with it by strong project and programme management.

Q13 Dr Taylor: May I pick you up on that, because strong project and programme management is a lovely cliché. What does it mean?
Mr Phoenix: For us it means having dedicated resources, properly trained, who understand the subject, with enough time to be able to handle whatever the issue is effectively.

Q14 Dr Taylor: Have you sent them off on expensive courses to get them trained, like the marvellous course for improving your reputation?
Mr Phoenix: No, but people have been trained in project management skills and I am not going to apologise for training staff to do their job well. The second thing is that you need sound and effective financial planning so that you are able to take proper account of the changes that are likely to come along. We also have to try to make use of the changes as they come up. For example, with Agenda for Change we have tried to manage that effectively, closely and tightly and I am not convinced that everybody has been able to do that for a variety of reasons.

Q15 Dr Taylor: How have you managed the GPs’ contract and the out-of-hours service particularly?
Mr Phoenix: Some of the same principles apply, but what I should add is that we worked very closely in partnership with the GPs. Indeed the GPs on our executive committee led the implementation of the GPs’ contract with strong guidance and support from managers and that worked very well indeed.

Mr McIvor: Some similar things there as Steve, but firstly we have taken very much of a systematic approach to assessing the risks that we have and also understanding the context that the NHS has been operating in. If you go from our deficit time of about £6 million in 2002 through to the surplus we have operating in. If you take the position on pay awards that you have already alluded to, add to that in some cases an underlying deficit that goes back many years and has been halfheartedly tackled or not tackled, add to that where you start in different places, if you had three or four consultants in an accident department pushing hard for the 98% target, it may be a question of working them harder. If you have two consultants, you are into the step cost of avoiding a third, so where are you on the step change in costs? Add onto that this mixture of the complexity of payment by results and something even more complex called the purchaser parity adjustment for primary care trusts and believe me you would not want to go there in a technical manner, but if you add that complexity together, for some organisations that is an almost lethal mixture of complexity, too much to cope with. Add to that the fact that in some places chief executives, finance directors leave, other people cannot be recruited, so they have an interim person who lasts six months, nine months on contract and, for some places, all added together, it is too much to cope with. Other places do not get it all added together or they have had a strong stable management team. That is my theory; I do not have evidence to back it up.

Q16 Dr Taylor: Any comments from the SHA on some of your organisations which have coped well with these and some which have not coped so well?
Mr Ford: Yes, happy to do that. As you acknowledge, SHAs are a sort of conglomerate, in our case of 21 separate or legal organisations, PCTs and trusts. Sometimes I use the analogy of why an aircraft crashes: it is very rarely a single catastrophic incident, it is very often a combination of things which if they had happened on their own, would have meant the plane would have carried on, but, happening together, it comes down. If you take the position on pay awards that you have already alluded to, add to that in some cases an underlying deficit that goes back many years and has been halfheartedly tackled or not tackled, add to that where you start in different places, if you had three or four consultants in an accident department pushing hard for the 98% target, it may be a question of working them harder. If you have two consultants, you are into the step cost of avoiding a third, so where are you on the step change in costs? Add onto that this mixture of the complexity of payment by results and something even more complex called the purchaser parity adjustment for primary care trusts and believe me you would not want to go there in a technical manner, but if you add that complexity together, for some organisations that is an almost lethal mixture of complexity, too much to cope with. Add to that the fact that in some places chief executives, finance directors leave, other people cannot be recruited, so they have an interim person who lasts six months, nine months on contract and, for some places, all added together, it is too much to cope with. Other places do not get it all added together or they have had a strong stable management team. That is my theory; I do not have evidence to back it up.
The plethora of targets we have been issued with. To understand which are the most important out of to know and the contacts and the networks et cetera. It is actually about managing them as one issue or one set of issues rather than saying we need to hit this target, we need to spend that sum of money, forgetting about the financial consequence.

Q18 Dr Taylor: Would the others agree with that sort of approach?
Mr Phoenix: I should just add that we have tried to take the approach that targets are a way of trying to increase standards. One of the effects, for example, of the waiting-list target is that we have been able, over the life of the PCT, to reduce the inpatient waiting list by 35%. At the same time we have been reducing waiting times. We can wrap the term “target” around it and it feels pejorative, but actually we have been trying to take those targets locally and use them as a vehicle for driving up standards and that has been a good thing.
Mr McIvor: There are targets and there are targets and it is about identifying which are the important targets to achieve and knowing which you are going to get hung for perhaps if you do not do it right.

Q19 Dr Taylor: Do you feel you can pick those out?
Mr McIvor: Perhaps I get it wrong too often as well, but there are some which are definitely more important than others. We all know that waiting times, we all know that financial balance sits right up there. We all know that smoking cessation will make one of the biggest differences to this country; having more people not smoking. We are definitely held to account for some of those targets on a much tighter basis and I suppose the trick is having the experience to know and the contacts and the networks et cetera to understand which are the most important out of the plethora of targets we have been issued with.

Q20 Dr Taylor: Do you condone that approach?
Mr Ford: We have not met other than outside this room just now. Clear unambiguous targets are helpful. The problem comes when targets are either unclear, ambiguous or there are so many of them, that you have to begin saying “Ah, but which are the important ones?”. I am afraid two or three years ago finance somehow was articulated as an important target, but with the sort of underlying way of spreading the message that it was not quite as important as the others, or rather it was okay to have a recurrent underlying financial problem that you dealt with by a non-recurrent savings programme, freezing vacancies temporarily or backlog maintenance and that is when the targets are a problem. They are not a problem in and of themselves. I speak as an ex-hospital chief executive as well as a finance director. They are good when they are clear and you know what you are doing, what they are there for, but it is when there are too many and you get ambiguity.

Q21 Dr Taylor: Finally, to Southend, a question which has just been handed to me by one of our experts. You say in your evidence that your planned surplus of £5.2 million in 2006–07 will largely be due to your gain from PBR.
Mr Shipley: Absolutely; yes.

Q22 Dr Taylor: How much did you gain from PBR in 2005–06 and what will be the gain in 2006–07? How do you see your current position of being under the national tariff helping to make you more productive in the future?
Mr Shipley: There are three or four questions in there. The gain from PBR in the previous year was around £1 million. It was smaller simply because only elective activity was covered by PBR in 2005–06. The actual gain that the trust will make from PBR in 2006–07 is more than £5 million; we calculate it at about £8 million and we get, as a foundation trust in 2006–07, 75% of the potential gain, so there is more gain in the following year. We have taken two decisions: one is to accrue most of our PBR gain for future investment on the hospital site, so we have a 10-year strategy about spending over £100 million on the infrastructure. We have also recognised that there are some pressures in the system in the hospital and we need to spend some, even revenue, monies on things like backlog maintenance. It is a conscious decision. Part of the foundation trust application process which we have been through rather latterly is that you have to think further than the end of your nose and you have to have a strategic plan and that is basically our plan. Thank you for the question.

Q23 Sandra Gidley: A very quick question. Going back to the targets, there seems to be a certain amount of vagueness about what was important and what was not. I come from the area served by Hampshire and Isle of Wight, which, as you will know, Sir Ian Carruthers came in and shook up significantly, but he made quite clear to all of the chief executives and chairmen of the trusts what the key targets were. He gave them a list and he told them not to worry too much about all the others, that these were the eight he wanted them to concentrate on. Are you saying that does not happen elsewhere, because it seems like quite a good idea to me?
Mr McIvor: It does happen elsewhere. It is whether it is eight or six or five or two, and that is one thing. The other thing you need to understand is that we are also held to account by the Healthcare Commission now who have a whole set of other targets and I do not want my residents to have a failing or identified as failing PCT against the Healthcare Commission targets either. There is a set of Department of Health targets and the Healthcare Commission will make a judgment on how we perform on other targets as well. It is sometimes quite a balancing act, but everybody in the country
should know about the top two or three or four. There is no question about financial balance and no question about the waiting time targets; they sit there higher than anything else.

**Mr Shipley:** Sometimes as well it is about emphasis and pressures even at board or executive levels and you get some sort of conflict between consultant and nursing colleagues who believe that they need to be this, that and the other. Sometimes finance has, in the past, not been necessarily right at the top of the agenda or has been seen to be the finance director’s issue “You will solve the problem. You solved the problem last year by pulling a non-recurrent rabbit out of the hat, I am sure you have some money stacked away somewhere”. That is about integrated management and governance at board and executive-team levels, all understanding the targets.

**Mr Ford:** In the SHA where I am now, we have said financial balance is a prerequisite, so we have made it the single most important target. Three years ago, when I was running a hospital, what was measured? 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 and finance was measured monthly and the distinction between the recurrent and non-recurrent got blurred.

**Mr Phoenix:** There are layers of targets. John has made the point that there are targets and targets and there are targets that are not targets which are called milestones or guidance. I was talking to colleagues outside about the newly released fitness-for-purpose assessment for new PCT organisations and I stopped counting the pages at about 500. Those are the questions that will be posed to new PCT organisations when they are created in October and there is not a single measure or a single question in those 500 plus pages which is not important, significant, right and all the rest of it, but wrestling with, teasing what is important out of all of that is going to be quite a challenge for new organisations.

**Q24 Chairman:** We were told by the last chief executive of the NHS last year during another inquiry that target-setting was going to move to local target-setting in the next few years. Is there any sign that that is happening at this stage? I think that is a no.

**Mr Ford:** To a degree, yes. The targets which have been set in the past have not gone away, but new targets, apart from the 18-week maximum from GP to surgery, have not been added to to any great degree.

**Mr McIvor:** It is probably also about not quite pick-and-mix but the important targets. There are targets that cover most areas and in Rotherham, no doubt about it, it is essential that we make rapid progress on most of the coronary heart disease targets. They might not be the most heavily monitored, but for local purposes they are some of the most precious and most important targets.

**Q25 Chairman:** Is that where central would like you to move in terms of local target-setting within your health communities, on the basis of need and not national targets?

**Mr McIvor:** Yes.

**Chairman:** That is for another debate.

**Q26 Dr Naysmith:** That is a good point at which to come in and change the emphasis slightly in that we have been talking about pressures coming nationally in terms of management and quality of management and I suspect all of you sitting there would agree with the Government when they say that good results tend to go along with good management. I suspect you would all say that, since you are all doing reasonably well in your organisations. Leaving aside the national stuff for a moment, there must be local factors which present strong challenges to your organisations. Are there any lessons to be learned from that? I am just going to start with Mr Ford who has already hinted at the fact that there were some very important challenges in particular in the North Bristol Trust in the Bristol area where we moved into a deficit of something like £44 million at one stage and now things seem to be doing a lot better. May I just make one other point about that, the Strategic Health Authority (SHA) at the time was receiving regular financial reports from North Bristol Trust, in theory at least, and did not seem to be picking up that there were problems there. We do not want to go into the details of NBT, but are there any lessons that can be learned from things like that? I shall start with Mr Ford, but I shall ask you all whether you have dealt with similar things in your areas and, if so, what has been the right way to do it?

**Mr Ford:** As you are aware, I do not have the long-term background in the area I am now in that you have access to the accounts, so I know the numbers for 2001–02 and 2002–03, but not what who-said-what-to-whom bit of history in the North Bristol Trust. I have access to the accounts, so I know the numbers for 2001–02 and 2002–03, but not what who-said-what-to-whom. As a general observation, no organisation starts in the same place as another organisation. It has a different inheritance of staffing structures, if it is a hospital the number of consultants, if it is a primary care trust the number of admissions per thousand population it is paying for. If it is a primary care trust, some provide hardly any services directly, some district nurses, some health visitors, peripatetic staff; others might run six, seven, eight, nine community hospitals. No-one starts in the same place with their assets, their workforce or the problems and issues which arise from the population. Each management coming in has to ask itself what the problems are that they are seeking to deal with and fine-tune their own solution to those problems. Sorry, I am sounding like a management textbook now, but it happens to be true. You have to arrive, take stock and decide what the most urgent thing to do is.
Q27 Dr Naysmith: One of the problems was that two different hospitals were combined in one trust and no one seemed to be able to cope with that properly at the time and the SHA was not very helpful either. Would the situation be different now?
Mr Ford: Mergers take time to get properly organised and they are very difficult things to do; people in the private sector would tell you that too.
You have some turnaround directors giving evidence later in the session and it would be interesting perhaps to put that question to them. Yes, mergers generally speaking take time before you get the benefits out of them.

Q28 Dr Naysmith: Are there any different lessons to be learned from this sort of situation than from any of the others?
Mr McIvor: I would just build on that; mergers take time. As a PCT which was formed out of five organisations in 2002, it took a while to settle down and one of the gains we have had is consistency of senior management and middle management, not a high turnover, and a lot of experience. Mergers take time to bed down and it is not just the management, it is also about building up relationships with those people who control most of the use of resources;
I go back to the comment about GPs. Those relationships are critical and in the local situation I have we are very fortunate in having a good relationship; we can work with GPs and community staff on alternatives to admissions. Under the context of PBR all my staff and everybody knows that every non-elective admission costs about £2,000. There is something that says that people make a judgment about how they then can access and undertake their professional practice, though that can only happen in an organisation that has been there for a while, has built those relationships and has a consistency of management and approach.

Q29 Dr Naysmith: How would you cope with demand rising faster than the funding you were getting to satisfy that demand? That is another local thing, is it not?
Mr McIvor: We do have demand in some areas which always will rise at a different rate and we cope by looking at the most efficient and effective way to meet that demand. We look at how we spend the £320 million and not just the £1 million or £2 million of pressure and we have made choices, which is why we are there as an organisation, perhaps not to invest as fast in something as we would in something else. The demand for new technology and some of the demands of the tertiary services are quite significant at the moment.

Q30 Dr Naysmith: What would the difference be between good management and bad management of that kind of situation?
Mr McIvor: The biggest difference might be taking a systematic, rational approach, looking at the evidence around effectiveness, looking at the evidence around cost and clinical effectiveness and then taking people with you on that decision, both the public but also, as equally importantly, the professionals who are part of it.

Q31 Dr Naysmith: Mr Amess earlier was talking about putting two or three smaller units on one larger unit and I do not know anything about that situation at all but presumably the aim was to get the economics of scale from doing that and yet, he said all it did was create new problems that you had not really thought of at the start. I wonder whether either of the other two could comment.
Mr Shipley: We have discussed the Rochford/Southend situation. You are right; you have a set of issues. One of the benefits that Southend has had is consistency or very little turnover of senior management. I am relatively new to the trust, but it has benefited from that consistency. One of the things I would say is that you have to deal with issues over a wider timescale and the NHS is not very good at this. We have been very narrowly focused on a particular financial year, taking decisions, whether locally or nationally, that impact upon this year and not thinking about the consequences in year two, three, four and five. One of the things I was alluding to locally is actually having a strategic plan—and I know you have to have a degree of flexibility in that—that is for a 10-year period. We certainly need to do something with our hospital site.

Mr Phoenix: The way the system is developing, we need to look at issues of hospital and provider productivity and asset rationalisation and so on in a different way from the way we need to look at the way in which commissioners will work. The point that Brian was making earlier on about the assumptions of gain from practice-based commissioning and so on and needing to have a low asset base will make very little difference to the amount of care that the commissioner can commission. Commissioners, particularly with their GPs—and this emphasises the point that both John and I have made about partnership with general practitioners—are going to have to find ways of re-providing care in community and primary care settings at lower costs. If we do not, the kind of strategic aspirations that trusts like Brian’s will have, will have the effect of huge pressure on PCT budgets that we shall be unable to sustain. We are going to need much more of a twin-track approach between commissioners and providers than we would have needed in the past and that is an important way that we are going to have to work.

Q32 Dr Naysmith: One thing which is supposed to happen is that if you have a deficit in one year it is carried over and you get less money for the following year. That is going to happen in future, is it?
Mr Ford: Yes, the system is that you have to break-even over a five-year period so your deficit is carried forward on your books and there is this resource accounting and budgeting adjustment where you lose the money out of your income base for the following year. You will find that is mentioned in the
National Audit Office report on the 2004-05 accounts. I think the Secretary of State was asked to look into this.

Q33 Dr Naysmith: Their report suggests that different strategic health authorities do different things theoretically using the same technique, is that right?

Mr Ford: I have not done a study of other strategic health authorities. I thought we were applying the rules as they were supposed to be applied. Our auditors have not told us we are not.

Q34 Dr Naysmith: According to the National Audit Office and the Audit Commission that is not the case.

Mr Phoenix: There is also a different financial regime for primary care trusts, where primary care trusts are required to break-even annually, which puts a similar, but different pressure on PCTs to make sure they have an in-year balance.

Q35 Jim Dowd: A general question. Are the financial management structures within the NHS adequate and effective?

Mr Ford: Not universally. Again, like the answer I have given to other questions, it is too tempting to generalise and look at the 21 organisations in my patch.

Q36 Jim Dowd: Where are they strong and where are they weak?

Mr Ford: They are strong where a finance director is experienced in board management, which is different to and a step above accountancy, has a decent sub-structure which is handling the basics well enough, that he or she does not have to delve down into the basics and is doing good forecasting as well as financial control and saying “Don’t do that”. He is also forecasting ahead, is probably managing his or her board well, and I include the chief executive in that, making sure the chief executive has the right data and has their backbone stiffened when they need it.

Q37 Jim Dowd: All the things you have mentioned are essentially about the qualities of the individuals concerned, they are not structural issues. So what you are saying is that there is nothing really wrong with the structure, it just depends whether you have people who know what they are doing or not.

Mr Ford: Some structural things can get in the way. If you have an information technology system that is not helping, that can be in the way. Sometimes finance directors are given extra responsibilities which get in the way; they are given information technology, maybe a bit of corporate governance, in some cases maybe even estates management and once you widen their span of control beyond finance, sometimes that stretches the ability.

Q38 Jim Dowd: So good management saves money and poor management wastes money.

Mr Ford: That is an over-simplification of what I was trying to say. With hindsight, you can always post-hoc rationalise and say that if they delivered a balanced budget et cetera, that must have been good management and if they did not, that must have been bad management. It is often a combination of factors.

Q39 Jim Dowd: I know you mentioned this earlier in some of the discussion on targets, but how well integrated are the financial and the clinical priorities within the health service?

Mr Ford: It is the job of the chief executive to link them in any organisation. One of my colleagues pointed out that it is a danger if the finance director is told his job is to balance the books and produce a little bit out of his back pocket at year-end to make sure it comes right and that is not linked in. It is an equal and opposite danger if clinicians are told to deliver targets regardless of the money. The job of a good chief executive is to link those.

Q40 Jim Dowd: Particularly in an environment over the past few years where unprecedented amounts of money have gone into the health service, is it not the case that a lot of difficult issues were simply sidelined as regards financial discipline because the money was flowing in and they could be pushed down the road and dealt with in a few years’ time and now the few years are up?

Mr Ford: It was the case that with the money flowing into the NHS at national level a number of targets were set, a number of policies were deemed to be a good thing, improved cancer waits, improved cardiac, rapid access chest pain clinics, A&E and so on and each of those policies was undoubtedly a good thing in itself, but not necessarily costed properly at national level. The consequences of that were felt at local level as those policies came on down and we all chased them individually. The cost of those was aggregated back up after the event nationally.

Mr Phoenix: Keith’s point is a very, very strong one. We, the system, should have done better at connecting the likely costs of national initiatives, national service frameworks, targets and so on into when the costs were likely to fall, programmed over time and trying to understand the implications and we did not do that effectively enough. I should just like to go back to an earlier point that Keith made and not disagree, but perhaps add to it. If we look forward, as opposed to looking back, about finance capability, we are going to have to have systems which are significantly more up to date than we have now. I am not saying that what we have now is not adequate to do the job.

Q41 Jim Dowd: Does that equate to accurate as well as up to date?

Mr Phoenix: If we are moving into much more of a market-based system, it is going to be important for clinicians, referring clinicians, hospital clinicians, chief executives to have information which is much closer to real time than we have at the moment. At the moment we have systems which are significantly
off being useful for day-to-day operations, so that is the first thing. That is something we are going to have to move to. We also have issues about capacity and capability to manage that kind of system that we are going to have to gear up for as we move forward. The environment in which we are going to be working in the next five years is going to be significantly different from the preceding five, 10, 15 years and that is a big issue for us. It is a big issue for us in relation to making sure that clinicians are at the point of making rational decisions about treatment costs, alternatives and so on and in better places that decision making comes together, but that is going to have to be universal in the years ahead if the system is to work effectively.

Q42 Jim Dowd: Are there characteristics by which we can identify these better places and therefore identify the not so good places?

Mr Shipley: Could I just tell you about a process that we have just been through which was the foundation trust application process. That was very rigorous financially. It looked backwards at things that we had done over the last three or four years, it made us produce detailed five-year plans, it assessed our financial capabilities, it assessed our board capabilities and it did an awful lot of things. That has introduced some sort of rigour. You could say actually—and I know there are exceptions—that those who have got through that process are those people who are in better financial health though there is the odd exception. The NHS is beginning now to push that piece of diagnostics that is being done for organisations before they get ready and that needs to be more extensive because that does prepare the organisation. I made the point earlier about it being the finance director’s responsibility sometimes. This does teach boards to look at the wider picture and the consequences of investment decisions.

Q43 Jim Dowd: Just back on that question of the targets earlier. It was an over-statement, a generalisation. Nobody really thought that the target was an end in itself and did not carry a financial discipline with it surely? Is that what people were thinking, that just because the Department said we have just been through which was the foundation trust application process. That was very rigorous financially. It looked backwards at things that we had done over the last three or four years, it made us produce detailed five-year plans, it assessed our financial capabilities, it assessed our board capabilities and it did an awful lot of things. That has introduced some sort of rigour. You could say actually—and I know there are exceptions—that those who have got through that process are those people who are in better financial health though there is the odd exception. The NHS is beginning now to push that piece of diagnostics that is being done for organisations before they get ready and that needs to be more extensive because that does prepare the organisation. I made the point earlier about it being the finance director’s responsibility sometimes. This does teach boards to look at the wider picture and the consequences of investment decisions.

Q44 Jim Dowd: Finally, and I know this is a generalisation, is the finance function across the NHS adequately resourced itself and are people and units encouraged to report bad financial use as soon as possible?

Mr McIvor: From our point of view, yes it is. The amount of investment we put into the finance function is something that is our decision as a PCT and people are definitely encouraged to report financial problems as soon as they are identified. Some of the problem is that the time limit often around data transfer means that some of these problems are identified somewhat too late and we need to speed up data transfer in the NHS.

Mr Phoenix: I should say the same thing but just make the point that the responsibility for good financial management does not rest with the finance department. The finance department have a part to play, but—

Q45 Jim Dowd: You are just the police, are you?

Mr McIvor: Who are the police!

Q46 Jim Dowd: You said the activity itself is nothing to do with you and you are just policing the financial arrangements.

Mr McIvor: No, the point I am trying to make is that the responsibility for financial management does not sit with the finance function alone. I am not a finance director, I am a chief executive, but the finance director’s responsibility, corporately, is to work with the whole organisation to ensure that financial management is the responsibility of all budget holders. I have had experience in the past where there is an assumption that the responsibility for financial management sits with the finance department and my experience has been that that is a recipe for disaster. The finance function has an absolutely crucial part to play but if the entire organisation does not see itself as being responsible for delivering on their financial responsibilities, however good the finance function is you will not have good financial management.

Q47 Chairman: Would it be over-simplifying to say that national targets did not create these problems that it was something lower down than that? Everybody says national targets have created X and Y problems, national contracts have created X and Y problems for us and yet we are told that 70% of trusts have kept within budget.

Mr McIvor: It is not quite fair to say that. Some of the national things have created local problems which we should then have managed our way through. The implementation of the new GMS contract cost us around about £600,000 more than had been calculated nationally. That was £600,000
we had to find elsewhere. 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. We cannot totally say it is local management; national targets have not perhaps been properly costed and the national contracts have not been costed as rigorously as perhaps they could have been.

Q48 Chairman: It is a mixture of all these things.  
Mr McIvor: Yes; a mixture.  
Mr Phoenix: Earlier Keith made the point about different organisations in different circumstances and the impact of national targets being felt differentially depending on local circumstances. Certainly that is what I see as I look at some of my colleagues, that it is a consequence of the application of those pressures locally that can be the confounding factor.

Q49 Mike Penning: Similar question. You all seem to be doing so brilliantly well, so if I picked you up, each individually, took you out of your trust where you are doing so well and dropped you into a trust with a £47 million deficit, everything would be rosy within 18 months. Is that the assumption we can make? Is it down to management? Is there no other reason why things are going wrong?  
Mr Phoenix: I do not think that is the case.

Q50 Mike Penning: I still have not got to grips with why you are doing so brilliantly well. You are in surplus, but there will be chief executives coming here this afternoon, very similarly qualified, very similar amount of experience and they will be having major problems with huge deficits and you guys have not. Surely if we transferred you there, everything would be rosy then?  
Mr McIvor: We have not said it is just management, but management does come into it, good management. We have also said things like length of time that organisations have been created for, cultural issues in the organisation and relationships.

Q51 Mike Penning: Nothing to do with the spending formula? Nothing to do with the amount of money you get to treat your patients compared with what they get? Nothing to do with that at all?  
Mr McIvor: If you look across the country, there seems to be no correlation between the PCTs that are in deficit—

Q52 Mike Penning: That is really interesting because the House of Commons Library gave me a figure this morning for my PCT which is £960 per head and then if I go to Hackney it is £1,400 and if I go to Sedgefield it is £1,210. There is a massive difference. Are you just ignoring that?  
Mr McIvor: No, what I am saying is that there is a resource allocation formula which takes into account multiple things like deprivation, like the elderly, levels of morbidity and so on which presumably leads to those sorts of adjustments.

Q53 Mike Penning: It works very well for your trust and not very well for others. I do not understand that at all.  
Mr McIvor: I am below capitation. If I had my capitation level—

Q54 Mike Penning: I am asking all of you gentlemen. Brian, you are above capitation level, are you not? You are doing fine.  
Mr Shipley: The two PCTs locally are mixed: one is slightly above and one is slightly below. Some of the important thing is about the good working relationship that we have with our PCTs. I think management is very important. It is not a panacea to all of the issues, but I have worked in other trusts where the degree of interest or collective interest in financial management has not been the same. We have identified as well this morning that maybe two or three years ago the balance was not quite right. My first impression of Southend, when I went there nine months ago, at both board and executive level, was how interested they were in financial issues and the financial strategy.

Q55 Mike Penning: This does not make sense, to be fair. You have had trusts which have been amalgamated, whole new management systems brought in, year after year after year the same areas of the country are in deficit with new management, different trusts, different PCTs—PCTs are going to be abolished now because they are doing too well—and we move on, but you still come back to the fact that it is management and yet it is different people in different jobs, year after year, and it is the same areas which are in deficit.  
Mr Shipley: I did not say that management is the panacea to absolutely everything. All I am telling you from my experiences and having worked as finance director in three NHS organisations is that the emphasis placed on financial management at Southend is greater than the other two organisations that I worked at. That is my experience.

Mr Phoenix: I should say that, in a way, if we knew the absolute answer to your question, you probably would not need this inquiry.

Q56 Mike Penning: That is why I am asking the question, to be frank.  
Mr Phoenix: The pursuit of a single answer is not the issue. As you have rightly said, the places that are doing well are inevitably going to argue that they have strong management that has been around for a long time, good systems, et cetera, that is almost inevitable. We have also seen successful managers go into difficult, challenging circumstances and find it difficult to turn those organisations around. Equally we have seen good managers go into organisations and do very well. There is a whole raft of issues which are contingent on circumstance, history, structure, funding, a whole raft of things that go to make up the mix of why organisations have done either well or have done badly. It is actually quite difficult to pick through the thread of that.
Q57 Mike Penning: It is just the fact that year after year, no matter how much you change the trusts, amalgamate, wipe out the debts, the same areas come back with the same problems. It must be more than just management; it must be more than just attitudes within the organisations. It basically has to have something to do with pounds, shillings and pence coming through the system.

Mr Phoenix: I would agree with you that it cannot simply be about management alone, however much that might be a factor, but there is a whole raft of other factors, one of which could well be to do with local allocations, local circumstances, local history and so on.

Q58 Charlotte Atkins: Clearly financial management is very important to this whole process. I should like to put a question to the two chief executives, because it would be unfair to ask the directors of finance. Does the NHS just lack sufficient good financial managers in terms of the numbers of financial managers we need at whatever level, PCTs, trusts, SHAs, and is there just a lack of expertise there? We cannot rely, can we, on turnaround teams each time we have a problem?

Mr Phoenix: The last point is true: we cannot rely on turnaround teams and we shall need to see how effective the turnaround process has been. We are still in the middle of it; we need to see whether it is the kind of intervention that would be helpful for the system. The distribution of finance directors is probably no different in the NHS from other large organisations. I suspect we have a distribution curve which has a small number of top quality finance directors, a small number of under-performing finance directors and the vast majority in the middle. That is probably true of chief executives and just about everybody else. If you go back to my earlier point about where the NHS is heading, it will require a different and improved sense of finance director. It basically has to be more than just management; it must be more than just financial information. We shall 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.

Mr McIvor: I should agree with that. I am talking from a PCT perspective and we created 300 and something PCTs a few years ago from 100 health authorities and a few trusts as well and perhaps the finance function, just like the chief executive function and so on, has had to grow into some of those roles in many areas. The current reorganisations should ensure that the best people are appointed to the important jobs. There is no lack of those people around. There are now some very, very experienced finance directors around.

Q59 Charlotte Atkins: So the Department of Health does not need to do anything else in terms of creating more financial management expertise apart from its present leadership scheme which already operates quite successfully?

Mr McIvor: A lot is already done on the financial development front from taking new graduates into finance and working those people right through and supporting them right through to director stage. I know in the north of England there is a very well developed scheme and very well recognised scheme which has produced some excellent finance directors.

Q60 Dr Stoate: My background is as an ordinary straightforward general practitioner and I am frankly used to straightforward no-nonsense replies, so I want to cut through some of the jargon which we have heard bucket loads of and frankly I have heard so much this morning, my head is still going around. When it stops going round I want to ask the first question, which is fairly straightforward. It is really to the three trust members here. What have you done to cut costs and improve efficiency? Just straightforward examples of what you have done to cut costs and improve efficiency.

Mr Shipley: I shall give you one example and then I shall pass on. We started a piece of work last year looking at our sickness levels and focusing on those. There are obviously reasons for sickness, but actually looking at benchmark statistics.

Q61 Dr Stoate: How have you done it? Let us get right to the nitty gritty. What have you done in order to reduce sickness?

Mr Shipley: Two things. We introduced a system called Bradford scoring, which is a way of comparing the incidences of sickness. Is somebody who has five days off, one day every week, as significant as somebody—

Q62 Dr Stoate: What have you done about it?

Mr Shipley: Interviewed staff, put staff through capability and disciplinary processes and that has had the impact of reducing our sickness levels to just above 3%.

Q63 Dr Stoate: That is what I want to hear. What have you done Mr Phoenix?

Mr Phoenix: May I take a slightly different example and that is about trying to reduce waiting times in our community services? We have done that across a range of services. One that springs to mind is our wheelchair service which had a waiting time of 18 months, now down to three for routine waits. We did that by training people in a technique called Lean Six Sigma, which is about reducing waste and reducing variation; a series of techniques largely drawn from the manufacturing industry. What we have been trying to focus people on is looking to improve the process that people go through as a way of reducing waiting time or waste and so on. That would be an example, if you were looking for something specific.

Q64 Dr Stoate: Okay. Mr McIvor, what have you done?

Mr McIvor: Three quick things. Under the old health action zone programme we introduced dynamic case managers, basically specialist nurses in heart failure, frail, elderly and COPD, airways
Mr Phoenix: I did not have those figures to hand.

Mr McIvor: That is exactly my point, where do you start looking?

Mr Ford: I have not finished yet. Benchmarking: what is the scope, where are you on the wrong end of an average, where are you above average, where do you look? Then, what sort of programme management do you have to get it out, who owns that target, when are they going to deliver it, by what date, how many posts are going to come out as a result of it rather than a sort of vague "Let us take a couple of per cent off your budget" and you have to make it, a line-by-line programme management approach to delivering a specific figure.

Mr Phoenix: Of course.

Mr McIvor: I cannot give you a specific figure. In gerontology it was around £200,000 to £250,000; on the orthopaedic triage, difficult to assess but probably getting on towards the £1 million plus; on the dynamic case manager and community matrons, it is an ever-increasing number of admissions which are not going to hospital. If you look at our rates compared with others, perhaps in the order of well over £1 million.

Mr McIvor: By doing things differently.

Mr Ford: A point about the context is of course that the Department of Health’s agreement with the Treasury always contains an annual efficiency saving requirement. I have been knocking around for 20 years now and it has been floating around doing 1% to 1.5% up to 2.5%. Every trust and PCT in the country has to make at least 2.5% worth of cash releasing efficiency to stand still with its allocation base.

Mr McIvor: Take the dynamic case, the heart failure. Airways problems are well-known problems in our part of the world, so that was a real need, there was an enthusiasm to do it across the clinical fraternity in the hospital and in the community and there was a commitment from general practice to use the services and use new services differently.

Mr McIvor: Well, I cannot give you a specific figure in gerontology where it was around £200,000 to £250,000; on the orthopaedic triage, difficult to assess but probably getting on towards the £1 million plus; on the dynamic case manager and community matrons, it is an ever-increasing number of admissions which are not going to hospital. If you look at our rates compared with others, perhaps in the order of well over £1 million.

Mr McIvor: Yes.

Mr Phoenix: So you would all agree that there are millions to be saved by these initiatives then?

Mr McIvor: I cannot give you a specific figure. In gerontology it was around £200,000 to £250,000; on the orthopaedic triage, difficult to assess but probably getting on towards the £1 million plus; on the dynamic case manager and community matrons, it is an ever-increasing number of admissions which are not going to hospital. If you look at our rates compared with others, perhaps in the order of well over £1 million.

Mr McIvor: Do not forget, we are operating within a PBR regime as well, so the fact that admissions come out at full cost from the trust means those full costs can then be invested in the other services which are significantly cheaper which means we can then use the rest of the money on other things.

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Q79 Dr Stoate: That is helpful. I want to ask you another question Mr Ford. How come the SHAs have managed to save so much money compared with the forecast expenditure at month six? What have you done to get your figures looking so good?

Mr Ford: I can only speak for my own SHA. We went through a rigorous programme and meeting with all the trusts, first of all to establish their proper forecast, what they actually thought would happen as opposed to the hope value in it or stripping out language like “That’s unacceptable” which only encourages people to under-report their forecast, to get the forecast right and then for each of them to do a programme approach which said “What are you going to do in the next six months?” line by line. It turned the SHA from what was supposedly a strategic body with a light touch into quite a hands-on performance management body.

Q80 Dr Stoate: One of our worries is that some of the saving SHAs have made might have damaged the training budget. Is there any truth in that?

Mr Ford: There were no sacred cows at all, so it would not surprise me if some training officers felt hurt and bruised by this.

Q81 Dr Stoate: I am not worried about the training officers; I am more worried about the training of NHS staff.

Mr Ford: Well that is done through training officers. I am sure you will have evidence from almost anyone in the NHS that they have been unfairly treated and had to take savings. That is what happens if you have financial balance as a prerequisite.

Q82 Dr Stoate: Can you each give me an example of what impact on patient care hitting these targets has had? Can you honestly say there has been no detriment to patient care with these initiatives that you have been pursuing to save some money?

Mr Phoenix: I should say the opposite was the case, that where we have been pursuing targets that has been to the advantage of patients. The particular example I gave was of significantly reducing our workload and wheelchair wait times. John gave you an example and we pursued very similar programmes. We are making sure that people are seen faster, closer to home. In the case of the community matrons’ programme, we are trying to make sure that people do not get ill in the first place when we know that they have a pre-disposition to do that if their condition is not managed proactively. I should say the opposite is the case really.

Q83 Dr Stoate: Do you agree as well Mr Shipley?

Mr Shipley: Yes, a lot of them are.

Mr Phoenix: Yes.

Mr McIvor: Yes.

Q85 Dr Stoate: So why is it then that you have managed to achieve these things and others have not? It comes back to the same issue. Is it just line management, is it luck, or is there some other magic formula?

Mr Phoenix: It is not luck; it is not a magic formula. It depends what you mean by management; we can have a debate on that. Working in my last three jobs, the relationships with clinicians, the relationships with those who have to undertake change is critical to this. Where you do not have those good relationships, it is much harder. If you take your fraternity, the general practice fraternity, the relationship with things like the MMC is critical to the implementation of some of the changes we want to see in the NHS and the implementation of the new GMS contract, how we tackle PMS in the future, the personal medical services contract, will all be critical to whether we can do these things easily or whether people will react against them and they will not be able to be implemented.

Q84 Dr Stoate: What we are saying then is that they are all no-brainers, are they not?

Mr Shipley: Yes, a lot of them are.

Mr Phoenix: Yes.

Mr McIvor: Yes.

Q86 Chairman: Could I ask a question about top-slicing? I have to declare an interest. The top-slicing that is currently taking place as a contingency against deficits will potentially affect patients. I have to declare an interest and say that Mr McIvor’s primary care trust covers both my home and my constituency. Do you think that this top-slicing that is going to take place in this financial year is going to have an effect on patient care? Have you any idea, if this top-slicing is going to be repaid, as we are told by ministers, when that is likely to happen?

Mr McIvor: We were prudent last year in building up a small reserve. A 1% variation in PBR is about £3.5 million for us, so we built up a reserve of about £5 million deliberately ahead of being told anything like that and I would suggest that was just prudent management. However, we are now losing £7 million as a result of a top-slice, plus £2 million on purchaser parity adjustment, which means we have a £9 million problem. If it were not for the fact that we had done so well in our resourcing and the NHS had had a very good settlement, we would be having to cut patient services or at the very least we are already not developing them as fast as we could do. There is no way I could sit here and say we have lost £9 million and that has had no effect on patient services. It has not meant that we have had to reduce, change or stop any services, but what it does mean is that we cannot develop them as fast as we should like because that £9 million has to go elsewhere. We are assured that it will come back to us, but we do not know the timescale yet. Equally, the last set of guidance which came out said that the top-slice was negotiable and it also promised that it would come back. At least we found some solace in losing the money that we would eventually get it back and looking at the settlement for future years, perhaps to have it then might be a sensible time to spend it as well.
Mr Phoenix: With a slightly bigger challenge in this year than John, the purchaser parity adjustment element for us affected us by £7 million and in total we have lost £16 million when you add the top-slice. Again, a bit like John’s organisation, we had tried to create a degree of cushion for this year as we have done in previous years to allow for service developments and service improvements. We are now looking quite hard at how we can provide the care that is needed in cheaper ways, so that we are able to operate within balance. I have to say, a hit of £17 million in one year is a not inconsiderable challenge and we have plans and proposals that, at the moment, would get us to that point, but it is going to be extremely difficult to do.

Mr McIvor: One thing I meant to say as well was that we have three key roles, not just to provide services and commission services, but also to improve health and with our allocation last year there was a line that said “Choosing health: £1.7 million”. It is unfortunate that perhaps those are the lines which we all have to look at first, so things like smoking, things like obesity, exercise, investment in some of the public health initiatives that will have the most long-term effect are ones which perhaps do not always get through and the ones that we cannot do this year because we have lost that money.

Q87 Chairman: When you say “in a cheaper way”, is there any effect on quality of care or patient care?

Mr Phoenix: The objective will be for us to provide the same quality of care in a less expensive setting. Inevitably that means in primary care, in community settings. It means trying to make sure that we are only sending to hospital those patients who really need to be in hospital and that we can look after patients in the community or in primary care as well or better than they would be looked after in hospital. We do know that there are large numbers of patients who are treated in hospital when they could be treated as effectively in the community or in primary care and that is what we are working at, but £17 million is a lot of money to re-engineer in one year.

Mr McIvor: Not in my organisation; not substantially. We are still trying to invest in new mental health services, although we are probably in aggregate spending more on mental health services than we ought to be. We are probably under-investing in mental health services for children and that will be a priority for us, but we have tried to protect mental health services as far as we can.

Mr McIvor: We have plans to invest further in primary care mental health services and further into crisis resolution services, both of which we have already, but not to the extent we would wish to have. We cannot now take those plans forward until next year, assuming there is not going to be a top-slice next year.

Mr Ford: I just wanted to pick up something you said earlier about lessons to be learned. 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 and, in particular, this thing called the purchaser parity adjustment, which came so very late. One thing that does make management incredibly difficult is that management is about forecasting, planning to do something then implementing it and if you push those processes so close to the start of the financial year, you give yourself much less chance to do it. As the architect of the top-slicing policy in my part of the world, from an average growth or uplift of 8.8% we top-slice 2.1%. It has gone as a loan to the seven organisations out of 21 that are in trouble and they are expecting to have to pay it back in 2007–08 on the policy as written.

Q89 Dr Taylor: At the moment you are managing to break-even. Are you fairly confident, with all the problems, that by the end of this year you will still be breaking even?

Mr Shipley: Actually, we have set ourselves a target of a £5 million surplus for this year which is part of our strategic plan. There always will be issues that will arise during the year that you had not forecast. It is very important that the message we get across to our organisation, now that we are a foundation trust, is that we need to achieve those targets to be able to re-invest so clinicians and managers have choices. If we do not achieve our financial balance, we shall not achieve our long-term goal, so it is about spreading that message.

Q90 Dr Taylor: As a foundation trust, by definition, you have no long-term previous deficit.

Mr Shipley: No. We should not have got through the process, if we had had underlying financial problems.

Q91 Dr Taylor: And the other two? You have no previous long-term deficits that you have not coped with?

Mr Phoenix: No. We have a principle that not breaking-even is not an option, so we are currently forecasting break-even. We are presently over-spending slightly but I expect us to break-even, though this will be the most difficult year that we have faced.

Mr McIvor: The words “fairly confident” are where I would probably go with you on that one. Losing that £7 million to £9 million when we had about £1.3 million deficit the previous year and come out of it, will be hard.

Q92 Dr Taylor: Now Mr Ford, you have a selection of organisations, some that are in surplus and some that are not. How confident are you that as an organisation as a whole, you will be able to be in balance at the end of this year?

Mr Ford: I am not. I am advising the board at their meeting next Tuesday that I expect the organisations in AGW to turn out somewhere between £30 million and £60 million over-spent.
Q93 Dr Taylor: You are one of the organisations whose surplus has dropped from six months ago to the end of term.
Mr Ford: No, we were in deficit six months ago and it stayed.

Q94 Dr Taylor: Not as a whole; your own expenditure.
Mr Ford: Sorry, the headquarters. I was answering the question for the 20 trusts.

Q95 Dr Taylor: You went from £18 million to £11 million, according to the figures that we have.
Mr Ford: That sounds right. We lent some money out to some of the trusts as part of that.

Q96 Dr Taylor: So that is where it went. You did say earlier, you implied, that education budgets had been unfairly hit, is that right?
Mr Ford: I said there were no sacred cows and the people on the receiving end of the education budgets would probably whinge to you if given the opportunity.

Q97 Mike Penning: What was the figure, £60 million?
Mr Ford: Between £30 million and £60 million is the figure that will go to our board in public session next Tuesday.
Chairman: May I thank you all very much indeed for coming along and starting this session in our deficits inquiry? I suspect, as we have run over time today—and apologies for that—that we are going to run over time in the following months as well. Thank you very much indeed for attending.

Witnesses: Mr Philip Davidson, partner in Restructuring Advisory Group, KPMG. Mr Kevin Ellis, partner in PWC Business Recovery Services. Mr Sean Sullivan, Turnaround Director, Essex, Bedfordshire and Hertfordshire and Mr Martyn Everett, Director of Recovery, Kensington and Chelsea PCT, gave evidence.

Q98 Chairman: Gentlemen, may I welcome you to this first session of our inquiry into NHS deficits. May I first of all ask you to give your name and your position for the record please?
Mr Everett: Martyn Everett. I am the Director of Recovery at Kensington and Chelsea PCT.
Mr Sullivan: Good morning everybody. My name is Sean Sullivan, I am an independent Turnaround Director and I have been asked to assist Essex, Bedfordshire and Hertfordshire SHAs.
Mr Ellis: Kevin Ellis. I am a partner in PWC.
Mr Davidson: Philip Davidson. I am a partner in KPMG.
Chairman: Thank you very much for coming along and apologies for this late start. If you have nothing to add to a previous answer to a question, I suppose we ought to say you do not really have to say anything, we shall take that as some sort of agreement. Mike Penning is going to open the questioning in this section.

Q99 Mike Penning: I should first like to declare an interest because Mr Sullivan has been helping Hertfordshire, which is where my constituency is, in particular West Herts Hospital Trust. Is one of the main causes of the deficits in the NHS bodies that you have been working with all about financial management or is it about the way that it has been handled? What do you feel as professionals are the main causes of these deficits?
Mr Everett: In Kensington and Chelsea part of the submission that I made to the Committee was PriceWaterhouseCoopers’ public interest report on the PCT and what that makes clear is 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. The other area which came out of that was really the fact that the primary care trust provides a lot of services on behalf of other people in the health community and the trust was actually not recharging those services out properly, which was creating an increase in the deficit in the trust. I suppose the last issue in terms of the reason for the deficit is that Kensington and Chelsea is quite unusual in that there is a large provider element to the PCT and there was a lot of excess capacity in the provider services which was not tackled.
Mr Sullivan: Good question. Looking at it from the independent external point of view, as we have heard before, there is no one major reason. There seems to be a set of reasons. Let us take the trust that you mentioned at West Herts. That trust has been in deficit since 2000 when it was formed.

Q100 Mike Penning: It was in deficit before that as well.
Mr Sullivan: Yes, that is right. There have been three reorganisations there. It seems always to have been in some sort of deficit as far as I can see. The CEO there tells me about the M25 effect, but we prefer to call that the proximity-to-London effect, where he sees inflows of expenditures from PCTs that he would like to have going into London so they can look at UCL, Royal Free, Barnet and Chase Farm Hospital. They have had six FDs in six years, which is not an advantage; he was the third CEO when he was appointed 18 months ago. The duplication of services on multiple sites is a significant issue in that particular trust and it affects others as well. The near-London effect has another peculiarity in that staff costs are relatively high, though not as high as inside London, and therefore recruiting people for a salary is quite difficult. If you cannot fill the post, you have to look to your agency and bank staff to cover that post and that gives you an extra cost over
a period. The combined set of these issues actually bring us to the point where they have the sort of deficits that we have experienced.

Q101 Mike Penning: Interestingly, the CEO, who is sitting behind you, told me also one of the problems which I have brought up with them over the years is the funding formula, the way that funding is allocated. You did not bring that up at all.

Mr Sullivan: I actually think that this organisation can come back to where it ought to be irrespective of the funding formula right now.

Mr Ellis: One change that has happened more recently is that there is more transparency around individual trust’s performance. The removal of brokerage, where geographically surplus and deficits were shared and individual trusts now are held personally accountable for the deficit, has caused some of these deficits to surface. In addition to that, you mentioned the funding formula, but the move from bulk tariff to national tariff has also meant that where some trusts had negotiated good deals for the local PCTs under the bulk contract, moving across to a national tariff has taken that advantage away and that again has added, in some of the cases I have seen, to surfacing deficits.

Mr Davidson: My firm was involved in the baseline review of 96 organisations either side of Christmas and we have also worked with 13 organisations in helping to develop financial recovery plans and across that population of organisations. I can say with some confidence that there is not a single cause. It is not solely local issues which cause deficits, it is not solely management which causes or alleviates deficits and it is not solely systemic national policy issues which cause or alleviate deficits. We have found some themes across the organisations that we have looked at. We have found, at local levels, excess capacity and we have seen over-trading at local levels that has masked excess capacity, that is where organisations are running down waiting lists and that delays the realisation that there is excess capacity at local levels. We have seen, in a number of cases, cost improvement plans that are believed to be recurrent but actually have been non-recurrent and have delayed the realisation of problems. We have seen organisations which have not been able to cope with increased costs arising from, for example, Agenda for Change and we have seen organisations, many organisations, whose management have not put in place adequate processes and systems and high quality financial information to allow them to see all of these problems emerging quickly enough and therefore have not been able themselves to respond quickly enough.

Q102 Mike Penning: Thank you very much indeed. May I just ask a very quick question? Mr Sullivan, here it says Essex, Bedfordshire and Hertfordshire Turnaround Director. Who employs you?

Mr Sullivan: I am employed by the Department of Health.

Q103 Mike Penning: Thank you very much; I thought you might be. Moving on to another question for KPMG and Mr Ellis, why do you think the trusts and PCTs in the South East are predominantly in trouble compared with the rest of the country? I know there are problems in some other parts of the country, but predominantly the Secretary of State has told us several times, it is the South East where the problem is. Is that the case and if so, why?

Mr Ellis: From the work we have done in individual trusts, I cannot say I have seen that trend. I have not seen enough evidence to say it is specifically those trusts. The comments that Mr Sullivan made earlier are very relevant. Those within the outer London corridor probably have more pressures in terms of staff and retaining staff than areas in the wider geography of the UK.

Q104 Mike Penning: If they are not particularly close to London?

Mr Ellis: If they are particularly close to London.

Q105 Mike Penning: If they are not particularly close to London and we can go into Cambridgeshire and Bedfordshire and further down into Sussex, why are they still having problems year in year out? Mr Ellis: It comes down to what Philip said earlier. Individual trusts do not always start from the same point. Some trusts have historic problems which go back years and therefore are often re-recurring unless they are dealt with.

Q106 Mike Penning: But there must be historic problems in the North East?

Mr Ellis: Yes, there are; there are trusts in the North East which have deficits as well.

Mr Davidson: The basis of your question is sound because there is some evidence that there are greater deficits in the South and the South East than elsewhere. In our first phase of work, where we looked at 62 organisations, of the six highest deficits, four were in London or close to London, one was in the North East and one was in the Midlands. It is not possible to say why that is yet, because all of the organisations that we have looked at are in a process of significantly improving efficiency and addressing capacity issues. When you have reached the stage where organisations are running as effectively as they can, then you are in a better position to assess whether other pressures, national pressures or different forms of local pressure, are affecting organisations.

Q107 Mike Penning: On that point, we have heard today already in other evidence, that year on year the same trusts are very often the ones that are having problems, et cetera. If we are coming to this pinch point where we shall start to know why, once they have done their efficiency reviews, what will that timescale be, because some of these trusts have probably had problems for 10 or 15 years? When are we going to see the light at the end of the tunnel as to why it is happening?
Mr Davidson: The organisations we are working with are probably typical of those organisations turning around from significant deficits and the period of time that that is going to take is up to two years.

Q108 Mike Penning: From when?
Mr Davidson: From the point at which they began significant activity in effecting their turnaround. In a lot of cases that is around April this year.

Q109 Mike Penning: So it is going to be two years from April this year.
Mr Davidson: Turnaround will typically take up to two years. Over that period, it will become clearer whether organisations are simply dealing with local issues, management issues or whether they are actually having to deal with issues that are beyond their immediate control or their SHAs’ immediate control.

Q110 Mike Penning: It does seem from the evidence that we have seen that the larger trusts do tend to build up more significant deficits than the smaller trusts. Is that correct and if so, can you expand on why?
Mr Everett: I can only comment on Kensington and Chelsea. In our position, our cumulative deficit is £26 million and our income is £250 million, but I have not done an analysis.

Q111 Mike Penning: So if you were smaller, would you think it would be easier to control your deficits?
Mr Everett: No. I think it would be better if PCTs were bigger, it would be better from a financial perspective in terms of efficient operation. I think £250 million is too small for a PCT personally.

Mr Sullivan: I should like to support that statement actually. Going back to your first question on larger trusts and actually having to deal with issues that are beyond their immediate control or their SHAs’ immediate control.

Mr Sullivan: Whilst Mr Sullivan correctly points out that the maths would seem to suggest that larger trusts would have potentially larger deficits, actually the evidence that I have available to me does not support that as being the case. We have seen a number of small trusts that have large deficits and a number of large trusts that have relatively modest deficits, but in the latter case there are sometimes entrenched issues that make the resolution of those deficits quite difficult. As an example, there is a hospital in the London area that has a cost base of £108 million and it has planned savings of £18 million. Planned savings of £18 million for a hospital that has a cost base of £400 million would probably be seen as pretty good in a single year. That particular correlation is difficult to draw.

Q113 Mike Penning: One of the areas of growth in deficits in recent times is in the PCTs. Is there any knowledge of why that is happening?
Mr Sullivan: I can only comment on the PCTs in my area and I see my concerns are usually with the smaller PCTs where there are several PCTs surrounding one trust provider and where they also commission services into the London area, where they are a minority commissioner and therefore do not have the weight of a larger percentage PCT commissioning services as the major supplier of funding. The smaller PCTs are probably more prone to build up a deficit. When they move to a larger group of PCTs, they are likely to able to afford greater commissioning skills, be able to concentrate their skills on where they are needed most. It is a tough call for a small PCT.

Q114 Mike Penning: When the PCTs were formed in their present format, the Government said that it would take three years for the best possible outcome to start to come to fruition.
Mr Sullivan: I could not comment on that.

Q115 Mike Penning: How long do you think before these new PCTs, which are going to be much larger, county based, basically what we had before near enough, will start to produce the sort of savings and things that bring them out of deficit?
Mr Sullivan: From my viewpoint, given the lessons that are being learned fairly sharply at the moment, I would expect those PCTs to perform to a higher level within the next year to 18 months. Some of these PCTs have very good individuals who have great skills in this area.
Q116 Jim Dowd: This is principally for Mr Ellis and Mr Davidson. I asked the previous batch of witnesses what their experience of financial management structures within the NHS were as practitioners. As outsiders to the NHS, what is your assessment of the strength or otherwise of the financial arrangements?

Mr Ellis: I have seen trusts with deficits, so we have probably seen an unfair sample across the whole NHS, but in most cases financial forecasting is very weak and therefore a number of trusts, faced with some of the national initiatives, found it hard to predict how that national initiative would affect them and their deficit and therefore probably took their time in taking action because they did not realise the negative effect that was coming their way. That is actually quite a key thing and in a turnaround process we find that trying to work with the clinicians and engage the clinicians and trying to de-mystify the finance function for the clinicians actually makes quite a big difference. 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.

Q117 Jim Dowd: That is very much the second part of my question, but Mr Davidson, do you have anything to add to that?

Mr Davidson: Yes, I can confirm, again looking at the baseline assessment that we did, the 96 organisations, that when we reported back to the Department we said very clearly that whilst it is dangerous to generalise, we did have a body of evidence that suggested that the quality of finance management, financial control and reporting was of a lower standard than we would have expected from similar sized, similar complexity organisations in the private sector. It has become increasingly apparent to us as we have worked with organisations that there has been significant investment in service development and patient care over years but less investment in financial management and financial systems, which leads to a position where, if, for example, an organisation puts in place a cost improvement plan, they are not always able to measure whether that plan is being effective, whether it is generating recurrent savings and whether it is a reliable plan. Consequently CIPs fail many times. I also agree with Mr Ellis. We have found that when clinicians are given better, more understandable financial information which demonstrates why a particular process is leading to significant cost, they are often able then to identify different ways of working which lead to better patient care and a reduction in cost, but that depends on the quality of financial information that they consider to be sufficiently reliable and that often is not available now.

Q118 Jim Dowd: But your comparison is with similar organisations, or similar sized organisations outside the NHS, it is not between well-run and badly-run NHS organisations, is it?

Mr Davidson: I did not have the benefit of visiting many or indeed any organisations that were generating surpluses, so my population is fairly limited.

Q119 Jim Dowd: May I just say to Mr Sullivan and Mr Everett then on the question of competence and ability, that the Department maintains strongly that deficits, certainly continuing and repeated deficits, are largely the function of poor local management and some of the evidence we have heard this morning seems to support that. If that is the case, was the Department right in your view to introduce so many reforms, particularly amongst organisations that clearly were struggling to cope as it was?

Mr Sullivan: The organisations which are not struggling are managing to deliver surpluses and are managing with the reforms. There is an analogy that if you want to get something done you should ask someone who is busy. The organisations I am looking at are in deficit, some of those organisations are led by people who are very capable and my experience from outside, my independent experience, tells me I am dealing with quite good managers with quite good strong management skills. However, they are in a difficult situation and in some instances we have quite awkward positions with PCTs and trusts that have had a history of deficits, a new management team has been put in and they still have a hard job. It is not necessarily just the management team itself. Some of it is historic build-up of deficit and the attitude towards that and it takes time for this to take effect. I should echo the previous statement that we are not talking about things happening in a matter of weeks and months, it is going to take a year or so for some of these things to work their way through.

Mr Everett: I suppose I would say that whilst the number of initiatives is not helpful in terms of potential distraction, it is no excuse in terms of achieving a balanced budget. You can actually do both. It does make it more difficult, but I do not see why you cannot do both.

Q120 Jim Dowd: Are you saying that there was a lack of clarity in some quarters as to their primary purpose to maintain financial balance?

Mr Everett: In Kensington and Chelsea there was a complete financial breakdown in terms of the information that was being presented to the board. That has been rectified now, but for a long period of time the board was really flying blind without the information available to make decisions and there is still some way to go in terms of making sure that people at the front line actually have the information available to know how much things cost. The information that is going to the board now is reliable but there is not enough information going to the
people that are actually doing the job so that they can understand how much things are costing. That is something that is in train to be put in place.

Q121 Jim Dowd: Just generally to anyone and everyone, the deficits in the unaudited 2004–05 accounts significantly understated what the turnover actually was. Do you have any feeling as regards the 2005–06 position?

Mr Everett: Certainly in our case we are expecting the 2005–06 position to be that the information that was presented to the auditors will be the information that actually ends up being the result of the audit. We had a very large difference the year before, £7.1 million, between the information that was provided and the final audited numbers, which was the reason for the public interest report. This year the audit is still taking place but the initial indication is that the numbers that are being presented will be accepted.

Q122 Jim Dowd: May I just come back briefly to lack of clinical engagement and responsibility? In your estimation was that because of an unwillingness of the management to engage with clinicians or a belief which is more widespread amongst clinicians that their job is to deal with people and just send someone else the bill?

Mr Ellis: The finances of the National Health Service are complex and if people do not overtly engage with people who are not in finance, the chances are that they do not actually get engaged with at all. A good example was that I worked with the Southampton University Trust and one of the things we did was actually come up with a kind of project management unit trying to get the deficit in-year down and we had that run by the CEO, that is to say a non-finance person. That way he was able to have conversations in layman’s terms rather than finance terms with both the clinicians and the people leading the directorates. The medical director himself said at the board meeting that he was far more comfortable with that because he felt it was de-mystified, he felt he had as much chance of understanding the finance as the CEO, whereas if the finance guy was leading it, sometimes he felt that it would be just over-complicating it and it was not something he understood. Getting that level of engagement with the clinicians makes a huge difference. When you are trying to do a turnaround plan, you are completely reliant on those in the front line both coming up with the ideas and actually buying in and owning what you are trying to do and the success at Southampton last year in actually making quite significant savings largely came down to de-mystifying the finance and making everyone feel they are speaking the same language.

Q123 Chairman: Obviously you report what you are finding at some stage to the health service. Are you reporting anything in terms of how these deficits have come about? Mr Sullivan, you were saying earlier that some of the trusts you have been looking at have been in deficit for many, many years now. Is that a part and parcel of your report into the centre?

Mr Sullivan: Not exactly, but one of the things we are trying to do is establish exactly what the deficit is and where exactly it is. Is it £5.1 million, is it £5.2, £5.3 million whatever the actual sum is? We try to establish the real number, so when we start to look at the control total, we can actually nail that to the mast and say this is the number we want them to go for and to concentrate on and actually establish that it really is the right number.

Q124 Chairman: We assume, from what we hear and what we hear in Parliament, that the real reason why you are going in there is to look at the current situation and how that can be improved and addressed. Obviously you are finding that some of these deficits have been around for many years in some trusts and I just wonder whether there is any historic perspective that you are given that may give us some lessons learned beyond what we hear around this table at this stage.

Mr Davidson: When we carried out our baseline work, some of the quantitative and qualitative reporting to the Department related to the causes of deficits, for example, over-capacity in local areas. So some of those issues have been covered. Certainly the point of the base line was to establish a line after which improvements could be accurately measured. In the 13 organisations that we subsequently worked with, we do not directly report to the Department, but we arm the organisation with the ability to report.

Q125 Sandra Gidley: I should like to move on to the recovery plans or the turnaround plans. We have had a copy of one from Kensington and Chelsea, so I am sure you will say yours is excellent, but I just wondered how the rest of the witnesses would assess the quality of the recovery plans generally, bearing in mind that it is okay having a plan but how effectively are the plans actually being implemented? Are there any particular barriers which are getting in the way of implementation?

Mr Davidson: What we found when we looked at the recovery plans that were put in place for last financial year, which is what we reported on in the base line, was that in a number of organisations plans had been put together—and, by the way some plans had not been put together, Kensington and Chelsea being one of them at that time—that I would categorise as aspirational rather than deliverable. That is because the framework for measuring the success of any particular action had not been established properly, so nobody could tell whether it was actually working. The planning was not at a sufficiently detailed level such that individuals within the organisation knew what they had to do and how they were going to be measured and some of the very difficult decisions had not been made. In order to save cost, somewhere along the line somebody has to be paid less. Whether that is paying fewer people or whether it is paying less to suppliers, somebody had to be paid less. That decision is sometimes quite a difficult decision that was being avoided in a number of plans.
Q126 Sandra Gidley: You seem to be saying that one of the big problems seems to be a lack of monitoring structures within trusts. Was that a common theme?

Mr Davidson: In any turnaround, public sector or private sector, unless you can measure the consequences of the actions that are being taken to effect the turnaround, then the likelihood of those actions being delivered is significantly reduced. Because of the quality of the financial reporting systems, it was difficult, and still is in some organisations, to measure the effectiveness of actions and progress against those actions.

Mr Ellis: I agree with what Philip says. A number of organisations had top-down plans where finance departments had allocated savings to various areas of the trust and then assumed those areas of the trust would actually implement those types of savings. Unsurprisingly enough, whenever that happens, it does not work. The whole point of the plans now is for them to be bottom-up. So in the work that was done at St George’s, which was effectively done virtually a year ago now so that is one of the earlier turnaround plans, you can see some traction there. That was a bottom-up plan and the chief executive there had his top 100 clinicians sign up to that plan to say that they bought into it and agreed with it and they are now very much crusaders in terms of helping to make sure that the plan is actually implemented. That was a particularly good point of ownership which has made quite a big difference.

Several trusts’ plans now have that degree of ownership and everyone feels that it is their plan, it is not a plan that PWC has turned up, written for them and it then gathers dust on the shelf. It is very important that the trusts believe that is their turnaround plan and that nurses, clinicians and management have all been involved. That makes a huge difference. The successes of some of the ones which started last year, St George’s delivering £21 million savings, East and North Herts £8.8 million savings against the plans that they set themselves, is a good example of that. In terms of your second question on barriers, there is a huge amount of energy going into it and there are some very good early signs of it but, as the other gentlemen have said, it will take time. There is a capital cost and the recovery of that capital. You could probably say that their planning processes have not been at their best this year. I would say that the late agreement of service level agreements between PCTs and trusts is not helpful. There is a time constraint here and the capacity of these management teams to do this who have not done it before. Some of them need capital to institute the changes they want to carry out and there is a capital cost and the recovery of that capital. You see the whites of the eyes of the actual people who are going to deliver this, one, two or three levels down, it gives you as Turnaround Director the feel that people really are managing the process and they are accountable for their expenditure.

Q128 Sandra Gidley: Would you say there are any barriers or is it too early to say?

Mr Sullivan: I guess there probably are. I guess time is a barrier. There is a time constraint here and the capacity of these management teams to do this who have not done it before. Some of them need capital to institute the changes they want to carry out and there is a capital cost and the recovery of that capital. You see the whites of the eyes of the actual people who are going to deliver this, one, two or three levels down, it gives you as Turnaround Director the feel that people really are managing the process and they are accountable for their expenditure.

Mr Ellis: I know that the SHAs are monitoring that at three levels down, it gives you as Turnaround Director the feel that people really are managing the process and they are accountable for their expenditure.
savings. That is the critical thing and that is the phase we are at the moment: making sure that the plan is implemented.

Q129 Sandra Gidley: We have actually been sent a copy of your plan and it was nice to see something practical rather than well-sounding management-speak. There were certain concerns, for example, certain initiatives, non-acute commissioning, renegotiating all mental health contracts, £1.5 million savings identified; we are forever hearing in this House how mental health services are under-funded anyway. You also chose HIV, learning disability, old people and voluntary sector budgets. It seems to me that you are picking off easy targets here. My question to you and maybe for others to pick up on is: are these financial pressures forcing decisions which actually are not in the wider interests of the health service or health economy?

Mr Everett: 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.

Q130 Sandra Gidley: You say you are maintaining core services, but it seems to me that you have chosen the services to cut where there will be the least flack from the public. People do not come to us and complain about access to sexual health services for example and there is not a strong mental health lobby. Have you picked off the easy targets?

Mr Everett: No. All parts of the PCT have been looked at in detail and in the areas that you are talking about the Commission have been fully involved in the process and have identified the areas that we should look at. To take mental health as an example, our mental health expenditure over the past three years has gone up 30% by £9 million. In terms of looking at £1.5 million, when you put it in that context, we spend £40 million on mental health. In terms of the expenditure on mental health as a proportion per head of population, we are the tenth highest spender in the country. We are not looking at dismantling a mental health programme; we are looking at tinkering in areas where we think that efficiency savings can be made.

Q131 Sandra Gidley: Those sorts of phrases always frighten me and frighten most of the public. Obviously the rest of you do not have any specific examples that you are working with solely, but have you noticed anything similar in other trusts you have been working with?

Mr Ellis: There are some significant savings which can be made just by process improvement. In a number of trusts we have been involved in where they have made changes to length of stay, there has been no clinical change there, but if you actually change the rostering of the ward visits of doctors to earlier in the day and you change the prescriptions given to patients on discharge, those savings alone in, say, north-west London took one day off length of stay, which is the equivalent of about 90 beds and a saving of £3 million. There is no clinical impact in doing that, it is just doing things more efficiently. There are several examples like that, which is where a lot of the savings will come out.

Q132 Sandra Gidley: That is the advantage of involving clinicians presumably.

Mr Ellis: Yes, that is right. They are involved, they believe in it and there are several examples like that where clinicians and nurses say where the savings should be made and they work towards getting them in place.

Mr Sullivan: A typical saving across the PCTs I am dealing with is in prescribing generic drugs as opposed to specific branded drugs which are cheaper now they are out of their patent or whatever protection mechanism they have. It still provides the same level of service at a lower cost and there is no reason why it should not be done for organisations which are in deficit or in surplus frankly.

Mr Davidson: I can say that I have not observed in any of the organisations we have been working with a tendency to identify savings which are more publicity friendly. The complexity of identifying and implementing savings is such that organisations now have to go about it in a sufficiently detailed fashion that does not lend itself to that.

Q133 Dr Taylor: On the same sort of topic, I am amazed that you are finding savings in the prescription of generics. I thought that was something which had been tackled ages ago and that most PCTs had already got plans so that mostly generics were used. Have you found that is not the case?

Mr Sullivan: No, it is not.

Mr Everett: No. In Kensington and Chelsea the prescribing team have done an excellent job. We have a £17.5 million prescribing budget and out of that we have identified £300,000 that we can do; it is a very small percentage and it is really just focusing on one area which is the prescribing of statins and whether we can do that in a more effective way.

Q134 Dr Taylor: We have already been told that will save the whole National Health Service almost the whole amount we need to save.

Mr Everett: In terms of the statistics, in terms of our prescribing costs per head of population, we are one of the lowest PCTs in that area. I am just giving you my example. I do not know about the wider health community.

Q135 Dr Taylor: I did like Mr Sullivan’s comments that if the savings are made lower down the organisation, they are then going to have the least impact on staff and on patients presumably.

Mr Sullivan: They are going to get done, are they not? If you make the decision at the top of an organisation there is less chance of it getting done.

Q136 Dr Taylor: We have had publicity all over the country about job losses. With your recovery plans, what are the job losses you are looking at?
Mr Everett: In total we are looking to take roughly 100 positions out, of which 70 will be redundancies and 30 will be vacancies which were going to be recruited to which will not be now.

Q137 Dr Taylor: So you are doing a relatively small number compared with some of the others.

Mr Everett: We have about 800 people, so you are looking at 12% of the workforce.

Q138 Dr Taylor: By not replacing vacancies can you be confident that you are not going to affect quality?

Mr Everett: We have looked at basically redesigning the service. In our area we had teams working in the south and the north of the borough and projects being done in terms of how we can have unified teams working across the organisation to improve efficiency.

Q139 Dr Taylor: The nursing home you are actually closing was not a private one, was it, it was one that you ran?

Mr Everett: We use three main nursing homes: one is private, one we own and one we rent but manage. An independent study was done of the nursing homes in the area and the nursing home which is out for consultation for closure had the poorest rating in the independent review. Its capacity is something like 30 or 40 residents but was actually operating with only 13 residents in it. Not only was it extremely inefficient and costly, but, more importantly from a resident’s perspective, it was the worst of the three homes that we had.

Q140 Dr Taylor: Did you tell us that you had quite a high proportion of provider services compared with other PCTs?

Mr Everett: Yes, we do; we are unusual. We run two nursing homes at the moment, although it will be one, subject to consultation. We also have the St Charles site where we have a palliative care unit, a minor injuries unit and an inpatient bedded facility.

Q141 Dr Taylor: Is that one of the reasons for your high deficit?

Mr Everett: It is; definitely. Looking at the St Charles site alone and looking at alternative provision, there are potential savings there which are not built into the basic plan of between £5 million and £7 million each year. The site is costing us something like £10 million a year to run and there is very little activity on the site which belongs to Kensington and Chelsea.

Q142 Dr Taylor: So the encouraging message is that you can make most of these economies without actually affecting patients so much or quality of care.

Mr Everett: That is right. An awful lot of the savings are efficiency and removing excess capacity. I do not want to mislead you: there are elements of the 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. If you were looking at the plan as a whole, a big element of it is removing excess capacity and improving efficiency.

Q143 Dr Taylor: So you are getting rid of waste which should have been got rid of a long time ago.

Mr Everett: Yes, that is right.

Q144 Dr Taylor: Mr Sullivan, with your experience of a lot of groups can you say the same?

Mr Sullivan: Yes. For example, if you reduce the length of stay and you reduce the need to have X number of beds, then clearly you need fewer people to look after the large number of beds and you have a smaller number resulting so you need fewer people. Most organisations have a reasonable amount of churn of staff and therefore if you are going to reduce staff you can do it reasonably painlessly.

Q145 Sandra Gidley: Are there trusts which, despite their recovery plans, will not recover because the financial deficit is too large to have any hope of turning it round in the timescales involved? If you believe that is the case, what options are there for those bodies?

Mr Davidson: We believe, from the work that we did on the baseline exercise, that 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. Nevertheless, it might be appropriate at a local level or through a national decision for those organisations to continue in the shape and form and location that they are, in much the same way as a private group may look at its portfolio, decide that it wants a minimum level of return on assets from all of its subsidiaries but actually there are strategic reasons why a particular subsidiary can have a lower return because it has value in a particular location, servicing particular customers who could not otherwise be serviced. For example, an acute hospital in a relatively remote location, with a reducing population, with a substantial asset base which has been built up over the years, may not be able to reach financial balance, but there might be very good reasons why nationally or locally it is decided to keep that in place.

Mr Ellis: One of the advantages with the exercise involving ourselves and other firms is that we have independently assessed the turnaround plan and have said effectively what we think is achievable. If the real situation is where you can only get the process improvement so far, then at least people can stop saying keep trying and say independently that we think that is as far as they can go. That is of some comfort to medical teams who felt historically beaten up consistently because they cannot get the efficiency levels of other trusts. Often when you bring in independent people, you can get all the stakeholders to understand what the achievability is of that trust.

Mr Sullivan: As a Turnaround Director it is very important to realise what is actually deliverable. There is no point in hearing from somebody “Yes, I can deal with that” when clearly they cannot. If they have targets they really can deliver, have faith in the...
management team and do actually achieve the milestones which lead to that target or that control total, that is very helpful for them. If they continue to fall short, it is not very motivating for them. I am quite conscious of that with some of my organisations. I want them to get to that control total, I want them to achieve that and they will go on in the second year and third year to repay any deficit. If they fall at the first hurdle, that is not very helpful.

Sandra Gidley: Thank you very much; that sounds positive and we shall wait and see.

Q146 Dr Taylor: Are you optimistic that as a whole the NHS will get into balance by the end of this year? 

Mr Sullivan: I cannot comment about the NHS as a whole.

Q147 Dr Taylor: The bits you see.

Mr Sullivan: In the bits I see I am fairly confident in the management teams and that in the majority of cases what they say they can do they can do. I have a lot of confidence in some of the chief executives because I think they are excellent.

Q148 Dr Taylor: What about the gentlemen from outside the NHS? 

Mr Ellis: There has been significant progress as seen from the achievements of some of the trusts last year. There are still some big challenges ahead, so I think it is too early really to say as a whole when they will get there.

Q149 Dr Taylor: Do you think we shall remain with a mixture of those in surplus and those in deficit for quite some time? 

Mr Ellis: For the turnaround cases it will take two years. If “quite a long time” is two years, then yes, there will be trust in-year deficit over the next two years.

Q150 Dr Taylor: Do you have any view from the outside about the funding formula and whether that does tie in, whether you are above it or below it, with deficits?

Mr Ellis: I can only talk about the trusts I have seen. In all the trusts I have seen there have always been opportunities to make savings and to do things more efficiently. From the whole health economy, focusing on the trusts with deficits, it will be a benefit to those. I cannot say that I know enough about the funding formula generally.

Mr Davidson: I agree with the fundamental point. There is no single organisation with deficits that we have looked at that cannot make significant improvements in its deficits regardless of the national policies which are in place. Speaking personally, I am optimistic that over time the deficit nationally can be eliminated on the basis of what I have seen at the organisations we have worked with.

Q151 Dr Taylor: Do you think we shall be okay by the time the PCTs which are top-sliced are going to have to be repaid?

Mr Davidson: I would hesitate to put a specific timescale on it.

Q152 Chairman: Did any of you learn any lessons from the NHS itself? It did have a record in some parts of the NHS of running cost improvement programmes and really turning round the National Health Service without having to have the intervention from the outside. Any lessons learned there or was it just a matter of going in and dealing with the 30% which cannot manage budgets?

Mr Davidson: The non-financial targets and objectives which have been set within the NHS were in my view managed exceptionally well and to great effect. We could see lessons from the programme management which was involved in delivering that and it is that programme management which the part of the NHS which is now dealing with deficits has drawn some lessons from as well. Yes, there were some positives.

Chairman: May I thank you very much indeed. Apologies again for the lateness of the hour but, as you can imagine, this inquiry is a bit like Topsy and we have yet to bring in the third session this morning. Thank you very much for your attendance.

Witnesses: Mr David Law, Chief Executive, West Hertfordshire Hospitals NHS Trust, Mr Antony Sumara, Chief Executive, University Hospital of North Staffordshire NHS Trust, Mr Simon Pleydell, Chief Executive, South Tees Hospitals NHS Trust and Mr Andrew Kenworthy, Chief Executive, Kensington and Chelsea PCT, gave evidence.

Q153 Chairman: May I welcome you all here today? I do apologise for the lateness of the hour; we are running terribly over time at the moment. May I ask you for the sake of the record to introduce yourselves and the organisations you are from?

Mr Law: David Law, Chief Executive of West Hertfordshire Hospitals NHS Trust.

Mr Sumara: Antony Sumara, Chief Executive of University Hospital of North Staffordshire.

Mr Kenworthy: Andrew Kenworthy, Chief Executive of Kensington and Chelsea Primary Care Trust.

Mr Pleydell: Simon Pleydell, Chief Executive of South Tees Hospitals NHS Trust.

Chairman: Once again thank you very much for coming along. Sandra Gidley is going to start the questioning in this session.

Q154 Sandra Gidley: Why are the health economies in deficit predominantly in the south and east of the country? Are you in a position to answer that question?

Mr Law: There are several factors for us. We have a relatively healthy population which is why the capitation funding is lower than some other areas. What we see is higher than average expected presentation of patients, so, given the disease level,
we take standardised mortality ratios as an indicator of disease in the community. In the area that Mike represents, it is 10% below the national average. We should expect to see a low presentation and actually we see quite a high presentation, around the national average. That drives some of it. Sean Sullivan referred to some of the geographical factors earlier: the pull of London hospitals, the impact of resources going into London and the impact of staff going into London. There are several factors for us.

Mr Sumara: I am afraid I cannot answer that because I am from the north Midlands, so I am one of the exceptions I am afraid.

Mr Kenworthy: I have worked in the north of England and also in central London. One of the things I should say about the south is the level of expectation of accessibility to hospital care is probably far higher than it is in the north. When I worked in County Durham our patients would travel 70 miles to get to their nearest specialist hospital. That level of expectation in London would not be acceptable from a patient perspective. Equally one of the factors, particularly for London, is the expensive nature of the facilities we have, particularly primary care facilities. There is a difference between some of the quality and the expense and the ability of the primary care facilities, certainly in central London, due to the high cost relative to some of the primary care facilities we have had in the north of England. That means that perhaps in the north there is great scope for nurse-led clinics and for other services which keep people out of hospital as opposed to smaller primary care facilities which see them going to hospital.

Mr Pleydell: I come from the north-east and Middlesbrough and County Durham and Tees Valley, the previous SHA, always balanced its books so the issues I can share with you today are more institution-specific than about the whole healthcare economy. I shall do that when you want me to.

Q155 Sandra Gidley: My second question, about which there seemed to be a little bit of contention earlier, is why do you think the largest acute trusts are more likely to be those in deficit?

Mr Law: I do not think that is the case. If you look in the area where we are you could look to Addenbrookes, a very large institution with a very healthy financial position. For us the complexity of the organisation which has gone through three mergers in the last 12 years, runs services off four sites and has emergency services on two sites, is a significant factor.

Mr Sumara: I do not think there is any evidence of that. Ours is a very large acute hospital and probably the one area where it might have an impact is that we run tertiary services which are high cost and do not tend to generate the sort of recompense you might expect. Particularly where we have a trauma service with helicopters coming in all the time with patients we do not tend to get what I consider the appropriate recompense for that work effectively through the tariffs. There are issues around the margin like that but there is no evidence that there is any difference between large hospital deficits and small hospitals.

Q156 Sandra Gidley: May I just pick you up on the tertiary centre point for the moment. That is an argument which has been put to me by my local acute trust which is in deficit. Will those pressures mean that perverse decisions will be made around services offered?

Mr Sumara: Not yet, because we have to go through a process.

Q157 Sandra Gidley: Not yet?

Mr Sumara: There are issues around where it becomes very expensive to provide a tertiary service when you are in an urban area and it might be better for one place to provide it rather than separate places without inconveniencing the patient. That is where I am getting to.

Q158 Sandra Gidley: That one place is still going to receive a lower amount of money.

Mr Sumara: Not necessarily, because they can reduce their costs as a result of aggregating them all on one site. If I could give you an example which is not a perfect example, in the West Midlands you have four cardiac centres which do coronary artery bypass grafts and actually you could probably manage the activity of those four centres in three. Unfortunately we had a brand new cardiac centre built in an area close to us which is currently only about one third full in terms of activity. That is a cost on the Health Service. That was not their fault, it was because life changes. The fact that people can now put stents in your veins rather than you having to go through an operation means that activity dropped dramatically. Nevertheless it is quite a big cost on the service. Eventually we shall get to the point of looking at what is the best option for cardiac surgery. I happen to have a hospital which provides very good, very efficient cardiac services, so I am not too bothered about losing it, but overall there is an issue about tertiary services and the best place to have them.

Mr Pleydell: There is no doubt that the more specialist end does drive higher costs. If you talk to every university teaching hospital up and down the land they will say that to you and there is a balance and we have to look at PBR and how that is going to work because that is driven by average cost formulas which is a problem for us. In the institution where I work, if you take cardiac services, we are very efficient at surgery and more expensive on the interventional cardiology side. The two balance off and I am not that worried about it because it does balance. We are going to decide with our commissioners on a strategic basis where these services are most effectively and efficiently provided because there is an issue about numbers driving efficiency. The other thing I am sure your local chief executive will have said to you is that these institutions typically teach a lot of medical students, middle grade doctors, et cetera and that takes a lot of time. We are in the process at the moment of modernising medical careers, looking at run-through training for people to get to consultant grade faster and that is going to put a tax on those
teaching institutions in terms of senior medical time. We are very wary about the added costs of those kinds of initiatives.

Q159 Mike Penning: This is where I need to declare an interest as well because David Law is the chief executive of my hospital trust and the excellent Hemel Hempstead Hospital is one of the hospitals in his trust. Is the funding formula you are getting from central government fair? If it is not fair how much of an effect is that having on your deficit and the decisions you have to make on a day-to-day basis?

Mr Law: An interesting article has just come recently on some research by Chris Ham, which looks at the correlation between the deficits in PCTs and the characteristics of those PCTs. It is the more affluent and rural PCTs which have more of a problem. There probably is something which warrants some further investigation there. It is illuminating to have that piece of research. I am clear that the task for us is to manage within the resources available to us. We have to take measures which mean that we can deliver a good healthcare service within the budget available.

Q160 Mike Penning: Would you have to make the types of cuts you are making in the proposals you have put forward now, if you had a fairer formula? The House of Commons Library gave me some figures this morning: on last year’s figures you get £960 per head which is almost half of what you can get in some other PCTs.

Mr Law: The income is clearly a factor. The fact that we have four sites against a lower level of income is a factor for us as well, which is why we are putting forward proposals for reconfiguration of services. Whether the formula is entirely fair or not is a whole debate in itself and I am not sufficiently familiar with all the details of the formula. The principles are absolutely right, that those areas with greater experience of disease receive more money is quite appropriate. Clearly Chris Ham’s work will generate some further questions about the exact nature of the formula.

Mr Sumara: It is going to sound as though I am always the exception really. Stoke is a very deprived inner city area surrounded by two relatively affluent rural areas. The funding formulas, if you add them up and balance them out, because they are my four main PCTs, add up to very little distance from target so they are there or thereabouts in terms of what you might expect them to get as part of that formula. Interestingly, if you then look at the amount of money per head of population, they are between £1,400 and £1,600 per head which is considerably more than you are getting.

Q161 Mike Penning: He would love that; he would be over the moon with that.


Mr Sumara: Bear in mind that Stoke in particular has a very high deprivation score; however I am still in deficit. Having all the money has not meant that the hospital has benefited from that additional growth. Over the next two years those PCTs get considerable amounts of additional growth.

Q162 Mike Penning: We heard earlier on from chief executives and finance directors that it is all to do with management. Does that mean you are a bad manager? You have all that money and you are in deficit.

Mr Sumara: I do not have the money; it is those nasty PCT people who have it.

Q163 Mike Penning: You know the place I am coming from.

Mr Sumara: I am a bit like the corner shop; I just give them what they want.

Q164 Mike Penning: You must not pass the buck, you must come clean.

Mr Sumara: If you want an honest opinion, I think the money is there in terms of the system. I do think it is an issue of us making sure that we cut our cloth to fit. In the memorandum I produced for the Committee there are issues for our hospital in terms of the amount of money we spend as a hospital to do similar amounts of work any other hospital would do, that is our productivity measure. We are inefficient and unproductive in that sense and that is the area I need to tackle.

Q165 Mike Penning: West Herts has a predicted rollover deficit of about £460 million for this year.

Mr Law: The deficit is £28.3 million.

Q166 Mike Penning: Yes, but when you roll over.

Mr Law: £43 million accumulated deficit.

Q167 Mike Penning: What is your accumulated deficit?

Mr Sumara: It was £15 million last year plus whatever happens at the end of this year, which will be £22 million; that is the controlled total we have agreed. I have an underlying problem of £43 million, £17.5 million of which is about PCTs and taking out income and activity to address their deficit.

Mr Kenworthy: The funding formula is a very complex piece of work and whichever formula we have had to date there has always been controversy about whether it adequately reflects diversity or rurality. That is perhaps a piece of work which could be undertaken, but it always is going to be a really problematic process. From my perspective though, the additional resources going into the health service, into both primary care trusts and to NHS organisations, means that we need to be focused on moving our former deficit position because having a deficit with the level of additional resources going into the NHS is unacceptable in this current environment.

Mr Pleydell: We have a mix of PCTs very similar to Antony in terms of some inner urban PCTs in Middlesbrough which are gainers and we have
Hamilton/Richmond which is 900 square miles of rural northern England which is a loser. If I am really candid, I think you can spend too much time thinking about the injustice of some of this. I know what my job is and my job is to balance the books of the organisation so I can deliver quality care and that is what I am there to do. I shall follow the machinations of the funding formula and if people and academics can do work on it, then that would be interesting. Ultimately I think I know where our problems have come from and we are sorting them out.

Q168 Mike Penning: I hate to be rude, but I am not an academic, I am a member of the Committee who has asked you a question. Is the funding formula fair in your view?

Mr Pleydell: I do not know how to make that answer to you in an honest way.

Q169 Mike Penning: That is fine; okay. I should rather have that than go round in circles. Will the changes to the primary care trusts and amalgamations help or hinder the work you are trying to do to bring yourself back into balance?

Mr Law: From our point of view it will help in the medium term. There will be some disruption in the short term but in West Hertfordshire we have had four PCTs which are relatively small. They have struggled with the commissioning agenda and it is welcome that they will be able to focus resource and skills on commissioning the services that the population needs.

Q170 Mike Penning: But a regional SHA, which is what you are going to have...

Mr Law: A lot will depend on the performance management regime they put in place. Initial indications are that that will be a strong one, certainly in the sort of circumstances that we are in. They will probably give differential levels of attention to different organisations and on that basis I should expect probably to have more rather than less. Yes, they can function effectively as well.

Mr Sumara: Same answer really. I am probably quite significantly worried in the short term that we are not going to have new PCTs, new boards and new chief executive in place until later on this year. One of your previous witnesses mentioned this thing about continuity and memory which disappear when you get management of change happening. In the long term I think the changes are positive, because you will get more expertise, you will get more robust organisations and so on.

Mr Kenworthy: The focus for PCTs on the commissioning bodies will lead to significant improvements. PCTs have not managed their own community hospital services to the same level of rigour or efficiency as acute providers and the focus on commissioning and being very clear about what their role is will significantly help. I do not believe that size and structure of PCTs is something in itself which will bring significant benefits. As a relatively small primary care trust, we work with our colleagues to make sure that one organisation negotiates contracts with one acute provider and we are working across London to look at how we pool and provide shared services which would result in the same level of organisational efficiency as larger primary care trusts. There are different ways of achieving the same end. In terms of the larger SHA, that will be really positive because it will bring with it a far more robust bottom-line approach to performance management regime. I also think the new SHA has a really key role in terms of overarching strategy for the health community so that it can actually make sure that primary care trusts are key trusts, mental health trusts, and not seeing themselves as fiefdoms but actually working in the interests of patients to design new pathways to cut across primary, secondary and tertiary care.

Mr Pleydell: I can concur with all of my colleagues in terms of worrying about disruption. When you look at where patches are successful up and down the country a lot of that is based on good working relationships between acute trusts and primary care organisations. Some of that will be disrupted in the short term, some organisational memory may get lost and that is a concern. However, the objective of better strategic commissioning has to be welcomed by all hospital trusts because it is clear that we have not always benefited from that in the past. I want to know what the strategic views are of my local commissioners for the next three to five years and we have not always had that clarity. We cannot financially plan with the rigours of a foundation trust without understanding that. As far as bigger strategic health authorities are concerned, in the North East we have actually come back to the old northern region in terms of its boundaries and I have to say I welcome that because the North East has a collective identity. In terms of strategic planning where specialist services are going to be provided, I think that they will provide a real focus to plan and determine that over a strategic timescale, which has to be welcomed.

Mr Law: May I add one other thing which is a distinct benefit coming out of the change process, which is that it is putting consultants and GPs much closer together in terms of their dialogue around the provision of services. We are seeing that very substantially in our area and that is to be welcomed. Patients want continuity of care when they go from primary care to secondary care and back and it is through that clinical dialogue that you can really enhance that continuity.

Mike Penning: That has to be balanced with a loss of local accountability by getting rid of the PCTs which were designed to have local accountability for an infrastructure in a local area. That is in our previous report.

Q171 Chairman: What have been the main local challenges which have contributed to the difficulties you have faced and how have you handled them?

Mr Pleydell: Whenever you look at the diagnosis of the problems, there is always a combination of national and local environmental factors which in coming together produce the problems you have. If you look at my trust, in 2003 we did commission a
new PFI building at the James Cook University Hospital, a £150 million development, and closed two other hospitals. The Friarage at Northallerton, into the trust. A merger is something which is a disruptive feature in any organisation’s life and it contributed to what we now see, looking back, as a loss of real control over our financial position. The second element to that was a major growth, particularly in emergency activity. In 2004–05 and 2003–04 we saw an average of 8% growth in emergency activity and therefore, in order to do the elective target, we have to subcontract a lot of our elective activity either into the private sector or ask consultants to do extra work at weekends or in the evenings. When I arrived in 2003, the annual bill for that was around £6 million. In terms of delivering those targets you can see people building up a head of cost which was over and above our normal unit cost for doing the work we needed to do. The final issue for us was that there was some debate and I left this, because I did not see we would be able to resolve it, about whether or not we were traditionally under-funded by our primary care commissioners. What has happened though with the advent of PBR is that in the first stage of PBR we gained £2 million and this year we have gained £11 million in terms of our overall position. When you put all those together, what you see is a picture of an organisation which was challenged in terms of its financial control over that period, which was struggling to meet the targets and incurring extra costs to do that and was having an internal debate and therefore not aligning itself with the true task, which was reducing its costs in terms, debating about whether their position was under-funded or whether it was down to them. My task as the chief executive arriving in 2003 was to make sure that people recognised that our destiny was in our own hands. That is where we were. We started in 2005–06 with a £56 million problem, £26 million historic debt and £35 million recurring problem and we saved £35 million last year.

Mr Kenworthy: When I came into post recently I came in on the back of a description of failure of both corporate and financial governance. The main priorities for me, certainly in the short term, have been establishing robust financial and corporate management systems. Also I think we need to be far more on top of matching changing needs in the health community and realigning our services far more quickly to those changing needs. For example, we had a community hospital which had a 135-bed capacity, which had services relating to 12 or 13 patients. The nursing home which is referred to in our consultation document has a 74% vacancy rate. To operate an astringent business environment we have to be able to tackle levels of efficiency whilst recognising that people are looking for alternatives to those ways of provision. My major concern is actually that I am really proud of the services we provide. I am really proud of the fact that nobody in Kensington and Chelsea waits over six months for inpatient treatment; we achieve our cancer targets; waiting times for A&E are significantly lower; we have 100% access into primary care. These are things we should be celebrating in terms of our community, in terms of our health provision. I feel for our workforce, because the only thing our workforce see in terms of the excellent work they do on a day-to-day basis is a lot of coverage about the financial position. One of the things I really want to do is to get ourselves back to a position of financial stability so that we can begin to talk about the excellent provision we have in the NHS in Kensington and Chelsea rather than re-runs about how we are going to move to a more financially stable position. Mr Sumara: This is the second time I have been asked to go to help support a failing organisation. I remember one of your questions to previous witnesses was about the key themes for organisations in turnaround. You heard some of them, but they are exactly the same in the two organisations I have worked in. The one which has already been mentioned was about a failure of corporate governance. If anything, one of the things we could think about as a health service is how we support that non-executive side of boards to be better at the sort of corporate governance bit. That has been addressed, particularly through the foundation trust diagnostic stuff which was talked about earlier. It was the same in the other organisation I went to, it was the same in this one and the public interest report mentioned that. The second typical theme is what I call a strategic misfit. This is not an individual, but it is about relationships between the acute hospital and the PCTs, where actually the one organisation is talking about downsizing activity and the other organisation is going hell-for-leather to increase it. Both these organisations were exactly the same in that way: the acute trust was developing, the PCT was trying to think of a way to try to shrink them and there was not a good enough relationship between the two to resolve that issue. Certainly as part of that there is this thing about over-trading. Part of the reason that the hospital I am working at currently has a significant debt is because they were covering up previous debts by overtrading, in other words doing lots of activity which was there to meet waiting list targets or whatever as a one-off and they are not there again. A third theme is this stuff around not having the rigour to address cost improvements in a way that are recurring. I think you have heard from the turnaround people that lots of people had cost improvement plans, quite often they were dealt with non-recurrently and in some cases they were not real plans at all. In those two organisations exactly the same thing happened: these things just popped out of the woodwork in the final year. There are the national issues which we talked about earlier and
there is this issue about very clear, good rigour around financial control and systems. A theme which has come out is this stuff about whether it is management, financial control or whatever. That is certainly something which comes out strongly because in both those organisations there was not the sense that there was a grip of what was being spent and how much it cost and how you measure that, what your manpower figures are and what your productivity levels are and all that sort of thing. It was not transparent. The last thing I should say in terms of the local bit for us is that there are issues about split sites, there are issues about estates, about infrastructure. I have two hospitals separated by a fairly large road so you could not really call them split sites but one has the most appalling accommodation that I have seen in terms of the age, the functionality and so on and desperately needs a capital solution to enable the doctors, nurses and other people in there to do a better job. I do not know whether that is true of other organisations in failure, because certainly the one where I worked previously did not have that issue particularly but this one does. Those are the sorts of particular themes you think about when you go to those organisations but they are local, they are not national; they are things which we need to get a grip of, not things which have to be dealt with nationally.

**Mr Law:** I shall reiterate some of the things my colleagues have put forward. I found myself needing to do two things: one was to stabilise an organisation and refocus on clinical performance and the other was to start to build capacity in the organisation, where there had been instability for very many years. In terms of stabilising, I came in at a time when there had been a breakdown in relationships with PCTs and the SHA. The internal relationships were not strong either; clinicians felt disengaged. There was a lot of work to do and we focused that on the delivery of services. We looked at our emergency care performance, we looked at our cancer management, we looked at our waiting times for patients and we are delivering on all those targets now. That seemed a basic thing which we needed to get right in the first instance. Whilst that was going on, I have been trying to build a platform to stabilise the organisation and move forward. There is only one executive director in post now who was there when I took up the role. We have a new chairman and we have three new non-executive directors. The organisation has been heavily criticised for its corporate governance arrangements which is why we are making some of those changes. The instability we have referred to during the course of the morning was a substantial feature of West Hertfordshire. There was also a history of deficit which went back 15 or more years and it had become the norm, so there was an attitude issue, working to get people to recognition that they need to deliver a number of things: one is quality of care, one is the performance standards required of the NHS and the other is good value for money. It is not a choice between those three, it is how you do all of those things. That is the message I seek to get across all the time for staff in the organisation: that it is not an either/or, it is the job and that is what makes it quite difficult at times.

**Q172 Chairman:** One of you mentioned PFI as being potentially one of the reasons you are in that position, but have any of the other three of you had PFI projects in the trusts you represent?

**Mr Sumara:** Hopefully my PFI is almost concluded so within the next few weeks I shall be delighted when colleagues round here and everybody else announce that Stoke is going to get its new hospital.

**Mr Law:** We desperately need one. One of the consequences of financial problems over a long period is that you under-invest in the estate and the kit and that is the case in West Hertfordshire. That impacts on staff morale and confidence: if you cannot find a pump when you need one, if the anaesthetic machines are old and a bit liable to be temperamental, those things are debilitating for individuals and for the organisation and that is the situation we find ourselves in. We need investment in West Hertfordshire in order to deliver really good services. We have a business case going forward, but we are clear that financial balance is a prerequisite of being able to proceed with that.

**Q173 Chairman:** It is a lack of PFI or a lack of capital. What you are saying is that investment is what is needed.

**Mr Law:** Yes, a lack of capital is a really big problem.

**Q174 Chairman:** What about the independent sector treatment centres? We hear a lot, but how do they impact on your financial plans?

**Mr Pleydell:** We do not have one in our area. We have some private hospitals which compete with us for activity, but in terms of PCT commissioning this year, they have brought a lot of that back to us to help us in terms of our financial position.

**Mr Kenworthy:** In terms of commissioning, the choices need to be determined predominantly by the patients.

**Q175 Chairman:** It is the financial planning side we are interested in; whether it has a positive or a negative impact as far as your particular trusts are concerned.

**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, we shall second our staff into the organisation and there are risks associated with that. We are negotiating sub-contracts at the moment for provision of services and there may be some loss of services and some further impact on us as an organisation. There are substantial risks. We are working hard to complete
Q176 Chairman: Have you had discussions with the SHA in relation to the implications of that?

Mr Law: We are starting to do that with the new SHA, Beds and Herts, on the basis of being able to accelerate the programme of change and obtain support and capital investment chosen to go with the private provider. We shall be talking that through with the new SHA.

Q177 Mike Penning: There is a much larger knock-on effect on the money, in the particular hospital we are talking about, in that whole parts of the hospital exist at the moment which are run, and run very efficiently, which will be surplus to requirements if the ISTC goes ahead and thus would almost certainly be sold off for development. When you look at the £1.5 million effect on you, have you looked at the other knock-on effects or whether you have excess capacity elsewhere within your Trust?

Mr Sumara: If I lose £1.5 million of income I have to take out the equivalent in cost, do I not? Whether I take it out of the area which is being disbanded or not we shall have to look at. The bottom line is that the more income I lose the more costs I have to take out. I cut my cloth to meet that. My only problem with ISTCs—and this might almost sound politically incorrect—is let us do it on a level playing field, patients' choice not contracts. I would quite like the contract Burton are getting for the activity they are getting in my hospital.

Q178 Mike Penning: The burden is not just on the amount of money it is going to cost you, not only in part of the estate which will become surplus and sold off, but actually the knock-on effect. Say for instance the consultant does not turn up at the ISTC centre, that burden falls on you; you have to supply the diagnostics, et cetera, which actually increases the cost to you while there is an ISTC sitting there, completely independent, from the independent sector. Have you done an analysis of that cost or whether you could actually absorb that?

Mr Law: That is what we are doing at the moment. We shall complete that by 31 July and shall then really appreciate the full impact. You are right that the turnaround times for things like diagnostics, the key performance indicators, exceed what we do currently, so essentially, unless we can change the process substantially to improve performance, there would be some costs to us as a consequence of that.

Q179 Mike Penning: Just to reiterate, because we have not looked at this before, all the facilities you have, which the ISTC is coming to replace, will then become surplus to requirements on two different sites and are then lost to the NHS.

Mr Law: We shall have some redundant estate. We have a good facility in St Albans with five theatres and beds that will become redundant.

Q180 Sandra Gidley: May I pick up on something Antony Sumara said? If PCTs are being encouraged to transfer activity to the ISTCs then you picked up on the point I was going to make which was about patient choice. What if patients do not choose to use the ISTCs? Who is going to win and are they not paid up front anyway?

Mr Sumara: Ask the policy people that question, because I do not understand it either.

Mr Law: There is a guaranteed income for the private sector.

Q181 Sandra Gidley: Why should there be?

Mr Law: That is the policy decision.

Q182 Chairman: We are dealing with that in our inquiry and having our last session next Wednesday. Under normal circumstances it is expected that any deficit in one year will be deducted from income in the following year. We have been told that the NAO and the Audit Commission have suggested that some SHAs have applied different forms of resource accounting and budgeted in different ways. Has this applied to any of you in your particular SHA areas?

Mr Sumara: It is what happens anyway. How you deal with it in each SHA is a different matter. It is something called a RAB adjustor—for the life of me I cannot remember what RAB stands for; Resource Allocation something. If I overspend by £10 million this year and I have a budget of £100 million, I start off with £90 million next year, which is almost like a double-whammy because I still have the £10 million problem.

Q183 Chairman: I think it was called a double deficit.

Mr Sumara: In our particular case, because we have this bank-type process, that money is being dealt with as a loan and therefore we do not lose it in that following year and we just pay the interest on that loan back to the health authority. There is less of an impact in that sense and that is quite useful.

Q184 Chairman: Any other differences?

Mr Law: Beds and Herts is covering the income for us, so we shall not have the income loss, otherwise we would have lost £28.3 million as well as having the financial problem. We refer to it as a double-whammy as well, but it creates quite a strong incentive to get out of financial problems.

Mr Pleydell: It is the same position for us because the whole patch is balanced; therefore they are managing that through the patch rather than giving us that specific target.

Mr Kenworthy: Our position is very much as described by Antony.

Q185 Dr Taylor: We have talked a bit about national pressures, but which have been the main national pressures which have made difficulties for each of you?

Mr Law: Two spring to mind immediately; the workforce contracts have created some additional costs for us and clearly we have to manage that, but it goes back to the lack of stability in the organisation. It is less easy in a less stable
organisation to deal with those sorts of issues, hence we probably have more of a problem than some other areas. The level of costs in a number of other areas has been higher than the inflation allowance so the generic cost pressures have been quite significant for us as an organisation. Those would be a couple which I should draw out.

Q186 Dr Taylor: The first group of people we talked to felt that they coped with them by training and managing the workforce much better. Is that fair? Some of them had training in project management.

Mr Law: Tight management arrangements, tight financial controls play a significant part.

Q187 Dr Taylor: In your Trust had you limited the consultant's contract?

Mr Law: We have a maximum of 12; we have an average of under 12, 11½ and have set the objective that we get back to 10 for our consultants.

Mr Sumara: Exactly the same. 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. I heard this earlier; we have done nothing less than others did. It is a maximum of 12 and ours is on average about 11.4 PAs. Part of the issue and the difference in terms of a higher cost is that proportionately we have a much higher ratio of consultants to activity than other organisations we have so that would be an extra cost. There are more of them so you pay them more and get more PAs.

Q188 Dr Taylor: Is that something you are going to try to reduce if you have a greater ratio than other people?

Mr Sumara: Partly; certainly we are trying to reduce a great proportion of people generally. The bottom line is that our doctors, but clinicians generally, are the people who produce the quality at the end of day and we want to try to maintain those levels at their highest point. They are our means of production, for want of a better phrase, so I am not minded to go out and sack half our consultants because that would not be the right thing to do for the future. Certainly reducing the number of PAs is important as part of that.

Q189 Dr Taylor: What about the GP contract and out-of-hours? How have you coped with that?

Mr Kenworthy: Certainly in terms of out-of-hours we have coped very effectively and we have managed to keep great continuity. The GP contract is a really positive thing because it clearly identifies and links activity in primary care to increased clinical outcomes and the linkage between resource and clinical outcomes is a really positive one. It has brought additional cost pressures onto the primary care trust. The other major driver is around the focus and quite appropriate focus upon improving access to all levels of service in the health service and I should include waiting times but also the cancer targets within that as being a major driver of additional cost pressures and expenditure for primary care trusts.

Mr Pleydell: Workforce cost pressures were a significant issue for us. Somewhere in the region of £3 million was unfunded in terms of the cost of the consultant contract. We did not actually limit to 12 PAs. There is an interesting argument about numbers of PAs being a sign of efficiency. You can reduce your average numbers of PAs for your consultant body just by employing more consultants, which is not the most efficient way of taking things forward. In some very specialist services we have consultants who do more than 12 PAs. We are trying to reduce that at the moment for their work-life balance more than anything else. What we are really focusing on is the productivity of the clinical PAs which are within all consultants’ job plans. We got ourselves externally reviewed by our auditors to check our efficiency there and we looked pretty good in terms of our overall clinical efficiency. That was a big issue for us. One of the things about the history of this is that the consultant contract came at a time when we were trying to start to turn the organisation around and it was an extra cost which we then had to deal with which slowed our recovery down and that was a lesson we then had to learn from that.

Q190 Dr Taylor: May I just clear up a confusion which I have—I do not know whether other people have—and that is the difference between the unaudited end-of-year deficits and the cumulative deficits. For instance South Tees, your end-of-year deficit is roughly £21 million.

Mr Pleydell: Yes.

Q191 Dr Taylor: You mentioned a cumulative deficit of £35 million.

Mr Pleydell: We started at the beginning of 2005–06 with a £56 million problem: £21 million was inherited from the previous year; our recurring deficit was £35 million; we saved £25 million recurring and £10 million non-recurring to deal with that £35 million, so in essence we had taken out of the year the deficit that we had brought into it. Does that make any sense to you?

Q192 Dr Taylor: You are losing me fast.

Mr Pleydell: It is £21 million, but last year by April, on a month-on-month basis, the money coming into the trust equalled the money going out of the trust. We were on a monthly balance position, but what we had not addressed, which is why we are still a turnaround trust, the historic deficit which was £21 million which we brought into that year.

Q193 Mike Penning: It comes off the following year.

Mr Pleydell: Yes. It is the historic deficit. We are now in balance in terms of income and expenditure, with the exception of the historic deficit which is £21 million. Our target this year is to get an agreement with the primary care trust about how we in essence write off a one-off cost and get a one-off cost sorted out. These historic deficits are very critical to understanding a trust’s overall financial
position. Month-on-month I am now in balance. If I look at my budget statements for month two, we are actually balanced.

Q194 Dr Taylor: I am only looking for two figures: your end-of-year £21 million.
Mr Pleydell: This is the historic deficit.

Q195 Dr Taylor: That is your total deficit at the moment.
Mr Pleydell: Yes, it is the total deficit.

Q196 Dr Taylor: You have no other deficit.
Mr Pleydell: No and in terms of income and expenditure we are running on an even keel now.

Q197 Dr Taylor: That is your total deficit.
Mr Pleydell: Yes.

Q198 Dr Taylor: Can I do each one of you with the same thing? Mr Kenworthy: £22 million.
Mr Kenworthy: Our historic deficit is £26 million; we need to make £10 million this financial year in order to match income and expenditure but £7.6 million of that £21 million is related to the 3% top-slice.
Mr Sumara: £15 million non-recurring and £43 million underlying recurring deficit.

Q199 Dr Taylor: That is still there.
Mr Sumara: We spend roughly £3.5 million a month more than we get in income.

Q200 Dr Taylor: So £15 million at the end of this year but £43 million still to find somehow.
Mr Sumara: The £15 million is non-recurring. I wish I were in Simon’s position. If someone gave him £21 million his organisation would be balanced. If somebody gave me my £15 million, I would still have £43 million recurring deficit every single year unless I address that.

Q201 Dr Taylor: That is the figure I was trying to get at.
Mr Law: Our outturn last year was £28.3 million. Our accumulated position is £43 million.

Q202 Dr Taylor: So you also have a £43 million accumulated, but you have got rid of yours, which is amazing.
Mr Pleydell: Yes, through savings programmes last year.

Q203 Dr Taylor: And yours is not that much.
Mr Kenworthy: Relative to the size of organisation it is quite substantial.

Q204 Mr Amess: Gentlemen, I have sat here very patiently for three hours 15 minutes listening to a combination of hard evidence and waffle. I was certainly concerned about the evidence from the Southend chap and he had had his fingers taped up because he was not allowed to say too much and what is going to happen to his surplus? Given that we move in an area where no-one is to blame for anything, least of all the Government, all I want to know from you four chaps is while you are sorting out this mess—because it is a mess—can you tell the Committee whether patient care, given normal demands—forget whether it is south, east, Midlands, all the rest of it—is in any way going to suffer?
Mr Pleydell: Our obvious intention at board level is that should not happen. The question as the chief executive is how you make sure that does not happen. Clearly through your governance systems, your clinical governance systems, there are several indicators which you continuously look at. There are some obvious indicators like patient satisfaction surveys, what the staff say to you.

Q205 Mr Amess: So your board’s intention is that patients will not suffer.
Mr Pleydell: Yes.

Q206 Mr Amess: Kensington and Chelsea?
Mr Kenworthy: We need to make £10.1 million savings this financial year. We are looking to ensure that the vast majority of that is increased productivity or better value for money. There will be a number of areas where we are reducing services and that will impact on patient care.

Q207 Mr Amess: That is very honest.
Mr Sumara: Our plan is that patient care does not suffer as a result of our plan.

Q208 Mike Penning: I cannot agree with what you have just said. You are going to lose around 750 jobs. You are going to sell off almost completely two hospital sites. You have an ISTC taking over facilities which you have admitted to this Committee you would like to keep and we need. You will have people transported for acute care something like 30 miles from St Albans all the way through Hemel Hempstead and through into Watford. The only reason you are doing this is because you are in such a huge deficit that you need the capital from the sale of the sites so they can be redeveloped. I am not blaming you personally; you know that. How can it be squared that clinical care is being put at the top of the excellence, when we have already heard earlier on from other people in this Committee that the most important target in the whole of the NHS is budget balance? We have heard that. You have massive cuts, enormous cuts, job losses, services being cut, people being transported all around the county. How is that benefiting the patients?

Mr Law: The same for us. In some areas we have sub-optimal services at the moment, a function of the distribution of services and under-investment. We think that in a number of areas we can improve the quality and consistency of care.
intensifiers and we shall not have disruption to trauma services with patients and the ambulance trust not being entirely clear whether they can take people. Another example would be in cardiology. It is quite reasonable to expect that if you go to an acute hospital now there is a cardiac cath lab on site. We heard about angioplasties increasingly being a front-line treatment for heart attack. We have a cath lab on one site and not on the other, so we cannot provide the sort of consistency of quality that we need by distributing. What we shall not do is have cath labs on both sites; we do not have the capital or the revenue to support that.

Q209 Mike Penning: I can tell this Committee where a lot of this loss has gone. You have a brand new birthing unit on the Hemel Hempstead site, a brand new cardiac unit, a brand new stroke unit, all of which are down to close, be knocked down and houses built there. How is that the best use of the taxpayers’ money if you are going to knock those down and then pray and hope some kind of miracle happens and you get a new hospital somewhere else in the county if you balance your books? Surely it just does not stack up.

Mr Law: We are not praying for a miracle.

Q210 Mike Penning: You need one.

Mr Law: We are working to ensure that we are in a position to support investment in West Hertfordshire. It is desperately needed.

Q211 Mike Penning: Why knock down a perfectly good hospital?

Mr Law: May I answer your question?

Q212 Mike Penning: No, I do not want the waffle, I want a perfectly straight answer. Why are you knocking down a perfectly good hospital on the pretence that you may get one under private sector funding?

Mr Law: Because we cannot deliver good quality services with the resources we have on two sites.

Q213 Mike Penning: So you are going to knock down the hospital before you have built another one.

Mr Law: We have looked at both Hemel and Watford as the place where we could consolidate services. We took that to overview and scrutiny and have MAU on one of our sites and up the road we have an A&E department and we have 19,000 inter-hospital transfers. This is patients who turn up at our A&E department, someone assesses them and then they go down to our MAU department and they get re-assessed and put into a bed and whatever. That is just bizarre. What a waste of money. Somebody is saying they are going to impact on patient care there, which I am, but I am going to make it better, because I am going to move the MAU up to A&E and we are going to make sure those patients go through one process. That is going to save money. There are other examples where in our hospitals patients stay on average longer than most other hospitals in the whole country, regardless of whether they are in the South East, the North East or wherever. Our lengths of stay are some of the worst in the whole country. All I am saying is that if you can get those lengths of stay down to the average in the country—we are not even looking to be the best in the world but down to the average in the country—we can take out something like 187 beds. That to me does not say we are going to impact on the quality of patient care. What that says to me is that we are going to take out some of this productivity gap. If we benchmark our staffing levels per patient episode, per patient spell, per theatre spell, whatever, they are massively over. What we are trying to say is let us get them down to a level where other organisations seem to be able to manage high quality patient care. My only worry is that the speed at which we are being asked to do this, which for a turnaround organisation is two years, is quite a hard task. The expectations we have on primary care trusts to take over some of that admission avoidance and delayed discharge work, in terms of trying to get the Ambulance Service to work in a different way, will take time. That is my only worry. The classic worry for me is that we could end up making something like 200 nurses redundant either in October this year or early next year and then in 18 months’ time the PCTs in our area will need to recruit nurses. What a bizarre system.
Q216 Charlotte Atkins: When the Secretary of State visited your hospital, she spoke particularly about the functional relationships between the hospital, the PCTs, but also partly talking about the dysfunctional relationship between management and clinicians. I met some BMA representatives from your hospital and they told me that you are the first chief executive who has met to engage with them; rather than saying that he was leaving, actually talking to them. In your experience of the past management or what you have heard about past management, was part of the problem that the management did not engage with the clinicians, the PCTs and the Ambulance Service? Do you believe that by engaging you can actually do something about turning round the problem you have inherited?

Mr Sumara: Yes. You have hit the nail on the head in terms of one of the other things I meant to mention. 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 actually and relations with other organisations. The whole bit about whether the organisation is open, whether senior managers are visible out there in the organisation, whether they communicate with social services, whether they have effective relations with PCTs, are actually important in terms of making sure they are successful. In North Staffordshire none of that existed. There was clinical engagement, but it was relatively closed, it was a few. Decisions were made in very closed groups. You have heard it several times here. 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 and there is a way out there.

Q217 Charlotte Atkins: Having said that, you have very significant staff cuts and inevitably when you have staff cuts of the scale you are talking about, you will lose some of your best staff and hold onto some of the people you would quite like to shift. How will that affect your overall efficiency, given that you have a very, very tight timeframe to get this sorted out?

Mr Sumara: It might happen, but these days, as part of our redundancy and vacancy management process, we have agreed with our trade unions and staff side that we can build a performance issue in there as one of the criteria. So we can judge redundancies based on whether that person is a productive member of the organisation, what the issues are around their performance and that is one of the criteria as to whether they are made redundant or not. I think that has been quite productive with the staff side getting that agreement so we can perhaps not do what you say and the better, more productive, more caring, more competent people leave, but perhaps use it to get rid of some of the people who are less so.

Q218 Charlotte Atkins: Mr Law, you have an equally large recurring deficit. Would you tell us what the impact of your staff cuts will be on your efficiency as an organisation?

Mr Law: We are looking to improve efficiency, although we are a reasonably good performer in terms of things like length of stay. We still know that we can improve in those areas. We have been working closely with clinical staff to reduce lengths of stay so we have set an objective for the organisation that we, against key performance indicators, are in the best 20% of performers across the country. The clinical staff are very on board with that. The efficiency needs to come first and then the reductions in staff come following those improvements in efficiency and performance. We have done a study of bed performance. We know that if we get to the best 20% of performers in the country we would need 91 fewer beds than we have currently. That is something which clinical staff are working on today. I know our orthopaedics are meeting today to go through the sorts of things they will need to do and also how to get good outcomes. We are doing a review which looks at clinical outcomes and how you ensure you get good outcomes whilst making changes.

Q219 Mike Penning: May I just clarify something? The changes you are referring to are basically closing parts of one of your largest hospitals and those changes are about 750 jobs. Correct?

Mr Law: The figure we have quoted is 520 associated with that. We lost a number of staff last year. In the light of commissioning changes and reductions in activity that the PCTs intend to manage, we shall see further reductions. Yes, it is around that figure.

Q220 Mike Penning: Around 750.

Mr Law: Yes.

Q221 Chairman: I think you heard some of the earlier discussions we were having about the effectiveness of the financial management arrangements inside the NHS and whether individual organisations are encouraged to report financial problems early enough to be able to avoid some of the problems you have to deal with. There is also this question of how much difference it makes if you change senior management to look at issues around financial health. Do you have any strong views in this particular area?

Mr Law: We have had a fairly damning report from our auditors around financial management which looked back in time. We have started to make changes. We have a paper going to our audit committee next week which will make investment in financial management in the organisation because we have recognised the weakness there. We do not have the information flowing regularly as we need. We do not have the controls in place. We have referred a number of times to six finance directors going through the organisation in six years. That does not lead to a stable well-developed finance department unfortunately.
**Mr Sumara:** There is evidence in our public interest report that says exactly the same, that poor financial systems, poor financial reporting, poor financial management all contributed to the problem. Your second question is difficult. I am bound to say, because I am new, that new senior management are great and make a big difference, but I am not sure it is as easy as that. You heard elsewhere that there are complex issues around. It is more about leadership than management.

**Mr Kenworthy:** We have a very specific issue and a difficulty in recruiting more junior levels of financial staff that provide the mainstream of financial departments. One of the major problems identified by the auditors is that our organisation is very heavily reliant on agency staff and that is predominantly an issue which is about the attractiveness of the salaries we can offer based in Kensington and Chelsea. The major area for me about financial management is making sure we have systems which give frontline staff and GPs information which enables them to understand the financial implications of their decisions. Once GPs and nurses understand the difference financially between being able to manage heart failure for patients using our specialist nurses in the community, who are more locally accessible, as opposed to admitting to hospital, you can see changes in clinical practice which are to the benefit of the patient.

**Mr Pleydell:** We similarly had a public interest report from our auditors which criticised our financial reporting systems especially. There was a tendency to use non-recurring money to cover up recurring issues in the past, particularly in the early part of this decade. We did change our finance director and that was an important step for us in terms of our recovery. I would just echo what everybody has said here this morning that the real significant achievement of all of this is about aligning clinical staff to the things you need to achieve and if you get their support, and the staff side organisations, senior clinicians and professional staff throughout the organisation, you are then on the road to recovery. 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. They understand now that financial control is a prerequisite to being able to focus on the quality of care we provide. They have said that they want to take the difficult medicine quickly and get it over and done with and get themselves back on an even keel. Those members of staff are the critical audience that we need to engage.

**Q222 Chairman:** Does the division of the NHS into provider and commissioning bodies encourage organisations to act in ways which may not be in the general interest of the wider health economy?

**Q225 Mike Penning:** I would ask you gentlemen to be brutally honest in answering the next question because we are going to talk about turnaround...
teams. How effective do you think the turnaround teams have been? Were they value for money? Could you have done the job equally well yourselves and spent the money better and more wisely?

Mr Law: 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 that we have talked about, 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.

Q226 Mike Penning: But you had outside auditors in before the turnaround teams came in which were paid for out of your own funds. Could they not have done the job for you?

Mr Law: We had PriceWaterhouseCoopers, paid for by the SHA, and that set the basis for us to bring in a turnaround director to the organisation who has really taken forward the areas of work which PWC identified in conjunction with the trust.

Q227 Mike Penning: He is sitting behind you, so you can be honest.

Mr Sumara: You said “brutally honest”. Value for money they have saved me more money that they have cost, put simply, quite considerably more money, particularly on the procurement end of the business, the non-pay end. 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 which we did not have in the organisation in the short term. However, I do think they are a short-term support not a long-term support.

Q228 Mike Penning: You could not have done it without them.

Mr Sumara: Probably not, actually. The real evidence of whether they have made a big impact is not there yet; it might come later on downstream because some of the things they have been dealing with for us over the last few months will not come to material—

Q229 Mike Penning: You were saying a minute ago that you were hoping your PFI would go ahead pretty soon. Have they assisted you with that PFI? I understood that PFIs could not go ahead if you were in deficit and you are massively in deficit.

Mr Sumara: No, as long as you have an agreed recovery plan in place which is actually signed off by your regional turnaround director and your health authority. Ours is working quite well.

Q230 Mike Penning: David is making notes next to you.

Mr Kenworthy: The turnaround director we appointed brings a level of expertise from other sectors, brings experience of turning organisations round in a different environment and brings a level of challenge and a level of drive to NHS organisations which is crucial in the turnaround process. The most important thing for me though is that the turnaround director led a team of people consisting of both managers and clinicians and worked carefully with them. Those skills are now transferred into the organisation and we have a really enthusiastic group of senior managers within the organisation who are absolutely committed to driving forward the turnaround plan. If you get people who have worked in the community for many years in an organisation or community pharmacists or hospital pharmacists, as is the case in Kensington and Chelsea, driving forward a lot of clinical changes and a lot of the changes to service we need, it comes across as having a genuine benefit for patients and also delivering far better patient care. They have been excellent value for money and there is a lot to learn in the NHS from a lot of the skills of our colleagues from the private sector.

Q231 Mike Penning: So you could not have done without them.

Mr Kenworthy: No.

Mr Pleydell: We already had our own project structure set up, we had our own programme manager and it was all built in-house. We did spend some time with PWC brainstorming some of the approaches and had lots of links with St George’s and other places about what they were doing, doing a lot of networking trying to make sure we were in line with best practice nationally. I think the health service should do more of that in terms of these processes. When we were visited by the turnaround team it was December and we were already achieving what we were achieving. They validated and gave us a good quality assurance that we were doing the things we had to do and they were content. Since then it has been a very light touch and they have basically left us alone to work through our historic issues with the PCT and the SHA. It has been a very light touch experience for us because we were already getting on with the job. You cannot save the money we saved in a year from December onwards. We started in April 2005.

Mike Penning: Let us hope they send in some light billing.

Q232 Chairman: Having these turnaround teams coming in and working alongside people who have been in the institutions, be it an acute trust or a primary trust, have they effectively brought on the workforce and have the workforce felt they have some local ownership on the project now as opposed to the recent past?

Mr Kenworthy: The organisational capacity that we have, all the skills and enthusiasm we have now within the organisation for turnaround and the important link between achieving financial stability as a mechanism of improving quality of service have significantly improved as a result of the turnaround process. One of the major elements and one of the major strengths of our particular turnaround process was that engagement with the wider group of staff within the NHS and within our health
community as a mechanism for driving that forward. I really do think we do have better ownership of the plan and we have better ownership of what we need to do in the future. It is a very, very challenging agenda.

Q233 Chairman: Notwithstanding the reasons why turnaround teams were sent into trusts, do you think that this has been a good thing, a better way of spreading best practice?

Mr Law: Our experience was that ideas were brought from other organisations so it did help; there was that cross-fertilisation which is always beneficial. For us there was an immediate short-term impact. It is down to us now to make sure that impact lasts and that we build on some of the benefits that they brought.

Mr Sumara: Anybody parachuted in does not deliver ownership in the organisation, that is leadership, that is my job, that is the organisation’s job; they do not do that. They do bring in bits of expertise and help in the short term in terms of supporting the organisation which has recognised it is in failure, which is quite helpful. At the very worst the turnaround team will tell you what you already know. In the middle point they will tell you what you know and actually put in systems to try to help to achieve what you know. If they are very good, they will add a bit of value and point out things you did not know and things they can help you prevent as well. I should say we are about in the middle.

Q234 Chairman: Did they help you talk to your own people more easily and differently from the way you did in the past because of their presence?

Mr Sumara: No, not for me.

Q235 Chairman: They do not open doors for you to approach leading clinicians to suggest they operate differently from the way they have done in the past.

Mr Sumara: They have access to advice which helps support you going in and doing that. They have no impact at all in that area as far as I am concerned.

Q236 Chairman: Simon, you talked earlier about national best practice and then we have this local ownership. How does the NHS do this? How do we get local ownership of national best practice?

Mr Pleydell: There are several organisations within the Department of Health which share best practice and clearly the director of finance needs to make sure that some of the principles of project management and recovery are disseminated. I have worked in the health service for 25 years, I know an awful lot of people and I think most chief executives worth their salt, when they have a problem, should be ringing round and finding out what best practice is. Sometimes though that has to be presented in a more structured way and I think the health service is working towards that.

Chairman: May I thank you all very much indeed and once again apologise for the lateness of the hour. Thank you very much; it has been a very, very useful session for us.
Thursday 20 July 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess  
Anne Milton
Charlotte Atkins  
Dr Doug Naysmith
Mr Ronnie Campbell  
Dr Howard Stoate
Sandra Gidley  
Dr Richard Taylor

In the absence of the Chairman, Dr Naysmith took the Chair.

Witness: Mr Ken Cunningham, Former Chief Executive, Surrey and Sussex Hospital Trust, gave evidence.

Q237 Dr Naysmith: Good morning, Mr Cunningham. Can we welcome you to the Committee? We have a few questions to ask but first can you identify yourself?

Mr Cunningham: I am a retired NHS Chief Executive. I retired after 37 years' service in February 2005.

Q238 Dr Naysmith: Thank you very much for coming. Can we start with the fact that all the minority trusts have large deficits currently. Does this not mean that the deficits are the fault of local management and, if not, can you tell us what the problem is?

Mr Cunningham: It is a complex problem, as the Audit Commission and the National Audit Office identified. Local management have a responsibility but it is important to remember that no Trust or organisation operates as an island. You operate as part of a health economy and certainly these deficits should not come as a surprise to a local manager and, indeed, in my situation that was not the case. We were aware of the scale of the deficit which could only be addressed through a health economy approach.

Q239 Dr Naysmith: You are very familiar with the deficit at Surrey and Sussex. Can you describe to us perhaps why you think that arose?

Mr Cunningham: When I went to Surrey and Sussex I was seconded there in June 2000 and it had an underlying deficit at that time. I was seconded there to try and see if there was a strategic way forward and, indeed, one was agreed. We agreed a strategic plan which involved interim funding and complete service changes. I think that most of these larger deficits need to be addressed through a reconfiguration of the services, a change in the way that services are delivered and, indeed, the location of the delivery of service and, in relation to Surrey and Sussex, we agreed a plan. That plan was put in place. Unfortunately the plan was delayed at an integral part which cost the Trust in opportunity costs substantial amounts of money, and the health economy itself did not recover from that in the short to medium term.

Q240 Dr Naysmith: I was not quite sure just to what extent you thought that local management could have done something about it before you were seconded?

Mr Cunningham: Well, before my secondment we had health authorities, not primary care trusts, and I would suggest that it is the supplier/manufacturer relationship, if you like. The health authorities and, indeed, the PCTs have an integral intimate relationship with the provider trust, and if they do not see that as a financial relationship then it will not work and I think that was the difficulty that we had—organisations competing to protect their own financial base at the expense of each other, and what you need from local management is a joined-up approach to the financial issues rather than just the operational issues.

Q241 Dr Naysmith: And at that time when the deficit was being incurred, were the local management getting any assistance from, say, the Strategic Health Authority (SHA)?

Mr Cunningham: There was not a SHA at that time; it was a regional health authority. They were getting some assistance but it was a bigger organisation in the region, that just one local health economy, and I would say it was not working. It was described to me as a very difficult position when I went there.

Q242 Dr Naysmith: So do you think the changes that have been implemented are enough to turn Surrey and Sussex around now?

Mr Cunningham: Personally I do not because I have always seen that health economy as needing a complete restructuring because I think it is simply overheating. We were not doing anything wrong; we were not treating people who did not need treating. It is a question of getting the modality of treatment and the location of care right, and of course there are difficulties about how and where the services are provided in that area, when you have a number of providers over a relatively small geographic area. The solution we came up with was to focus services in one single area, (hospital) and that was not popular with local population or, indeed, politicians, as I am sure you are aware.
Q243 Sandra Gidley: I wanted to ask what you meant by "health economy" approach. I think you have explained to a certain degree, but are you referring to the financial buck-passing that happens in lots of trusts and somebody needing to get a grip on that, or were you referring more to the reconfiguration of services which, as you appreciate, everybody thinks of as a reduction? I am not quite sure what you meant.

Mr Cunningham: It is both actually. The financial buck-passing, as you describe it, is a fact of life, and where you have primary care trusts that are providers and are in competition with the acute trust there is a natural tendency to make sure their services are protected at the expense of the other acute services in order to develop their services. I am not blaming them for that, it is a natural reaction, but you end up with competing services and developing services in primary care that do not necessarily substitute for the services and the acute services.

Q244 Sandra Gidley: But should not the SHA have an overview of that?

Mr Cunningham: Yes, I would agree.

Q245 Sandra Gidley: So why did they not? What went wrong?

Mr Cunningham: I do not know. We set up under my chairmanship a local health economy board to oversee these changes and, indeed, the SHA were present at that board and all the constituent trusts were part of that, and it is a matter of record that we did that, so everyone was signed up to what we were doing, but in the event not everyone delivered what they said they were going to deliver.

Q246 Sandra Gidley: Are you able to give an example of that?

Mr Cunningham: Well, an example would be that part of the arrangement was that there was substantial investment in community-based services to reduce the number of acute emergencies presenting at the hospital front door. In the event that did not happen; indeed we got the reverse effect, but the money had still been invested in primary care.

Q247 Sandra Gidley: It would be interesting to know a bit more about why that did not happen because we are being told all around the country that this is the way of the future, so anything you could say now might help.

Mr Cunningham: No one has told the patients or the GPs, because there are undoubtedly new services being developed in primary care and very good ones and they seem to be filling an unmet need, because 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 and there are more people presenting, and the statistics show that, at the A&E front door, so all these schemes that were put in place, certainly locally, where I was, did not have the effect they planned to have to allow me to take the resources out of the front line so I did not have to spend that money, and that was part of the problem.

Q248 Anne Milton: Good morning, Mr Cunningham. I should probably declare an interest because my husband used to work for you.

Mr Cunningham: Yes.

Q249 Anne Milton: Just for the tape, if you like, reconfiguration services, ie closing services on some sites—yes?

Mr Cunningham: Yes. Moving services from one site to the other.

Q250 Anne Milton: So what effect do you think government policies such as PCT reconfiguration, payment by results, et cetera, is going to have on provision of services at Surrey and Sussex?

Mr Cunningham: I can only speak of when I was in post when there was a multiple number of PCTs, we had four, sometimes five PCTs, negotiating with us for the services we provided, and naturally they wanted to protect their local boundaries, as it were, so it was very difficult for us to achieve the strategic changes that we wanted to achieve because of local influence and local factors. I think the amalgamation of primary care trusts into larger commissioning bodies will be a better, good thing in that it will stop this competition of providing services, and it will mean we can take a much more strategic view of how services should be provided, but where we had the four PCTs and one trust I did have to change and modify my approach several times depending on which particular primary care trust we were talking to, so it did cause a lot of issues and problems.

Q251 Anne Milton: The SHA has produced a document, and there will be effects on Surrey and Sussex creating an NHS fit for the future, which is clear and explicit, that in order to save money they will reduce services delivered at certain sites. I should think they would like to close a hospital down. You obviously had a bad experience of that and you talked about your plan being delayed. How do you think the NHS should manage what amounts to closure of hospitals in the face of huge public opposition?

Mr Cunningham: Well, it can only be done by facing the public and educating them. I am afraid to say, and I spent months with my medical staff going to public meetings and talking to members of the public, and I felt when I came out of those meetings that I had had a fair hearing. They did not always agree with me but I asked them to trust the doctors
Mr Cunningham: In my opinion, yes, and the reason I say that is because the accounting systems within trusts are not so sophisticated as to be able to identify the cost base of every procedure, so although the costs are being standardised by payment by results there is a fair degree of flexibility within the way these costs are aggregated at trust level. On top of that, there is the opportunity for what I would call coding gain, because all procedures that go through a hospital are coded by an international classification of disease, and it is a standard classification that is used. Now, the PBR payment is based on that coding. Coding is a forgotten and ignored specialty in hospitals—or at least it was for many years—and it has suddenly become extremely important because it is on that basis trusts will be paid, 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.

Q252 Anne Milton: And, because it is going on in my constituency, across that SHA area, when the clinicians stand up publicly and do not support the service changes, what would be your view of the likely outcome?

Mr Cunningham: I think you will get an awful lot of opposition. I know what I got in some cases! Even with the clinicians on board I still got quite a lot of problems.

Q253 Anne Milton: So in order for the Government policies to work, what you are saying is you need the management team, if you like, to first get on board clinicians and GPs, and then present to the public and re-educate the public as to what is needed to look after their health?

Mr Cunningham: I would say so. That was the approach I tried to take and it was muddied, as I am sure you are aware.

Q254 Anne Milton: One more question: do you think you had enough flexibility in your accounting processes to make the investments needed to cut costs in the long term?

Mr Cunningham: No. We would like to have taken other steps to reduce expenditure in the years before I retired. Some of that was publicly unacceptable, if you like, in the sense that we wanted to move services to where they were more efficient and more economic, but there was a commitment to providing services in far-flung locations—when I say “far-flung”, eight or nine miles away from the base—which caused us a problem, and that meant we were spending money on duplicating services and maintaining facilities that were uneconomic around the patch, and I was not in a position to be able to change that.

Q255 Dr Naysmith: Can I clarify something that you were saying earlier about payment by results? You are on record as saying that payment by results is a good thing but it is going to cause real problems for some bits of the National Health Service.

Mr Cunningham: In my opinion, yes, and the reason I say that is because the accounting systems within trusts are not so sophisticated as to be able to identify the cost base of every procedure, so although the costs are being standardised by payment by results there is a fair degree of flexibility within the way these costs are aggregated at trust level. On top of that, there is the opportunity for what I would call coding gain, because all procedures that go through a hospital are coded by an international classification of disease, and it is a standard classification that is used. Now, the PBR payment is based on that coding. Coding is a forgotten and ignored specialty in hospitals—or at least it was for many years—and it has suddenly become extremely important because it is on that basis trusts will be paid, 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.

Q256 Dr Stoate: Are you seriously suggesting that some trusts might artificially inflate the codes in order to get more money?

Mr Cunningham: No, I am not suggesting that people will artificially inflate them; I am saying that the way the codes are interpreted by coders can be—

Q257 Dr Stoate: What is the difference? If you are going to interpret the code in a way that favours the trust, is that not the same thing as artificially inflating the code?

Mr Cunningham: I think there is as much as opportunity for downcoding them as upcoding them, actually.

Q258 Dr Stoate: Which do you think is most likely to happen? Downgrading or upgrading?

Mr Cunningham: In my experience, which is a relatively short experience, of looking at it, it happens both ways. If I was fighting on behalf of the Commissioner I could downcode things, and if I was fighting on behalf of a trust I could probably upcode some, because I think there is an opportunity for going away from the coding. It is not that precise—not in every piece of coding but in a fair number of times that is what we found.

Q259 Dr Stoate: So you are not suggesting, then, that people are using codes as an opportunity to make money?
Mr Cunningham: No, I am not suggesting that. Obviously it could be done but that is not my experience. What I have seen suggests that coding is a relatively inaccurate science and there is an opportunity for undercoding as well as overcoding.

Q260 Mr Amess: Mr Cunningham, the Committee has got you as a witness this morning because we think you will be an interesting witness and a truthful witness, because we do from time to time have people come and give evidence who are spinning a yarn. Now, you have not got any advisers with you this morning, have you?

Mr Cunningham: No.

Q261 Mr Amess: And you are a picture of sartorial elegance. I want you to think for a moment that it is just you and I having a conversation together. Now, before I get to the cut of it all, you said you had worked for the service for 37 years, is that right?

Mr Cunningham: Yes.

Q262 Mr Amess: Now, did you want to retire? Were you, in effect, sacked? Were you pushed? What are the circumstances of your departure? Because you certainly do not look that old.

Mr Cunningham: Thank you! I felt my time at that particular trust was at an end and I needed to move on and let someone else take on that role. It was a very challenging role and, had another opportunity been available within the service, I might have been interested in looking at that.

Q263 Mr Amess: I knew you were a truthful witness. Thank you very much indeed for that answer. Now, what do you think the consequences of the deficits themselves would be and of the trust’s attempts to eradicate those deficits?

Mr Cunningham: Are you talking specifically about Surrey and Sussex, or generally?

Q264 Mr Amess: You can talk specifically about your own circumstances, or generalise?

Mr Cunningham: If I can generalise, then, where a trust has a deficit of, let’s say, more than 8% or 9%, getting up to 10%, which some of these trusts now have, which is partly a consequence of the new financial regimes in themselves, which I know you are aware of, then I would suggest that 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. I have no evidence, certainly not in my case, of there being extravagant expenditure within hospital trusts, certainly to that degree, and given 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. You can deliver 1% or 2% cost improvement and that is a very good discipline and one we have maintained for many years in the NHS and it does help drive efficiencies, but once you get above 3% or 4% it becomes a very tough regime, and I would suggest it is not deliverable, if you continue to deliver the same range and scale of services.

Q265 Mr Amess: Well, the Secretary of State has been very firm on this particular matter thus far so, given that you do not believe that these financial changes can be met, do you think there will be hospital closures? And are you aware of any hospitals in particular which you can see closing?

Mr Cunningham: I think the term “hospital closures” is probably right in the sense that most large trusts are a combination of a number of hospitals and, indeed, in my experience, I have been Chief Executive of two trusts and both had multiple sites, and the only way to provide a viable economic future for these trusts was to consolidate your fixed assets, to get yourself on to a single site, reduce your overheads and provide the service in the most economic way, and I would suggest that some of these multiple site trusts will have to look very hard at their capital base, and that is what I intended to do at Surrey and Sussex.

Q266 Mr Amess: Can you think of any particular hospitals that you feel may be under threat?

Mr Cunningham: I would not like to go into detail because it is such an emotive issue. I closed a small cottage hospital of 20 odd beds in Surrey in 2001 and I had seven hundred people at a public meeting in opposition to that closure and the hospital was overrun with vermin and it was not fit for purpose, to use a common term, and I had a difficult time closing a hospital that really was a disgrace and it was only 20 beds.

Q267 Mr Amess: You know, Mr Cunningham, that most members of Parliament do not leave unless they retire on a voluntary basis, and no member of Parliament who has any sense would support their hospital closing, and their constituents are very keen on the local hospital. Now, given that you feel that there are, and quite rightly you are not prepared to name them, a number of hospitals under threat, what would be your advice as to how these endangered hospitals may be protected?

Mr Cunningham: It depends what you mean by “protected”. I think you will have to decide what you need to provide at some of these sites, and I would suggest that the term “hospital” is a very loose term and conjures up an A&E department and surgery and various other things, and we need to re-educate the public about what should be provided locally and what is safe to be provided locally, and I think a great deal needs to be done in education of the public through the media of what is right. Let’s say you had a child who was very ill. I suggest you would be happy to take him to the best hospital available. If it was Great Ormond Street or whatever you would...
travel whatever distance to get the correct treatment. Why should it not be the same for an adult who has a very serious illness? We should take people to the best location where they can get the best and most specialist service and not expect it on every local hospital site, and we need to get that message across to the public about what can reasonably be provided locally and what “locally” means.

Q268 Mr Amess: But you and I know, Mr Cunningham, that no education through the media is likely to take place in the particular way you wish it to, so in reality how can these hospitals, which are under threat, be protected?

Mr Cunningham: They can only be protected by providing basic outpatient-type services and explaining that to the public and having the courage to do that. That is what I had. I had the courage to close a hospital when it needed closing and to remove services when they needed changing, and I think one of the key factors of management is having the courage to make these changes and see them through, and have the clinicians behind them and to face the media over these things and explain your actions. As public servants you have a duty to do that, and I would be happy to do it if I believed in what I was doing, and that is what we need to do.

Q269 Mr Amess: So your final message is that others should be as brave as you have been, and to hell with the consequences?

Mr Cunningham: It is not a question of “to hell with the consequences”. You should be proud of what you achieve. You need to make changes and improve healthcare, that is what we are there to do, and I made a number of changes, some of which were not popular, but I believe they were right and they had the backing of clinical staff to improve healthcare.

Q270 Charlotte Atkins: Given that the model of healthcare is changing from the acute sector to the primary care sector, is it not the case that in some circumstances it would make sense to either close beds or, on occasions, hospitals because we are trying to take healthcare nearer the patient?

Mr Cunningham: Yes.

Q271 Charlotte Atkins: So would you say that when you are talking about possible hospital closures, some of those could be due to the need to get care nearer the patient, and because we are going away from the overbedding of the acute sector into delivery at a local level?

Mr Cunningham: Absolutely. I am proud of the fact that I have closed probably hundreds of beds as a chief executive but in doing that we have increased care because we have increased day care and local care, and the public have a perception that beds equals hospitals, that beds are the currency of hospitals, and they are not. It is the outcomes that are important, as you know. That is what we have to educate people about, what can be delivered locally? Day care can be delivered locally, diagnostic procedures can be delivered locally, and that is the range of services we need to get locally, and take the beds out of the system, which is where the high cost is.

Dr Naysmith: Thank you very much, Mr Cunningham. You have been very helpful to the Committee.

Witnesses: Sir Ian Carruthers OBE, Acting Chief Executive of the NHS, Mr Richard Douglas, Director of Finance and Investment, Department of Health; Dr Bill Moyes, Executive Chairman, Monitor, gave evidence.

The Chairman resumed the Chair

Q272 Chairman: Good morning, gentlemen. Could I ask you to introduce yourselves?

Dr Moyes: I am Chairman of Monitor, which is the independent regulator of foundation trusts.

Sir Ian Caruthers: I am acting NHS Chief Executive.

Mr Douglas: I am Director of Finance Investment at the Department of Health.

Q273 Charlotte Atkins: Is it the case that the Government blames local deficits on local management?

Sir Ian Caruthers: It is not a question of who blames whom, and the real point is to ask the question why has the position arisen, because I do not see the Government blaming anyone and I do not feel that from my position. Why did it occur? The fact is that the Audit Commission produced their report and we would agree with their analysis because it corresponds very much with the Chief Executive’s report which Richard Douglas put an appendix in. Firstly, there is not any single cause as to why deficits have arisen; there is a multiplicity of reasons; there is not necessarily a relationship between deficits, their size and the resources allocated; there are issues that need to be addressed because they are concentrated in one in 10 organisations and, if you look at them over time they are the same organisations that cannot escape from their histories, quite often, and there are a lot of issues to learn about governance at board level, leadership, a lot of issues to do with the accountability system.
is about how we engage clinical staff and how we engage our decision-making processes, so the notion to say that there is one part to blame I think is too simplistic.

**Q274 Charlotte Atkins:** That may be fine for you to say that sitting where you are, but in a situation where a hospital is in major deficit, and the chief executive and the chair person are up for sacking because of the management, then, of course, it is an issue and inevitably people point fingers, do they not?

**Sir Ian Carruthers:** I have only happened to be sitting here for the last four months. My real life is being out there, where I have sat in what we would call a high-performing system, which incidentally was high-performing when it had the lowest degree of growth and was in the bottom 2% or 3% growers, and I have also had the challenge in the last year for seven months of sitting in a so-called challenge system with a deficit of £120 million, and all I can say from both experiences is that sacking people is not necessarily the answer because what we need to do is lead more, and what we need to do is put in solutions that will deliver the business. But I can understand how people feel very vulnerable in those situations, and I know from the experience I had in Hampshire that was an overwhelming feeling for many of the people when I went there. Needless to say they got to a position where they reduced that £120 million to £24 million in eight months, and no one was sacked.

**Q275 Charlotte Atkins:** I know that everyone is delighted to see you out there, particularly you saying that issues like poorly costed targets, bad accounting practice, things like Agenda for Change and so on, have really made a big difference to deficits?

**Sir Ian Carruthers:** I will answer the question in this way, and Richard may want to comment. It is a fact that Agenda for Change has cost more. It is a fact also that the consultant contract has cost more. It is a fact that the general practitioner contract cost more than we estimated.

**Q276 Charlotte Atkins:** Cost more than you estimated?

**Sir Ian Carruthers:** Yes. 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 Richard can give us the detailed figures, 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. Yes, there are pressures but there are also leadership, cultural and other sorts of issues that are entangled in them, so the notion it was the fault of that is not borne to be true: the Audit Commission says it is not either, but there is no doubt that they have added pressures.

**Q277 Charlotte Atkins:** The King’s Fund seems to think that something a bit more Machiavellian is going on here, and they suggest that the problem may appear to be localised but, in fact, somehow the Strategic Health Authorities are shifting deficits on to individual trusts so that it appears that everyone, or every trust, every PCT, has a deficit so therefore the fault can be attributed to poor local management. How do you respond to that?

**Sir Ian Carruthers:** I cannot speak for everyone, only from my own experience, but that would seem to be an entirely bizarre thing to do from where I am sitting because what you want is as many organisations to be in at least balance or better, but I will ask Richard to talk about that because what is behind it is the transparency of the accounting frameworks.

**Mr Douglas:** I think Ian is right, first of all, it would be bizarre to spread poor organisations’ deficits across and to blame local management; I could not see why anyone would do that. What we have more of in the past is people moving money round the system to cover underlying financial problems, and this is something we have discussed before at this Committee. We have increasingly year on year tried to tighten up the regime to prevent that happening. Now, I am not saying that money is never moved about the system now to disguise deficits; it is in some cases.

**Q278 Charlotte Atkins:** It is done at the moment and interest is paid on it. There is top slicing and so on, is there not?

**Mr Douglas:** The interest paid and the top slice of local reserves is slightly different than moving the money about, because in that case you are not disguising a deficit. The key thing to us in trying to stop the money moving about was to focus on where the financial problems are. If you took money off one place and gave it to another place without acknowledging that and without anyone seeing that movement then you would not address the problem, and that is what we have tried to clamp down on. The system of SHA reserves is designed to allow a SHA as a whole to deliver a balanced financial position but not by moving the money about. So it is not intended from that for money to be moved from a well performing financial organisation to a poorly performing one.

**Q279 Mr Campbell:** Dr Moyes, I have read your evidence which you gave to the Committee, and I am a bit struck by this and that and I would like you to explain it to the Committee. “National Health foundation trusts are delivering rapidly a strong financial performance”. Now, how does it happen that the trusts can produce these strong performances? These were all hospitals before they became foundations so they must have been all in the black, I suppose, so how does that square with what
you said there? Is there something special about these? Are they getting more money off the Government?

**Dr Moyes:** No, they are not getting more money off the Government. I think there is a number of explanations for why foundation trusts overall are doing slightly better than the NHS generally. One is they have been through an assessment process, and that is quite a thorough process, and it really does force the trusts to understand the type of problems they have, and to a large extent to try and sort them before they become foundation trusts, so we would take a little bit of comfort from that; we think that is a good process. We think that the monitoring system we run and the compliance system we run 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. So I think those are two reasons why foundation trusts overall are doing better, but I would not want to conceal the fact that some foundation trusts have had serious problems and we have had to intervene.

**Q280 Mr Campbell:** So we could not apply that criteria to all the hospitals? We could not put what you have put in place for each foundation hospital trust in place for the other ones where they are in debt? That would not work?

**Dr Moyes:** I think financially over time the intention is all hospitals will become foundation trusts so gradually this system will apply to them all.

**Q281 Mr Campbell:** Would it have anything to do with the fact, as you said earlier on in your conclusions, that a foundation hospital can borrow on the commercial market, therefore they would have to be performing strongly, because if they are not they would not be able to borrow the money? Nobody would trust them?

**Dr Moyes:** There is some truth in that. There is an incentive to perform strongly in that if they were weak and rated by us as performing weakly then they certainly cannot borrow. Their borrowing limits are tied to their performance. I think another aspect of it is that we do allow an element of deficit in foundation trusts as long as they have a plan, and we also challenge foundation trusts with problems very rigorously and very robustly, so I would not, like Ian, put my finger on any one factor; there is a huge number of factors that have generated this rather different performance.

**Q282 Mr Campbell:** So the organisations that are in debt are not applying at this moment for foundation trusts, as far as you are aware?

**Dr Moyes:** Generally that is true. There will be some organisations, I am sure, that will apply to the Secretary of State—
decisions and they are down to broadly priorities, the scale of the agenda, how people implement them, and how good their control systems are. I want to make that absolutely clear because if you read articles I have written I am very unpopular because it is a popular thing in public service to say: “Well, it is the money that is always the problem”, and the money just does not happen in isolation. It is a retrospective figure for what people have decided to do, so I think we should deal with that very clearly.

Q285 Anne Milton: If you are going to bring in a Marks & Spencers analogy I have to come in and say that that jumper is needed so you cannot walk out of the shop, ie the hip replacement is necessary so you do not have a choice about getting it. You have to follow that through.

Sir Ian Carruthers: Yes, but I go back to my earlier point, and the Audit Commission report we would agree with and it is in Richard’s report, that there is no relationship between deficit size and resources allocated, because I can take you to some areas where they have more percentage growth and more deficits than in others where they have less percentage growth and they go about their job differently. I am not arguing the case of need because I do not believe people spend things on things they do not genuinely feel are appropriate, but there are always different ways of doing it.

Q286 Anne Milton: So how could managers and you underestimate the cost of something that I think would have been quite straightforward?

Sir Ian Carruthers: Well, I did not underestimate them because I was not there at the time. In my present role I accept I have to accept accountability, but Mr Douglas will deal with it!

Mr Douglas: As someone who was there, the first thing about the pay contracts is we acknowledged in front of this Committee before that we did not get the numbers precisely right on the three major contracts.

Q287 Anne Milton: So do you need a turnaround team in with you, do you think?

Mr Douglas: I do not think a turnaround team is needed for the Department of Health because we got the numbers not quite right for the pay contracts. 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. They are subject to negotiation all the way through. We took advice; we drew on help from within the NHS; we used internal people for it; we checked the numbers out; at the end of the day they were not quite right on those three contracts. At the same time there are other areas where you have had offsetting savings, so on prescribing we saved significant amounts of money for re-negotiating the PPRS contract. That saving was not initially built into my assumptions at the last Spending Review. Again, as we have had some discussions with this Committee before, delivery of elected waiting time targets has taken less activity than we would have expected, saving some money on that, so that is offsetting savings as well. We do have to keep working on getting policy costing right and we have acknowledged ourselves, and I acknowledged in my last report, that we need to improve the process of the department and make it probably more transparent than before, because the easiest way of testing whether we have the policy costing right is to open it up to challenge from people, so the key change in how we approach policy costing will be opening up that policy costing to a lot more people allowing it to be challenged.

Q288 Sandra Gidley: I want to turn now to the accounts for 2004–05. There was a big variation between the mid-year forecast position and the actual end of year results, and the NAO Audit Commission’s report stated that they were concerned about the level of audit adjustments required during the 2004–05 audit. What was the problem with forecasting correctly?

Mr Douglas: In some senses this was worse than the problem with forecasting because the big change was from the month 12 figures, which should be the final draft accounts, so the movement was between the draft accounts that were produced at month 12 from us and then those accounts once they had been through the audit process. There were a number of things, as we have said in our written evidence to the Committee, that led to that change last year, two or three particularly big things. One was Agenda for Change and how people accounted for Agenda for Change: how much money essentially they provided for the cost of Agenda for Change. There was a specific technical issue around how people calculated prescribing creditors. Now, it sounds very arcane, and it is actually, but a process that had been used in one part of the country for a number of years, other parts of the country tried to replicate and at that point the auditors said: “No, that is not acceptable accounting practice”, so there were those couple of big things.

Q289 Sandra Gidley: Can you just clarify the prescribing problem, because I do not understand quite what you are getting at? Surely if there was something that was not good accounting practice it should have been picked up by the Department earlier, not allowed to extend to others?

Mr Douglas: You do not always know what the practice is. We have accounting guidance and when the accounts come back, if they have not been challenged by the auditors, our underlying assumption is that the way in which they had accounted for things was in line with our accounting policies. The prescribing creditors one was essentially people making a standard assumption
about how many weeks creditors they would have to pay for prescribing, and it was something that it appears had gone back probably to the old health authority accounts days, even before PCTs. A number of other places had just picked up on this practice and tried to introduce it and, quite rightly, it was overturned. What we have done as a result of what happened last year is, first of all, on the back of the changes in the summer, I was in touch immediately with all the health authority finance directors asking for explanations from every organisation in the country; we have gone out and put out through the NHS SHA finance directors the lessons learned last year, what went wrong and why this happened; I meet with the Audit Commission about once every two months just to keep track with them about whether there are any practices they are not happy with, and if there are any we then send out correcting guidance to the NHS. Last year was exceptional; there will always be some movements between the draft accounts and the final accounts, but last year’s was an exceptional difference.

Q290 Sandra Gidley: But they moved in all directions which was the worrying thing. It was not just a case of the deficits were worse in every trust when you had the final outturn, which seems to me to indicate that there is a lack of financial scrutiny, for want of a better word throughout the whole process. What is happening to improve that?

Mr Douglas: Well, you will always get, where you have 500 odd organisations, some movements between the draft accounts and the audited accounts. In a previous life I was director of the National Audit Office and used to audit the accounts of lots of bodies, and I regularly made changes between draft and final accounts because there are matters of accounting judgment where your auditor will take a different view than your board will have taken, and that type of thing will happen. 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. We have worked with Monitor putting together a new training scheme, effectively, for all finance directors that we will be introducing shortly. The diagnostic process that we put all the trusts through that I referred to is helping us to educate boards more in financial management, so there is a continuing process of training, development and education to improve financial management.

Q291 Sandra Gidley: So there will not be such a large amount of change this year then?

Mr Douglas: I do not expect it. I have spoken to the Audit Commission probably three or four times since the accounts closed this year, and they have not identified any systemic issues that would lead to this degree of change. I have asked all the health authority finance directors to contact me personally if they become aware of any. There are one or two organisations that I am aware of where there will be movements but not on this scale and not across the whole country in this way.

Q292 Sandra Gidley: How confident are you that the more opaque kinds of brokerage, for example, through adjustments to service level agreements, have been eliminated?

Mr Douglas: I think it is difficult to say that we have eliminated every element of financial fudge in the system. Everyone is aware of how they should account and how they should operate. The auditors are on to this as well as ourselves more than ever before. The introduction of PBR is making things like the SOAs far more transparent, and the options for moving money about in that way are reduced, but I could not say every element has been taken out of this. What is changing now, I believe, is there is more of an appetite for transparency within the NHS itself, so organisations themselves, I believe, want to be clear about their financial position as a way of identifying the problems they have to address.

Q293 Sandra Gidley: You mentioned transparency and appetite for greater transparency, and that is I think very much to be welcomed, but are there cultural issues within certain trusts that stand in the way of progress in that direction?

Mr Douglas: I think there have been cultural issues across the system in the past that stood in the way of that, and that is not blaming the NHS issue, it is across the system including the Department of Health, including the whole way the system operates. I think we have overcome those. There will be some organisations I am sure still amongst the large numbers that we have where they will not want to fully disclose their position. It is our job, then, through the performance management system we operate in the strategic health service to identify where those are and then to correct those problems, and it happens in both directions. Some people will disguise financial problems; others will disguise financial surpluses because the culture of the system has been if you have a surplus someone else will take it off you, so we are trying to work with both sides to get the problems brought out but also be clear where the surpluses are as well.

Q294 Dr Taylor: Because I have only just found the figures with your permission I want to go back and make a comment. When you were talking about the estimates of the cost of the contract, Mr Douglas, I think you said you had not got them precisely right. I have just found the figures we were given and the four contracts we were talking about, in fact, you got wrong by £2 billion. We sent these figures after a previous meeting many months ago to the Department for their comment and as far as I am aware we never got comment, so if we sent them again can we get your comment?
Dr Taylor: You can have my personal comment. The consultant contracts I would estimate were out by £90 million.

Mr Douglas: We have not reduced it and we have not found it in the department; it is surpluses within the NHS. If you add up all the deficits across the system, you will get the 1.277, and then, if you add up the surplus across the system, you would get the gross surplus number and take one from the other to get the net deficit. The money has come from a number of sources. Some have been the surpluses in individual primary care trusts and NHS trusts, some have been the surpluses within the strategic health authorities, and in my report there is a table that breaks down where the surpluses and deficits came from.

Mr Douglas: No. The figure for that would be in the region of £250 million; about £100 million on out of hours and about £150 million on over achievement against the QOF.

Mr Douglas: If a PCT was lodging it with the SHA, then it would not be part of the SHA's budget number.

Mr Douglas: No. I know we had no overrun at all on the pharmacy contract, so I do not know where that comes from.

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Mr Douglas: No. I know we had no overrun at all on the pharmacy contract, so I do not know where that comes from.
Q307 Dr Taylor: So, why have we seen letters from Strategic Health Authorities to their separate units saying there is no money in their training budgets for training, for example, healthcare assistants to become nurses?

Mr Douglas: I would not know the individual letters that you are referring to. Undoubtedly, there have been underspends on the training budget. As I say, those have been running for the last three years at between about 80 and 120 million each year.

Q308 Dr Taylor: So the answer to the parliamentary question I got about where the 765 million came from was the same sort of fudge that you have given us?

Mr Douglas: I do not think it was a fudge. What I have given you was not a fudge; it was explaining where the numbers actually were.

Q309 Dr Stoate: Mr Douglas, my background is as a humble GP and, therefore, I am used to running a health related business. In my business we get income, we get expenditure and we get profit. I used to think that accounting was a pretty straightforward business until I discovered Smirnoff, and that led me straight on to resource accounting and budgeting, which does appear to be a bit of a black art. To quote from your recent report, you have said that the impact of RAB is to exaggerate the overspend by £117 million. Do you agree that is right and how do you explain it?

Mr Douglas: It is like the Government equivalent of the Schleswig Holstein question, I think. It is very difficult. I will start at the very beginning with resource accounting and budgeting. The 117 million you refer to is, effectively, the impact of the overspend in 2004–05 on the allocations we then made for 2005–06, so we reduced the allocations for the year by the amount of the overspend. You will not get to an exact match because of the way foundations trusts work. The basic principles of how resource accounting and budgeting work that people refer to as creating a problem in the NHS is that the department is given a spending limit by Treasury split into two parts, a revenue spending limit and a capital spending limit. They both control the amount of money we spend, not the cash that actually goes out of the door, it is the actual expenditure that has been incurred, and we then get the cash that supports those two spending limits. If the department overspends on its revenue spending limit in one year, then that money is basically taken off us the following year, if we underspend it is given back to us, and we apply the same system to the NHS. The NHS last year (2005–06) had we overspent net by £500 million, we will have to take £500 million off NHS organisations’ allocations for this year.

Q310 Dr Stoate: You are, therefore, saying that this is the correct figure. In that case, do you accept that the RAB favoured the NHS by allowing overspends in previous years, because I have got some figures here from public finance which show some very interesting positions? For example, in 2001–02 the reported position was a £71 million surplus, and yet, without the RAB, it would have been a £41 million deficit. If we look, for example, in 2003–04 the recorded surplus was £73 million and yet, if you took the RAB out of it, it would have been a deficit of £23 million. So, my contention is that you have been using RAB to prop up the system and mask the real situation over the last four or five years so that it ends up making it look much worse than it really is now.

Mr Douglas: It has not been using RAB to do that. The public finance figures—. Let me use correct numbers.

Q311 Dr Stoate: These have been verified by the department, I am told.

Mr Douglas: I know they are the correct numbers, I think they got them from me originally, but it is not masking a deficit at all. If I underspend on my budget by 10 pounds and I get that 10 pounds back, I am entitled to spend it the following year. What is happening is people have been spending the money they had underspent the previous year. What it does show, though, in this sense the public finance accounts are absolutely correct, is that the position has not dramatically suddenly deteriorated; the position has been a lot flatter.

Q312 Dr Stoate: The point I am making is that the real position has been masked in the public eye for the last five years and the what’s name has hit the fan now because of a sudden change of RAB from plus 77 last year to minus 117 this year, which actually has caused huge difficulties and problems for trusts around the country, whereas the reality is that there has been an underlying difficulty over five years which, convenient or otherwise, has been masked by the RAB.

Mr Douglas: I think, in terms of an underlying financial difficulty, I could probably go back 15 years within the NHS. The accounts do not identify underlying financial problems, and they never have identified underlying financial problems. What the RAB system has done and what other things like restricting capital to revenue transfers have done is start to open up those underlying problems to the things that have always been there and have been there probably quite constantly for a number of years. Just as public finance has done with the RAB figure, it could do the same thing with capital to revenue transfers. Three years ago we transferred probably £200 million capital to revenue.

Q313 Dr Stoate: Two hundred and fifty million pounds, but the point is that rather than accepting five years ago that you have a difficulty, which I believe should have been tackled on a year on year basis over the last five years, what has happened, in fact, is that this year it looks like a real crisis and the trusts up and down the country are now having to lay off thousands of staff and are having to make extremely unpalatable decisions, will probably make decisions in the short-term to meet needs which in the long-term they will deeply regret, simply because of your accounting system over the last five years,
Which has, very conveniently, looked as though things were going quite smoothly when the estimated underlying deficit in 2001–02 was 291 million, in 2002–03 was 225 million, in 2003–04 was 341 million. These are underlying deficits. In fact, the underlying deficit now is almost exactly the same as it has been for the last five years. Only now, because of this, has it caused chaos and melt down to a number of organisations which are going to face problems in the future which, I believe, could have been avoided by a different application of this system.

Mr Douglas: If what you are saying is these problems should have been tackled earlier, I would absolutely agree with you.

Q314 Dr Stoate: Why were they not?

Mr Douglas: What has happened is that, because people have been targeted, because the whole system has been targeted on delivering a zero position every year, everyone works to zero under the system that operated. If they get the benefit from a previous year’s underspend, they will spend that because they want to show people that they are using the money they have got, and that is some of culture change that we talk about, accepting that over those years perhaps we should have had a surplus in the system in RAB terms. Taking exactly what you said, we should have had a surplus in each of those years. That was not in the culture of the NHS and I do not think it was the way that any of us in the public or even in Parliament thought about it. We were criticised a few years ago for having 90 to £100 million surplus and being told that we were not using the money that had been given to the NHS, but this is a big cultural change for us. You have got to recognise that you need to build up surpluses to keep a buffer there.

Q315 Dr Stoate: Why do we not be a bit charitable then and just call it mere confusion and lack of transparency, because that is the way it has come out? Richard Taylor has made some very interesting points that we have not had answers to, the Committee has been looking at this for some time and we have not had answers to any of these points, and they are crucial, because if you are genuinely saying, “The situation now is only what it has been for the last five years, so what is the problem?” The problem is that we have now got trusts facing a meltdown that could have avoided that meltdown had we taken a much more strategic approach many years ago.

Mr Douglas: I am not saying that. I said that there have been underlying problems in the system that have not been dealt with. You get to a point where, if you do not deal with the underlying problems, then they start manifesting themselves in your bottom line position and you have to deal with them.

Q316 Dr Stoate: That is my point. You have had this for five years and you have not dealt with them, and now we are facing a crisis which, I believe, was probably avoidable.

Sir Ian Carruthers: Can I comment, we are sort of trading figures and losing the message. I think there is a real point behind what Dr Stoate is raising. If you look at the 1.2 billion that Dr Taylor mentioned and if you look at the Douglas Report, you will find that the greater share of deficit deterioration was not the present year, which supports your argument. I think we have to be clear, but if you look at the table in that report, I think it was 2004–05 (Richard will correct me if I am wrong) where actually it changed dramatically. So, whilst we have all got in a lather in the last year, actually the deficit growth has only been about 270 million, if you look at it.

Q317 Dr Stoate: That is my point.

Sir Ian Carruthers: I agree with your point. I am going to agree with your point, because we need to be clear. The point is that, if you look at it, there have been years where deficits have been increasing and it is partly a cultural problem, we would accept that, but we should not make excuses for this because overall the lesson to be drawn, and it is brought out in the Douglas Report, is (1) why is it that organisations that are in difficulty, unless they address problems early never get out of it? (2) that means that we need to address problems early, and (3) if I was looking back, there has been a lack of willingness to intervene and intervene strongly at the earliest point.

Q318 Dr Stoate: I entirely agree with all of that.

Sir Ian Carruthers: If that is what is behind your point, we are in complete agreement. What we are now saying is that we have changed those strategies quite dramatically because we are now intervening on turn-round, we have actually changed in a number SHA areas before we moved the leadership from 28 to ten, and in some that had a big impact. I think those are lessons to be learned, but there is no denying the fact that the deficit, when you look at the Douglas Report, has increased in years and some of it should have been addressed at local level earlier. In fact, the very successful systems did just that.

Q319 Dr Stoate: My point is simpler than that. My point is that it is very depressing indeed to be facing a crisis now which could and should have been predicted before and it has undone most of the good work done by your department where we have seen some genuine growth in the Health Service which has now been damaged, I believe, by a lack of taking this seriously before.

Sir Ian Carruthers: Let us get the crisis in perspective as well, because that is the other side of this. The fact is that all of the NHS is not in crisis.

Q320 Dr Stoate: I agree.

Sir Ian Carruthers: The fact is that everywhere is having a tight position. I have been in the NHS for 37 years, which seems a popular number this morning, but the plain fact is that every year I have been in the NHS people have told me it is the worst possible and it is tight and it is difficult, and this is regardless of which administration is in. This is very different, and I want to say it is very different for two
reasons. First of all, we are not in total crisis — let us get some perspective in it — but there are four areas of the country that have very difficult things to face, and they are Avon, Gloucester and Wiltshire, they are London, the East of England and Surrey and Sussex, and there we are talking about gaps, for whatever reason, in the biggest one a 3% problem. I can say nationally, as a business we are not in crisis, but if I just give you some figures, this last year we have put in 5.4 billion growth. The deficit is only 512 million, it is 8% of the revenue, it is the equivalent of each of us earning £20,000 and being £160 overspent on the credit card. All of us would love to have that position; we would not feel ourselves in crisis. However, the point is it is differential, and in some places it is really difficult, and I do not deny that.

Q321 Dr Stoate: But the politics is slightly different, and that is that the perception out there that it is facing real difficulty. I believe, was completely avoidable. As you quite rightly say, there is no real crisis but the perception out there is that there is a crisis and an awful lot of people have become extremely agitated and worried over a situation which, I believe, could have been avoided. That is my point.

Sir Ian Carruthers: If I may respond, I am not going to speculate, but it is quite clear that if there is early intervention and problems are addressed, the stitch in time rule applies, and that is one of the big learning lessons.

Chairman: I do not think we are going to sort this immediate problem out now, but hopefully later in the year we will be clarifying that a little bit further in terms of the figures that we have heard this morning. Can I move on to Ron now?

Q322 Mr Campbell: How fair is the funding formula? Does it need an independent assessor or should it be left in the parameters of the Government?

Sir Ian Carruthers: There are two things: the formula and the tariff. The formula itself is based on age, sex distribution, deprivation where you live and Richard will comment on that more, and the other is the tariff, which is the amount, in effect, PCTs have to pay hospitals for each of the procedures, and they are two different things. I will ask Richard if he will comment on both and pick up the point about an independent assessor.

Q323 Mr Campbell: What about an independent assessor? Would that be better?

Sir Ian Carruthers: The independent assessor really relates to the point of the tariff and Richard will pick that up as well.

Mr Douglas: On the resource allocation formula, we have got an external advisory group that advises the Secretary of State on the allocation formula; so we do open the formula up to independent testing, support and challenge through that process. I would find it difficult to envisage a situation where the Government would actually put the distribution of resources across the whole NHS into an entirely independent body. I feel that that would be a step I could not see any government taking. Opening all of these things up to more independent scrutiny examination I think is a very sensible idea. The tariff, as opposed to the resource allocation formula, there was a report produced for us that came out last week on some of the issues we had about setting the tariff this year that, amongst other things, points the way to greater independent scrutiny and challenge to the way the tariff itself is calculated, and Bill may have some views on that as well.

Dr Moyes: Certainly from the perspective of foundation trusts, getting the tariff right is quite important and increasingly it will require a detailed knowledge of hospital costing. We have been suggesting to the department that perhaps in the longer run, once the tariff is better established, some of the technical work of structuring it might best be located with us because we do know about individual hospital costings, but we also accept that the department has to ultimately set the prices in the tariff because that determines public expenditure, and I do not think you can transfer public expenditure decisions of this scale outside the Government department.

Q324 Mr Campbell: In regard to fair funding can I put something to bed. Is there a difference between funding in the south and the north, because all the debts are in the south and all the surplus is in the north. It has been argued that we are getting more money in the north.

Mr Douglas: Different parts of the country, different PCTs, get different amounts of money per head of population. That reflects the assessed need of that population. 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.

Q325 Mr Campbell: Looking at South Yorkshire, Norfolk, Warwickshire and Wiltshire, are there any factors, other than funding formula, causing unusually high levels of demand and cost in these particular areas?

Sir Ian Carruthers: What do you perceive to be happening in South Yorkshire and Wiltshire? They do not have higher demands per se then anywhere else, but there are problems. I can talk about Wiltshire, because I know Wiltshire, quite reasonably.

Q326 Dr Naysmith: It was one of the four areas you mentioned.

Sir Ian Carruthers: Yes. If you look back at it, Wiltshire has always had a very tight financial position. The difficulty in Wiltshire is that they have incurred debt over a period of time and they are in this cycle, which we discussed earlier, where they actually cannot get out of it. The strategy therefore is to look, and it is a pity Sandra has gone, because
it applied exactly to the New Forest as well. So, what do we do? We start looking at where we can save money and we then open a consultation on the nine community hospitals or six community hospitals in Wiltshire. We then start tackling things that will save money, which goes back to the point, which is where do they fit with the longer term view of healthcare. A consultation is taking place there, it is closed, but I think that it would be hard, without analysis, to say the demands are any greater in Wiltshire than anywhere else. There is an issue going on about the closure of community hospitals there, a consultation is taking place and now I am quite sure that will be reassessed as to whether it is the right way forward. I am not quite sure what you perceive the problem to be in Norfolk and Warwickshire. Perhaps you could outline that, because we do not have a real problem about Norfolk.

Q327 Mr Campbell: They are basically going into debt. What are we trying to find out is what is the common factor. Is there a common factor between them all?

Mr Douglas: I do not think you would find a common factor between those organisations. I think across the country there are different reasons for people going into financial problems. The South Yorkshire one is primarily around the PCTs where we have had a relatively successful hospital. The PCTs to some extent have got by on a degree of financial support from the SHA over a number of years, and what they are having to do now as part of the turn-around process is address how they manage effectively the need for that continuing support.

Q328 Mr Campbell: We are trying to see if the formula is the problem.

Mr Douglas: If you look at every deficit in the country against the formula allocation for every PCT in the country and run statistical tests against it, look at the links between deficits and resources allocated, there is nothing that comes out and says there is a link with resource allocation.

Q329 Chairman: Mr Douglas, could I just ask you about the formula and disentangle it from the tariff for the moment. We have taken evidence in this Committee that formulas are difficult where you have got multiple sites. Our evidence was that the formula largely assumes an average asset mix in terms of sites. If you have got multiple sites, that has major implications for expenditure in that area. Surely that would be recognised in a funding formula, would it not?

Mr Douglas: I would have to check on that point and give you note on how the average asset mix is dealt with in terms of the capital flow.

Q330 Chairman: Let me try this one with you. I am a South Yorkshire Member of Parliament but I have kept an avid interest in the funding of my Health Authority for over two decades now, since I have been a member of this place. If I go back to about 15 years ago, one of the neighbouring health authorities had got a bigger budget than us for the care of people with special needs, you would call it now, and historically they had always had more money. When I found out why they had more money in this area, it is because years ago they had had big institutions in there that had gone years ago but they still had weighted in their budgets historical weights for these things and they have changed them back again. Has that changed in the last decade in terms of these historical weights that we are having in formulas up and down the country?

Mr Douglas: I am just checking on the technical point.

Q331 Chairman: This is a conversation I had a long time ago. I asked the question about why these budgets seemed to be so different, because we work on comparing like with like in terms of socio-economic populations.

Mr Douglas: What I would have to do is give you a note on how this old long-stay adjustments works in the formula.1 I want to be clear on that before I answer. It is a very specific technical part of the formula that dealt with the closure of long-stay institutions, and I will just have to make sure I have got that absolutely right.

Q332 Chairman: We have also had major question marks about: it may give insufficient weight to the needs of elderly populations, it may give insufficient weight to the needs of rural populations. Could you give us a note on how the formula, not the tariff, is actually based?2 I think that might be useful. I think my colleague Anne has a question.

Q333 Anne Milton: Moving on from that, and I do not want to keep the Committee any longer than I need to, just to ask for your comments may be along with the note you send us. There is considerable evidence around from people like Professor Stone, Professor Asthana and a number of other people that there is a strong link between deprived and under-targeted PCTs in deficits and, in fact, that PCTs in both affluent and rural areas are significantly under-funded. I suppose the question I would like to ask is whether the department’s mind is closed to the possibility of any review of resource allocation formula given the evidence that is around, which you have not mentioned, Mr Douglas, and I would draw your attention to.

Mr Douglas: I will give you a note overall on the resource allocation formula. I do not believe the Government’s mind is closed about the formula. We are in the process currently, through the advisory committee on the formula, of commissioning three major pieces of work about elements of the formula before we go into the next allocation round that will look again at how we deal with needs. We will look again at the market forces factor and how that works. Perhaps if I was to provide the Committee with an explanation of how the formula works and the forward work programme for elements of the

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1 Ev 124
2 Ev 127
formula that are being reviewed and with specific reference to the old long-stay adjustments as well so that I could clear that point as well.

Chairman: Maybe we could just drop you a note in these areas and ask you to comment on them.

Q334 Anne Milton: For the record, I would challenge what you said to my colleague about links between deficits across the country.

Sir Ian Carruthers: What I would like to say, Chairman, is that of course all the south argues the formula is wrong in favour of elderly people. They do. It is fairly common.

Q335 Anne Milton: There is good robust evidence—

Sir Ian Carruthers: The point I am going to make is that the formula does not suit anybody when you get down to it, no formula ever does. The truth is that you have got to get the best fix. We will come back to that because, equally, some parts of the country would argue that the funding for deprivation is too great and others would argue that the weighting for the elderly, where most people, in fact, spend in their later years more on hospital treatment, is wrong, and that is basically a different argument. The point is that the formula is the formula, and I think Richard should come back on that, but there is a lot of debate about the formula because there will always be. If I was looking in the Isle of Wight, we will even get down to the ferry costs and its effect, so everyone has an angle on the formula is the point I am trying to make.

Q336 Dr Naysmith: I know you do not get involved in the politics, any of you, but there is a lot of debate about the formula and one of the things that is being said and one of the political parties is considering adopting is a straight abolition of the formula, where you take your money per head of population. What effect would you think that might have, in broad terms, if it was possible to say, “Well, maybe you would like to give us a little bit more detail next time?”

Mr Douglas: If what you are talking about is rather than allocating for weighted heads of population, just pure unweighted.

Q337 Dr Naysmith: Yes; and the same amount of money involved presumably.

Mr Douglas: That would make a significant difference to those areas with a population that, for example, was older than the average. As Ian says, the elderly consume health resources more than anywhere else. If you were to strip out and purely go to a formula based on unweighted heads of population, that would have a major impact on those areas that have a high elderly population or a highly deprived population. It would also have an impact on London, because you would not have an adjustment to the additional costs of London. So, you would come out with some very significant changes in the amount of money for each PCT.

Chairman: We will pass some of these things on to you, Mr Douglas, and you can comment on them in your own time.

Q338 Dr Stoate: Ken Cunningham, our first witness, pointed out some difficulties over the Payment by Results tariffs in that he said that some of them are difficult to code and there was significant room for interpretation of the code, which is actually quite an exact science. 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. On the question of coding, I think it is a good thing that people get to know their businesses better, because that is part of one of the good processes of moving to foundation trust status. They understand their businesses much better and they are able to handle these things. I do not think we should blame the NHS difficulties on the fact that we are learning more about how to deal with this. Neither do I think that it people need to be manipulated, but if you are either side, as Mr Cunningham said, you view things in that way. I think it is a good thing, because the more information we have, the more we will understand and the better we will be able to manage our resources.

Q339 Dr Stoate: Are you not concerned with the fact that there could be significant room for interpretation and that could lead to distortions, whether intentionally or unintentionally, in certain trusts?

Sir Ian Carruthers: I think that there could be distortions, but I am not overly concerned on that particular issue.

Q340 Dr Stoate: Practice-based commissioning is obviously going to be rolled out in the near future, and I think most people agree it will be a very quick move forward. My worry is that there does not seem to be any IT specifically allocated to the project. Certainly on the information we have got, there is no IT budget specifically for practice-based commissioning, and I am wondering how PCTs are going to be able to support it?

Sir Ian Carruthers: I think the setting of the practice budget is a matter for obviously the PCT with the local practice. I am not sure that any allocations have been particularly made for IT itself, but in the wider connect to the health programme, I can clarify this and get back to you. I know that there are things to do with Payment by Results, etcetera, and they are being picked up in the wider question, but on the specific question we will come back to you.

Q341 Dr Stoate: Have you made an assessment of the risk associated with the reconfiguration of PCTs and SHAs and how this might affect the local home economies?

Sir Ian Carruthers: What we are trying to do at the present time, obviously we are in a period of major change, but we need to get that in perspective. I think it is 79 out of 152 organisations are not changing, so
there is only 50% that are or are creating a further set of organisations—I think 82 is the figure—but that, of course, means change for something like 220. It is that sort of order. What we are trying to do is make sure that there are business continuity plans in place to manage those risks and SHAs have been doing that, but we should say it will be a difficult thing to achieve.

Q342 Dr Stoate: Would you at all say that some of these changes may have been partly responsible for deficits and, in fact, to some extent, the department, therefore, bears some responsibility for the difficulties that areas are facing?

Sir Ian Carruthers: Regardless of the structural change, there is a responsibility at all parts of the system to manage this. I do not actually think the changes are the cause of the deficits, but, obviously, it is an additional thing to cope with at a time when we are tackling a difficult agenda.

Q343 Charlotte Atkins: Dr Moyes, obviously your organisation monitors foundation trusts very carefully. Is there anything that we can learn—the department, other health organisations—from that sort of monitoring so that we can try to avoid these sorts of deficits?

Dr Moyes: I think the lessons that we have to offer are, first of all, making sure that there is a financial accounting system that makes deficits very transparent to the boards, and our accounting system does that. I think Ian and Richard have already indicated that they are interested in developing that accounting system across the whole patch. The second thing to say is that we force boards, in Monitor, by the way we work, not to ignore deficits. If they know about them, we require them, we have different ways of pressing them to make sure that they take effective action, and we know if they have are taking effective action. If, by any chance, they decide that they are not going to act, that they are going to let the deficit run, as we showed in Bradford, we are perfectly capable of intervening robustly to force change. So, if you take the three foundation trusts that in 2004–05 had significant deficits—Bradford, Peterborough, Devon, Exeter—in the course of 12 months they turned those three deficits from a total of around 23 million to a total deficit of round about two million, from memory.3 So, we think it is perfectly possible in most organisations to achieve rapid change, provided the board understands what is happening, providing it acts and provided there is some external pressure to get on with it.

Q344 Charlotte Atkins: Could you roll that out to the whole of the NHS organisations?

Dr Moyes: As they become foundation trusts, it will roll out anyway, but I think there are quite a number of lessons to be drawn from what we do and we obviously talk to the department a lot and share experience with them, and we can learn from them too.

Q345 Chairman: We have got a couple more questions on foundation trusts, then we want to move swiftly on to the consequences of deficits and your perception for the future. Foundation trusts have reported lower deficits than other trusts. Is this down to a good finance director, a good chief executive or board, an inherited position with no problems, or over funding?

Dr Moyes: It is certainly not over funding. I do not think. We have had a careful look at the impact of Payments by Results and although foundation trusts, because they were early implementers, have gained from Payments by Results, from being early implementers, the total impact is not so significant to make a huge difference. We think it is a number of factors, Chairman. We think it is partly, as I said earlier on, the assessment process that forces boards to understand their problems; we think it is the compliance framework; we do think that boards are probably much more prepared to tackle deficits within the foundation trust system because they know they are responsible, they are accountable and there is no where else to go; they cannot lobby for more money or anything like that, and so we think the system does produce the right kind of pressures and the right kind of information.

Q346 Chairman: University College London Hospital, of course, shows a bit of contradiction here. Why is that?

Dr Moyes: There were two main factors in UCLH, we think. We know quite a lot about UCLH, as you can imagine. One is that as they moved from a number of hospitals to the new PFI hospitals they recognised, and we recognised, that activity would be interrupted, but the interruption on activity was much longer in duration than they were expecting and when activity came back to the hospital their experience to date has been that it has tended to be activity on which they could make less money out of the tariff. The other thing in UCLH that emerged was that they had an underlying problem with costing of their facilities management, which only emerged once they were in the new hospital. So, there were two issues there with UCLH, but they have been tackled effectively, we believe.

Q347 Mr Amess: I just want to say to Mr Douglas, you do look marvellous and I think we can all benefit from this Yorkshire air, but I did listen to my colleagues, Dr Taylor and Dr Stoate, very, very carefully, and neither of them are accountants, but I did find the simple way that they put these matters of great interest to me personally, and I would just gently say to your good self that, rushing through it all, I thought the response was less than robust, it would be cruel to call it a lot of waffle, and I just think it was a very interesting exchange. Before I get

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3 Note by witness: The correct figure for the deficit after “turnaround” is £3 million. This is stated in the written evidence. We do not consider it is necessary to amend the evidence as the difference is not material to the point being made, but we wanted the Committee to be aware of the actual figure.
Q348 Mr Amess: I am not saying, Sir Ian, that it was his fault; I simply throw it in to stir it up. Are there really 125 to 175 hospitals that will meet the selection criteria which you have in place to become foundation trusts, Dr Moyes, or will the requirement of all hospitals to achieve foundations status just mean that in two to three years’ time more foundation trusts will be in financial trouble?

Dr Moyes: No, we think in principle that all hospitals, ultimately, can become foundation trusts, but we think that things need to be done in some cases by the trust themselves, in some cases by the SHA and in some cases by the department. The diagnostic project that you and colleagues referred to earlier on has given the trusts, the SHAs, the department and ourselves a lot of information about what action needs to be taken by whom in what timescale, and if that action is taken—in some cases it is simply improving the quality of the board or tackling cost overruns, in some cases it is service rationalisations, in some cases there are national policy issues like specialist tariffs to be sorted out—then we believe that all trusts can become foundation trusts and, ultimately, we believe that they will not be in financial incompetence.

Mr Amess: As Sir Ian said, everyone is very keen to become a foundation trust and, as my colleague, Mr Campbell, perhaps was hinting earlier, we are greatly reassured that there is no massaging and fiddling of the situation to give unfair advantage, but I think that is it, Chairman.

Q349 Anne Milton: On the basis that the Secretary of State is promising to return the NHS to balance this year, given the £1.2 billion problem, and we can argue about odd million here or there, the problem with the provider/PCT accounts, what is going to go? How many people are going to lose their jobs? What patient services will suffer? Something has to go to save that money.

Sir Ian Carruthers: I have not got a crystal ball, but I will come on to that.

Q350 Anne Milton: I want to know what is going to happen.

Sir Ian Carruthers: I have not got a crystal ball, but I will come on to that.

Q351 Anne Milton: Time is short

Sir Ian Carruthers: I shall say, because the point is that those are very local decisions. We are agreeing local delivery plans. It would be wrong to say there will be no change, because clearly to recover this position there has to be change. 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. The only two examples I can give are the experience of last year, and this is how it is, where South Tees indicated that they were going to reduce their workforce by 300. That came out as 300 redundancies. They ended up making, I think, three people redundant. What I am saying is that the announcement on manpower figures is quite difficult because they all mean different things, so it is not as simple as adding them all up, but reductions there will be.

Q352 Anne Milton: A job that was being done is no longer being done puts people out of a job.

Sir Ian Carruthers: Not necessarily. We may be employing people at a lesser rate because we are not doing agency work and improving the continuity of care by doing so.

Q353 Anne Milton: The issue of nurses and doctors coming out of training and not having jobs this year, the issue of patient services and, I think, the issue of job losses is still running out there.

Sir Ian Carruthers: I think we would dispute the point about—

Q354 Anne Milton: Mr Cunningham talked about four million jobs going in Surrey and Sussex, so jobs are being lost.

Sir Ian Carruthers: They will be lost, yes, that is absolutely the case, but not on the magnitude and scale. I can cite one hospital that I know where when they were having a deficit they continued to recruit a further 280 people. You would not do that in your own lives and neither should we expect public bodies to act in that way. On the training problem, there is obviously going to be a greater correlation, because we have said previously that 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.

Q355 Anne Milton: It was a question.

Sir Ian Carruthers: We do not expect that in big numbers.

Q356 Dr Taylor: Can I clarify that? The immediate aim is to save the 512 net deficit. Is that what you are aiming for?
Sir Ian Carruthers: The aim is to achieve NHS net financial balance.

Q357 Dr Taylor: So it is the 512 that we have to achieve by the end of this financial year?
Sir Ian Carruthers: Yes. For a net financial balance, we need to have changed that round.

Q358 Dr Taylor: As we have already discovered, the total deficit from PCTs and trusts is over a billion; so that means you are going to allow half of that to carry on?
Sir Ian Carruthers: No. What we are describing here is—. The question was what the Secretary of State had said, and I am just confirming that that is what has been said. Our aim is to reduce the deficit in every way we can. Dr Moyes has just mentioned the point about where we are on NHS trusts. We want them to become foundation trusts. They are not going to do that unless we tackle these issues. I think I just am being realistic, because what has built up over five years is hard to eradicate in one.

Q359 Dr Taylor: That is what I am trying to get at, because it is completely unrealistic to expect every trust to get into complete balance in one year by April 2007?
Sir Ian Carruthers: Yes, but we would want as many as possible to be in that position. I think we need to be clear. We are not saying every organisation will not have a deficit, because, I think, regardless of which government is in power, organisations in the public sector will always perform to a variable level because no-one can be at the top per cent.

Q360 Dr Taylor: What are you going to do in the longer term about the absolutely huge cumulative deficits that some trusts have got?
Sir Ian Carruthers: They need to be dealt with and managed through the system that we have got at the present time.

Q361 Dr Taylor: Going back to the difficulty with finding jobs, many of you may know there was a lobby by recently qualified physiotherapists either yesterday or the day before. One of my constituents told me that out of 90 trainees that have qualified from Brunel University this year only four have so far got jobs, because with knee-jerk economies that trusts make it is particularly things like physio, occupational therapy, that are hit. Is this a figure that you accept? This girl who saw me has put in 60 job applications so far and has been unsuccessful and is getting rapidly demoralised.
Sir Ian Carruthers: I think there are two things. It is important that we do not invest training in a lot of professional people and not arrange for them to work for the benefit of the community. In that particular instance, I do not have the figures, but I did talk to one of the Chairs on Tuesday night at something I was at and the real problem there is that there are not enough basic grade jobs. There are a lot of senior jobs in the physiotherapy world that can be filled and, indeed, are vacant, but it is the basic grade jobs, and that reflects some of the past practice perhaps with recruitment and retention arrangements, where it was quite common for people to inflate their grades because at one time we did not have the skill base to actually recruit to the basic grade, and I am quite certain that is a good point to raise and it needs to be addressed in organisations.

Q362 Dr Taylor: It is very distressing for these girls and chaps who three years ago were told in physio that there were lots of jobs and they were going to get a job. It is very sad. Can you take note?
Sir Ian Carruthers: We will take note because, obviously, if we have spent, as we have, a lot in investing in skills, we would want them to be used. The difficulty is that we are talking this up into a crisis. No-one is denying there are not problem, but the more the press talk it up into a crisis the more people take short-term actions. The real point is if we all have a more measured view of it and grit-determination, we will avoid the sort of short-term actions that would lead to that sort of situation.

Q363 Dr Taylor: So, we agree as near as we can after this one year. Is there a cut-off time where you will say that, if a trust still has a lot of its cumulative deficit in three years, five years, “I am sorry, you have had it, you have got to go”, what is going to happen at that point?
Sir Ian Carruthers: I think the only answer we could give is to say that cumulative deficits we need to manage until people are back into solvent positions, because if we want them to aspire to being foundation trusts, which we do, which is about improving institutional management, those things need to be taken care of or they will not be enabled to get through the assessment process. What I would be keen to point out is that that is already happening in every hospital through the diagnostic programme, but there is a long way to go and it will take some time for some.
Mr Douglas: Could I add briefly to that? 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. Once they have got to a monthly balance position, they can then start eating in for the problems that they have carried over from previous years. It is that sort of stage that they go through.

Q364 Dr Taylor: Can you give us any idea of the number of trusts that do hold cumulative deficits? Is it a very small number or very large number?
Mr Douglas: Cumulative deficit in their balance sheet, it would be a very large number, but not all of them will have to eliminate all of that deficit. The key number is what number they have finished with last year.

Q365 Dr Taylor: Why will not some have to eliminate all of it?
Mr Douglas: Some of the accumulated deficit goes back historically to when the organisations were set up or when they were merged with other organisations. That will not have to be recovered, effectively, in the future. That is a balance sheet issue, effectively, that they will not have to recover. The key number for all organisations is what was in that bottom line figure at the end of last year, and that is the real figure that matters. That will include the extent to which they had overspent the previous years, so we have taken the money back off them again, and these terms people use in quite different ways. Accumulated deficit, historic deficit are different things.

Q366 Dr Taylor: How do trusts know their particular cumulative deficit is going to be written off?
Mr Douglas: It will not be written off, it will be there in the balance sheet, but they do not have to do anything with it.

Q367 Dr Stoate: “This overdraft I have got, could you forget about it. Is that okay?”
Mr Douglas: What I should do for the Committee is write you a note that explains the terms. What is an in-year deficit, what is an accumulated deficit, what is an historic deficit and what is the impact of them? They are all different things, I am afraid.

Q368 Chairman: Could I ask you a question? Whether PCTs had deficits or not in the last financial year, all PCTs this year have been top-sliced because of that and a national balance, we understand, is being held. Quite clearly, from what you said, Sir Ian, they are not going to be in balance, as you would want them to be, by the end of this financial year as well. What are the implications for all PCTs faced with that situation in nine months’ time?
Sir Ian Carruthers: I think, first of all, we should be clear about what we have asked people to do. What we have asked people to do is to discuss and agree with their PCTs how they can create a reserve, because across all the 10 NSHA areas now, there is not one SHA area that has nobody in deficit and it is about how to create the deficit. The top-slice varies from .5% to 3%, so that in some parts of the country this just is not having a big effect at all; in others it is having a very big effect. The point is that the top-slice is not going to be taken away from them; it will still be credited to their financial position.

Q369 Chairman: They cannot spend it.
Sir Ian Carruthers: No, they cannot spend in.

Q370 Chairman: “It is not being taken away from them”, is a bit of a lose phrase in that respect, is it not?
Sir Ian Carruthers: Your question was: what will their end of year position be? The point I am saying is, yes, it will mean that they need to reorder priorities, it will mean they will have to readjust plans, it will mean that some parts are not having to go as fast because others—the four that I have mentioned—are in difficulty to achieve that; but, in terms of the question, which was, “How will they be credited in their books?”, they will have that credit in their books, so they may not end up in a deficit position for that reason of itself.

Q371 Chairman: My PCT has been top-sliced this year from being in balance. It has been top-sliced and it has taken some of its growth money away. It is not having to cut services, I accept that entirely, it would like to expand services, but it cannot because it has been top-sliced. Are we likely to see that happening in the following financial year as well?
Sir Ian Carruthers: The question is that we would hope not, but clearly what we have to do is recover the overall financial position of the NHS. I think the point is that at the present time it is our intention that we deliver a net NHS deficit this year and those rules can be reviewed, but, equally, what we are suggesting, to support organisations, is that where there is local agreement (and this is recommended good practice by the Audit Commission) SHAs do create reserves because we will always have across these areas some organisations that will have surplus and some will be in balance.

Q372 Chairman: Is that not just brokerage that has been going on, we now understand, for years and years and has got some people in this mess?
Sir Ian Carruthers: No. The difference is that the money will not actually be moved from one organisation to another; so it is different in that sense.

Q373 Chairman: Where does my top-slicing money go? They will be able to get it back, with interest, we have been told. When?
Sir Ian Carruthers: The assumption is that this is for a financial year only; so from 1 April next. That is the intention.

Q374 Chairman: That will be held until such time as it is released presumably?
Sir Ian Carruthers: They are holding it themselves with the SHAs.

Q375 Chairman: They cannot spend it.
Sir Ian Carruthers: They cannot spend it, that is absolutely right, but what we have got are lots of local agreements which SHAs have done with PCTs. As I say, some have got a .5% variation, others have got 3%, depending on their local circumstances.

Q376 Chairman: Providing that a PCT has been in surplus last year, it will be top-sliced this year and obviously will not be overspent, but it will not have spent as much as it wanted to. Would you expect that there will be any further top-slicing in the following financial year? That is what I am trying to get to.
Sir Ian Carruthers: I would expect that, firstly, they would receive their money back, but, secondly, I would expect that SHAs would have a discussion with all their organisations to make sure that they achieve net financial balance next year. It is like

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saying, if this year had not happened, but the fact is it has, and we have to get through the present year that we have to recover it. I think all I would say is it is not the intention that that should occur, but clearly that depends on how people deliver this year.

Q377 Chairman: I am a little confused, because between this year and next year there is going to be no added increase as far as any public expenditure rounds are concerned to the NHS expenditure. So, basically, my PCT will get the money back if other people save it.

Sir Ian Carruthers: No, your PCT will not lose the money, it will be—

Q378 Chairman: They will be able to spend it if other people save money?

Sir Ian Carruthers: No, they will not be able to spend it this year because they have agreed that they are going to hold whatever the percentage is in a bank.

Q379 Chairman: Next year they can then? This time next year they should be able to spend it?

Sir Ian Carruthers: If the planned health net financial balance is gone.

Q380 Chairman: Did you say “yes” to that?

Sir Ian Carruthers: I did, yes. That is the intention, but you cannot be certain. It depends on how people do it.

Chairman: I accept that, I realise that. By and large, most people on this Committee would want to know what the NHS costs as well, but it is just a difficult road that we have to travel to find out how it impacts on us and our constituents. Doug has got one last question you will be pleased to know.

Q381 Dr Naysmith: It is to Dr Moyes. In the interesting evidence that you submitted to us, Dr Moyes, you list seven criteria for successful turnaround for trusts in difficulties. It does not say much about management capacity or changes in management. Do you think that management is important, and in some of the turnarounds that you reported, did they involve changing management at the top?

Dr Moyes: Management is undoubtedly important. 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 and cost, to understand where to cut cost, where to try and increase income and so on. Having good management capacity in foundation trusts to tackle these issues effectively undoubtedly is important, but as well as that they need leadership from the board, they need good external advice and they do need good management systems.

Q382 Dr Naysmith: Also in the evidence you talked about a “focus on clinical efficiency” and suggested some of the foundation trusts were more able to do this than other trusts. I was not quite clear what you meant by that, and why other trusts cannot do what you are saying now.

Dr Moyes: I was not seeking to make that point. If that is what has come through then that was not the intention. The point I do make to foundation trusts, particularly the ones which are facing some problems, is there is no point in salami slicing 10% of the budget. Mostly, if you are going to achieve a lasting result, you do have to tackle how clinical services are delivered, and that means you have to understand where you make money and where you lose money. In places like the UCLH, in Bradford, the work they have done is down to the HRG level, they try and understand where we make money, where we lose money and what we have to do to make money. That is where they get the clinicians involved and that is where they impact how clinical services are delivered. That is key to a lasting turnaround.

Q383 Dr Naysmith: That must be true in other trusts as well?

Dr Moyes: Absolutely.

Q384 Dr Naysmith: What is it about foundation trusts that makes it more likely? Do foundation trusts work more as a team with clinicians? Does something like that happen?

Dr Moyes: In the case of foundation trusts, the key thing, as far as I am concerned, is that the boards realise that they are responsible, they are publicly accountable to the governors and members, they are publicly accountable to Parliament through Monitor and they have nowhere else to go. There is no point in asking us for money because we have not got any and there is no point in lobbying ministers because there is nothing much ministers can really do to help the foundation trusts’ problem. It concentrates the mind of the board very quickly and that in itself usually saves quite a few months. Also, we have been trying very hard with foundation trusts to get them to take really serious external advice from experts in this field, and they have done that, by and large, and it has been effective.

Q385 Dr Naysmith: It must also focus the minds of some clinicians if they know there is no point in spending time lobbying their chief executives to go and ask for more money, they have got to do something about it themselves?

Dr Moyes: That is correct. The anecdotal evidence that we have from the hospitals where we have been heavily involved, such as UCLH and Bradford, is that quite often the clinicians are surprised to see the pattern of expenditure and activity when it is put together. They are often very surprised indeed to discover what makes money and what loses money, and once they understand that, they are usually extremely able to suggest to managers how things can be changed to change the position and to get the trust back into balance. That is a key part of it.

Q386 Dr Naysmith: The new consultants’ contract applies to you as well, does it not?

Dr Moyes: Yes, indeed.
Q387 Dr Naysmith: Has that been helpful?
Dr Moyes: I really cannot comment on that. I have no evidence from foundation trusts that it has been a problem or that it has been particularly helpful, so I really have nothing to say on that, I am afraid.

Chairman: Gentlemen, could I thank you all very much indeed for coming along—I was going to say for “answering questions”—and taking part in the debate this morning. I found that enormously useful. Whether we will see you in the autumn or not, I am not sure. Thank you very much.
Thursday 19 October 2006

Members present:

Mr Kevin Barron, in the Chair

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

Witnesses: Professor Sheena Asthana, University of Plymouth, Professor Mervyn Stone, University College London, and Professor Barry McCormick, Chief Economic Adviser, Department of Health, gave evidence.

Q388 Chairman: Good morning. Could I welcome you to what is our third evidence session on our inquiry into deficits. I wonder if I could ask you to introduce yourselves please.

Professor McCormick: Good morning. My name is Barry McCormick and I am the Chief Economist in the Department of Health.

Professor Asthana: Good morning. My name is Sheena Asthana and I am a professor of health policy at the University of Plymouth.

Professor Stone: Mervyn Stone. I have been a UCL professor for longer than I care to remember.

Q389 Chairman: Thanks very much indeed for coming along. I wonder if I could ask, starting with Professor Asthana and Professor Stone, in very broad terms what is wrong with the existing funding formula?

Professor Asthana: I think there are three broad areas in which the funding formula, one could suggest, is flawed. The first is that the philosophy or the principles on which it is based, namely reading need off existing use, I think, is of questionable legitimacy. It would be preferable to read need off direct measures of health rather than existing use of health services, so that is the ‘principal’ issue. Secondly, there are a number of technical problems or problems with the technical design of the formula. I think the main issues are that there are problems around the way in which one controls for supply and there are problems about the conceptualisation and the measurement of unmet need. At the moment the main problem, I think, would be the relative importance that is accorded to age and additional needs factors in the final calculation of PCT allocations. Then the third area for which I think the formula can be criticised relates to its outcomes. For example, this inquiry is about deficits and there is strong evidence of a systematic pattern in deficits—that certain areas with certain population characteristics are far more likely to be in deficit than other areas. There is equally very strong evidence of geographical differences in waiting times which again maps on to the same sort of population characteristics that you can see with regard to NHS deficits. In terms of the outcomes, this suggests that it is not just a problem of local management, but there is something systematically flawed. It is likely that it relates to funding insofar as risk of deficit is strongly associated with level of funding.

Q390 Chairman: Professor Stone, do you agree with that? You seemed to be nodding then.

Professor Stone: Almost everything she said, I would agree with, but I would put it slightly differently and I would introduce a bit of history. I think we should distinguish two aspects of this formula, what it is and what it does. I think the way in which we look at what it is and what it does are completely different things and in both areas there is a vacuum of information and a vacuum of understanding. If we look at what it does frankly, as far as any particular year is concerned, at the moment it produces 303 numbers, the allocations to 303 Primary Care Trusts. That might change, but it does not matter, the formula is the thing which claims it can do anything for any area in the country by amalgamation. Then as to what it does, how do we say whether it is fair when we are just looking at those 303 numbers? There seems to be a kind of paralysis there in which currents of opinion go this way and that way, parties say this and other parties say something different. What we need is something that Sheena just mentioned. We have to have direct measurement of something in order to validate these numbers and say, “Yes, we’re happy”. Opinions are not enough. It is not enough to say, “Yes, the formula is about right”. People who say that or who perhaps say that it is perhaps as good as anything around should be challenged to say what the evidence is on that, “Are you sure that your feeling that some Primary Care Trusts should receive twice as much per capita as others”, which may be a warm-hearted feeling, but that is what inequality calls for, “are we sure that it is going to the right Primary Care Trusts?”

Q391 Chairman: Could I ask you, on that basis, are we to assume that you do not have an alternative on the shelf at the moment?

Professor Stone: I think we have an alternative, but I think it is in the future. This should have been recognised at a much earlier stage by the committees that dealt with this situation. If I cross to the “is” from the “does”, the “is” is frankly scandalous. I have a grandson who is interested in horrible histories and I would like to see this particular formula, and not just the formula but the machinery that goes with it that would produce a replacement for it, consigned to history and replaced by better
machinery, one that brings in independent opinion from universities which are letting this country down by not getting involved.

**Q392 Chairman:** Well, we may be asking for comments on individual issues on the current formula. Professor Asthana, do you agree that there is nothing on the shelf at the moment that you believe would replace the current formula with something which you believe to be fairer?

**Professor Asthana:** I think there is something on the shelf actually. In 2001, we presented a paper to the Technical Advisory Group of ACRA, demonstrating the feasibility and impact of developing morbidity-based computations. It is easy now. In fairness to the utilisation-based formula, I think the reason that the original model was produced in 1994 and the York team chose utilisation was because really utilisation data were the only data available at the time. Since that period, there has been an explosion in epidemiological data that can be extrapolated to create bottom-up estimates of need. Now, it is very easy to create morbidity-based estimates at quite a fine level within different disease categories, for example, particularly within coronary heart disease where you can start to go down to levels of angina, et cetera, not just a block of coronary heart disease. It is slightly trickier, I think, then to map on morbidity estimates to actual clinical need for services, but I do not believe it is impossible to do that. I can think of at least two methods and again we have suggested methods to do that very thing, so there is something else on the shelf and it is simply that for some reason the Department of Health has not shown much interest until recently in an alternative.

**Q393 Chairman:** Could I ask you, Professor McCormick, and clearly Professor Stone does not ringingly endorse the current situation, what do you feel about the issue of this mistrust in some circles about the allocation or people being trusted to allocate resources between different PCTs? How do you answer this type of criticism?

**Professor McCormick:** I think I would begin by saying that I think the Department takes a very responsible position in that it has an independent body that has sitting on it clinicians, economists, statisticians, a broad variety of people with knowledge of the health world. It commissions externally published work and makes recommendations to the Government based upon that externally published work and it is not just opinions, as Professor Stone has ventured, so I think the context in which we are working here is one in which alternative models are explored, are examined and, at the present state of play, we believe that we are using the best model that was available. It was developed under academic research at the University of Glasgow, not in a sort of opinion-forming climate, and I do not personally believe that it 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.

**Q394 Mr Amess:** You are all professors and I am clearly not one, but I am hoping that we are going to have a lively session and that my question may provoke some sort of academic falling-out. Now, the three of you seem to have a different view on the weighting which is given to age, and at the end I will tell you which side I am on. Now, Professor Asthana and Professor Stone, could you give the Committee your view on this matter?

**Professor Asthana:** If you look across a whole range of different conditions, I think, with the important exception of mental health, the vast majority of diseases, particularly the diseases that consume the most healthcare resources within this country, such as coronary heart disease, other cardiovascular diseases, cancers, et cetera, the age gradient or age is a more important determinant of disease risk than socio-economic status. So it is not denying that there are health inequalities. Health inequalities are very, very important, but I think sometimes we get so immersed in the whole concept of deprivation and health inequalities that we do forget the role played by age. I think what has been happening is a sort of muddling up really between the kind of concept of health care equity, which is what the NHS formula is supposed to be promoting—which is equal treatment for equal needs, and the concept of health equity which is based on a desire to reduce health inequalities. I am wondering if this might be underpinning the relative balance that has been given to additional needs (which is basically very strongly correlated with deprivation) and the age in the formula. Given the fact that we know that age is a major driver of the vast bulk of disease that will require hospital treatment, you would expect areas with the most ageing populations to get the most resources. But that is not necessarily the case because, in the way in which the formula is put together, the additional needs indices are given more importance. In other words, you could have a fairly young, deprived population receiving more per head than an old, wealthy population. Now, that young, deprived population may have higher relative needs and if you took a standardised mortality ratio, it might have a higher risk of premature illness, but at the same time it might have a lower absolute level of ill-health than your older, wealthier population, if that makes sense.

**Q395 Mr Amess:** Before Professor Stone comes in, Professor McCormick, why do you disagree with that point of view?

**Professor McCormick:** Firstly, because I think age is well captured in the formula. Age matters a lot in the formula, but it is just that need also matters too. Can I fill out some intuition perhaps for why I think it is often hard to realise why simple relationships between the age index in an area and the allocation to an area are less well fitted than commonsense might suggest. I have asked the Centre for Health Economics at the University of York to provide me,
and I will be able to pass it on to your researchers at the end of this meeting, with some evidence on the dispersion of costliness of running a hospital system in a deprived area versus a less deprived area within age/gender categories, so, holding constant your age/gender group, how much does the cost of running a hospital system vary as you move from a very deprived neighbourhood to a much less deprived neighbourhood, and the difference is up to 140% based on usage. This is actually not using a model, but this is cranking through HES data, the 13 million episodes of HES data that occur within the single year. It is up to 140% more expensive to run the more deprived neighbourhood, so the fact that we see large dispersions in allocations, holding constant your age/gender factor, should not surprise us. It is a lot more expensive to run a hospital system, in particular, in such neighbourhoods.

Q396 Mr Amess: Professor Stone, could I put words into your mouth and ask, do you think Professor McCormick is talking nonsense?

Professor Stone: No, not at all. I think what he is invoking is the idea of direct measurement because what he is doing is he is making an observation on what he can see from doing this, holding the age/gender category constant, and then looking at costs and he is looking at what the relative needs are and how it relates to ethnicity and things like that. He is coming close to making observations that would allow possibly, although I do not believe it would, to be honest, but it is on the right road to make that connection. But I must go back a little bit to what he was saying earlier. He was making a defence, I am sure rightly so in the sense that all the people involved in this have good intentions, but what I am suggesting is that they are victims of a government machinery which goes back through many administrations, it is not just one Party by any means, which does not open issues out at the early stage. There are many serious issues which I have tried to raise in the written evidence to the Committee which the bulk of statisticians would say were disgraceful in the way that that formula was concocted. There was one statistician, as far as I can see, in the group that prepared the bits and pieces that the Finance Division in Leeds decided to use and put together and there was no explanation of why the Leeds Division put them together in that way. The formula has never been tested in academic circles at all. It was presented from pieces prepared by the group to which Professor McCormick referred.

Q397 Mr Amess: But to get back to the point of age, clearly, Professor Asthana, you do not agree with what Professor McCormick is saying?

Professor Asthana: No, I do not agree.

Q398 Mr Amess: And I do not agree either.

Professor Asthana: I think there are two issues here. The first is that you need to make a separation, as the formula itself does, between measuring need and adjusting for the additional costs of providing services. What you have been talking about is adjusting for the additional costs, whereas what we were talking about is how you measure need. Now, in the need aspect of the formula, greater weight is given to deprivation than age and that is just wrong. Coming back to the additional costs issue, again I actually do fundamentally disagree with you. Most deprived areas also happen to be urban areas and if we look at additional costs, I do not fully understand. Okay, there is a difference between private-sector provision, such as supermarkets and hospitals. However, it is patently obvious that supermarkets find it a lot cheaper and can obtain far greater economies of scale in urban areas, whether they are deprived or not, than they do in wealthy, rural areas. So I am really unclear and I do not understand why your costs of provision per unit would be higher in an urban, deprived area. Coming back to your saying that we are reading off utilisation statistics, this is precisely the problem of using utilisation statistics. Your costs may be higher because you have pumped so much more money into those areas, so what you are reading off is simply the higher resourcing that is going in.

Q399 Mr Amess: Well, I think, Professor Asthana, you have done a magnificent job and we will not even let Professor McCormick defend himself! The Chairman wants us to move on, so would the three of you quickly tell us, do you agree that the market forces factor is fair?

Professor Stone: Well, I will contract out of that. That is beyond any expertise that I have.

Professor Asthana: I do not believe that the market forces factor is fair for a number of reasons and again I will raise the economies of scale issue. It is clear to me that certain communities, and I suppose I am putting my rural hat on here, but it is clear to me that it is more difficult to obtain economies of scale in rural areas than it is in urban areas. There are a whole other range of factors, such as your travel time. Delivering community nursing in a dispersed area is a complete nightmare compared to an urban area, so if you are visiting terminally ill people, you might be able to do two a morning compared to 10 a morning, et cetera, and that is patently obvious. Another reason is this idea that we adjust for the higher labour costs in metropolitan areas. 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. For example, if you are working in a community hospital, you actually have to do quite a lot more than a low-level nurse in a busy, large hospital would have to do, so for a whole series of reasons you could argue that rurality creates additional costs. Yet, with the exception of ambulance services, no adjustment is made for rurality at all. By contrast, it is driven by labour costs and I just do not understand that at all. It does not make any sense.
Professor Asthana: Yes.

we know that rural residents are older and, simply per capita than urban residents which, given residents make lower use of health services just in an urban setting? serious level than perhaps they would be in an health treatment, actually they are at the more and, therefore, possibly when they come back for health centre as often as they would in an urban area for instance, that in a rural area many people would Therefore, would you say, I very much agree with that.

Q401 Charlotte Atkins: Some PCTs appear to get twice as much funding per capita as others. Now, would you, and I think maybe I will start with Professor Asthana on this, accept that that funding formula is very much biased towards the urban, deprived, rather than rural, areas?

Professor Asthana: Yes.

Q402 Charlotte Atkins: Is that assumption made because it is assumed that rural areas are in fact affluent rather than having pockets of deprivation?

Professor Asthana: Yes.

Q403 Charlotte Atkins: In my experience of rural areas, there may well be affluent, rural areas, but there are other rural areas where there are significant pockets of deprivation and, what is more, not just in terms of deprivation of income, but deprivation in the sense that they have not got access to the sort of services that many people would come to expect in an urban setting.

Professor Asthana: I very much agree with that.

Q404 Charlotte Atkins: Therefore, would you say, for instance, that in a rural area many people would probably not present themselves to a doctor or to a health centre as often as they would in an urban area and, therefore, possibly when they come back for health treatment, actually they are at the more serious level than perhaps they would be in an urban setting?

Professor Asthana: There is some evidence that rural residents make lower use of health services just simply per capita than urban residents which, given we know that rural residents are older and, therefore, we would expect them to have a higher level of morbidity, would come as some surprise. What worries me, looking at the pattern of deficits, looking at the pattern of waiting times, looking at the way in which allocations vary so much between, as you say, rural, affluent areas and urban, deprived areas, is whether what you get depends on where you live. I am pretty sure, and I think it is highly likely, that there is a real postcode lottery going on out there now and that if you tracked two people with similar conditions in similar circumstances, they may get very, very different access to care. That said, I think some things in rural areas are probably done better. We have done some work, and I think there may be another way of looking at this, which is to look at the relative balance between primary management and hospital care. Some of the earlier work we have done suggested that prescribing levels were actually very good in your affluent areas, and I do believe that in the more deprived areas there is hospitalisation above the level that underlying morbidity would suggest. I do not think that is a good thing. We always seem to indicate that there is an inverse care law where people are using hospitals less, whereas actually that might reflect inappropriate hospitalisation and a failure of primary care and perhaps community management or compliance with drug treatments in the community, et cetera. In other words, rather than flinging more hospital treatments in urban, deprived areas, perhaps what we ought to be doing is actually considering how we could strengthen primary care and community management. At the same time, it is quite feasible that there is a need for more hospital treatment in rural areas because people have got to that age, they have got that level of morbidity and, although there is good primary management going on they still need curative care, particularly when they start to die. Death is associated with need for hospital care.

Q405 Charlotte Atkins: But are we moving increasingly now towards finding solutions in the primary care setting rather than the hospital setting and presumably in rural areas because of the distance that you will be going to a hospital, at least 10/15 miles, and you are more likely to be searching for solutions in the primary care setting and in fact you probably need more money, therefore, for things like lift programmes and health centres and so on which would take on a lot of the jobs which a hospital will perhaps do in an urban setting?

Professor Asthana: I think some of the reforms actually to primary care are also quite damaging in rural areas, some of the recent out-of-hours provision and things like that, so I think there are problems there as well. What we just do not know and what we need further information about at the moment is whether there is a relative under-presentation. I suspect that there probably is. If you look at sheer per capita use of health services, I think that there is suppressed use, suppressed demand in rural areas, but that could well reflect supply insofar as they are actually getting less to start with and, as a result, the expectations become slightly lower. As
I said, I think there is possibly inappropriate hospitalisation going on in urban areas as well, perhaps people going straight into hospital rather than being dealt with properly within the primary setting, so there is a whole range of different factors going on, but yes, I absolutely agree with your first question which is the fact that rural residents are losing out, I think they are definitely losing out.

Q406 Charlotte Atkins: I am a bit concerned that the assumption tends to be made of urban deprived and rural affluent, but is there any tracking of rural, deprived communities against urban, deprived communities because it is certainly the case that not all rural areas are affluent and there are certainly important pockets of deprivation in rural areas? Has there been any research done on what the outcomes are for those sorts of communities?

Professor Asthana: With regards to poverty?

Q407 Charlotte Atkins: With regards to how the formula works for them.

Professor Asthana: If you go to the more remote rural areas, I think levels of, is it, households under the 60% median income can go up to about 30% and that will be captured by the formula, so in areas where you actually do have pockets of deprivation, that will be reflected. I think, for example, west Cornwall would get a relatively higher allocation because it is possible to capture deprivation there. What is more problematic is, I think, in mixed rural areas where you clearly have deprivation, you have deprived people living amongst affluent people, but they are hidden. It is impossible, using aggregate statistics, to capture that, particularly, I think, amongst the indigenous, elderly, poor people who are living in areas which are poorly resourced with regard to health services. Because they are unfortunate enough not to be located amongst the rich, I think they are really losing out.

Q408 Charlotte Atkins: Does anyone else want to come in on those issues?

Professor McCormick: If I could address your initial concern which was because of the distance from hospital, from general practice or private hospitals that people in rural areas are less likely to use the facilities and that if we base a model of allocations on usage, we are going to under-provide in rural areas, that is absolutely correct, except we do not base the model solely on usage, we base it on need. The extent to which people are inhibited from going to their hospitals and their general practitioners or private hospitals because they are the far distance, from those institutions is incorporated into the model and we do not just pay back into those areas their usage, but we pay back an additional allowance based upon the amount of depressed usage that has been brought about because they are further from those areas as a way of enabling the authorities in those areas to put in place services which will compensate for that factor, so that is an integral part of the model. I cannot say that I agree with Professor Asthana that we cannot capture deprivation if it is laced, if you like, within middle-class communities. There are statistical methods of doing that and at the same time I think where I would share an agreement with them is that this model, this approach to funding, should not be seen as something set in stone, but it is something that is continually rolling forward, looking for improved and better methods of achieving, so last time round we introduced various morbidities that were not in the previous model of needs. We are presently putting out a tender for relevant educational organisations to come forward with proposals for a more developed model for the resource model, and I say “we”, this is the organisation, ACRA, that supervises and monitors that process, and we should see this process as something set in stone and certainly the independent body, ACRA, and government are continually looking to learn from this process and make it a more fair and reasonable institution, although I am not sure that we are vulnerable to the criticisms which have just been levied.

Q409 Charlotte Atkins: Professor Stone?

Professor Stone: Well, if I could comment directly on some phrases that were just raised there, “incorporated into the model”, “an integral part of the model”, here there is an invocation of a science-based procedure and this is what has to be questioned. The Department of Health ought to realise that there is a great deal of dissension about the fundamental technicality that allows this thing to be produced almost out of a sausage machine; that is where the statisticians will see this who have had experience in dealing with these kinds of multivariable nature. I recall working on the first computer we had in Aberystwyth as a naieve statistician and I had a lot of variables from Ireland and one of the variables turned out to indicate that it would pay the Irish farmers to pay other Irish farmers to take their land away from them. That came out as a negative coefficient. It was an absurdity arising from the technique used. A great deal of care has to be used in such things and the sloppiness with this formula relates to even the thing that was attempted to be fitted is extraordinary. There is plenty of room there for other models, none of which, as it were, could be said to be fair because they are not incorporating judgments of fairness, which have been raised indirectly by the last two contributors; fairness depends on value judgment. Health cost is a very variable thing. It is applied to IVF and it is applied to cancer. You cannot aggregate all of this together, but you have got to use value judgment. That is why direct measurement has to address the serious problems and, if I could put another thing into the mix, as it were, slightly different from the questions that Sheena has raised, Jane Galbraith and I have thought about this because we were challenged, “Well, you are very critical about this formula, but what would you do?” Well, I would actually go to a sampling of GP-registered patients in a pilot study of something first. I would use a small fraction of the money that I believe has been wasted by this formula, a very small fraction, to investigate, using
trained nurses, sampling patients, some of whom will not have had any costs on the Health Service in the previous year. So fine, that is a zero and then forget about it, but other patients will have had certain calls on the Health Service. A trained nurse would be able to elicit, as near as one could get, the real health need of that patient and then there would be another committee, a committee of committees, as it were, to put pounds on this and say what this really costs, but that would bring up the question of value judgments. The whole thing is a charade at the moment because it pretends to be science-based and it is not.

Q410 Sandra Gidley: Professor McCormick, you have touched on this partly, but can you tell us how the current allocation formula does actually take account of the extra costs of delivering healthcare associated with rural locations? Professor Asthana sort of gave an example of the density and how many patients nurses could see in a morning.

Professor McCormick: I think it is a mistake to suppose that for each different sort of topological structure across the country, whether we are looking at places that have got high blocks of flats or low-density accommodation, you need a different formula. I think you need a different health delivery system in terms of the way doctors and primary care practitioners work, but that is not the same as you need a different financial formula, if you like. What we have got inside the model at present is a set of factors, like the problems of achieving usage in rural areas, the distance factors, appropriate deprivation factors, which capture the differential nature of factors that would apply equally whether in a block of high-rise flats or in a less dense situation. We are looking for arguments and factors that, if you like, span over or umbrella different types of communities rather than picking out a fact and saying, “Ah, if you’re rural or in a high density, we should pay you more money per se”.

Q411 Sandra Gidley: Well, that is as clear as mud to me, I am afraid! It may be that I just have not followed you, but I do not see how that works in practice. Are you able to give a practical example of how that works?

Professor McCormick: I think what I am trying to tell you is that we are looking for reasons why we should pay more money to different areas and if we suppose that deprivation is one, we have got to make sure that we measure deprivation carefully, whether it is in a block of flats or it is in a group of small villages. As long as we measure deprivation carefully in either context and then place it inside the model in an appropriate and fair way, then I think we feel we are capturing how we should allow being rural or being in a block of flats to influence the money that we are sending down.

Q412 Sandra Gidley: I think the deprivation is probably a side issue to this. The point is that it actually costs more to deliver these services in rural areas. How is that taken into account in the formula?

Professor McCormick: Well, the formula should be capturing that on the provision side of the model.

Q413 Sandra Gidley: It should be. Are you convinced that it is?

Professor McCormick: I have come here today to talk about the relationship between the deficits and the formula.

Q414 Sandra Gidley: I was coming to that.

Professor McCormick: I am not the expert in the Department on the working of the model. I am happy to comment and I am happy to send you a note down, but I think it would be wrong of me to offer comments on other colleagues’ areas.

Q415 Sandra Gidley: If I tell you that PCTs in deficit are of a far greater number in areas with a lower population density, would that not indicate to you that there is something slightly amiss with the formula?

Professor McCormick: No, it does not actually, Ms Gidley. I have been, within the Department, looking quite carefully not just at PCT deficits, but at health economy deficits, so we have been integrating into the health economy of the local areas, some rural, some urban, the deficits of acute trusts and the other providers to a PCT with the deficits of the PCTs. 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. May I continue and tell you what I found when we do that?

Q416 Sandra Gidley: Yes.

Professor McCormick: When we do that, what we find for 2003–04 is no relationship at all between the age/needs index and the deficits of an area, and I will leave documentation for this and I will discuss it with your researchers after the meeting, if I may. 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. Now, 2004–05 was the year in which the aggregate deficits also arose on the scene for the first time, so this relationship between being a needy area or not and having a deficit or not, which has motivated some of the literature that Professor Asthana has contributed to and commented on, this relationship, when judged at the health economy level which we regard to be the appropriate way of thinking about it, did not exist in 2003–04, but did exist in 2004–05 in a moderate way. Now, the question is: why did it emerge in 2004–05 and was not driven by the resource model? I do not believe, and we do not believe in our research group, that the resource model has driven it for three reasons.
Firstly, the linkage between being a needy area or not and having a deficit does not emerge in 2003–04 which was the year in which the resource model was changed, but it emerges a year later when the aggregate deficits emerge, so there is not a simple time link. Secondly, 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. The PCTs that did well—

Q417 Sandra Gidley: Can you say that last bit again?

Professor McCormick: I would be happy to. The PCTs that did well in terms of the growth of their allocations from 2003–04 when there was no relationship that we have just discussed to 2004–05 when there was, that growth of allocation is not correlated with the deficits in the local area. In other words, the areas that did well in terms of income growth were no more or less likely to have deficits than the areas that did badly in terms of income growth. The third reason I do not believe that these deficits in the less needy areas have been driven by the resource model is that if you look over a longer span since the new model was introduced in 2003–04 through to 2005–06 at the movement of resources into those areas and compare it with the level of age/need in those areas, if you take out nine outliers of the 303 PCTs that had resource allocations over this period in excess of 39% and look at the 294 PCTs that are left, there is very little relationship between those organisations that have high age/needs and whether or not they got large growth in resources over that period of time. Therefore, if you ask me for an explanation as to why we are seeing a relationship between age/needs and deficits, it is because, for a reason that we are still trying to understand, the areas that are less needy have had a bigger blip in their spending, on the expenditure side of their budget in 2004–05, and we are still trying to come to terms with why that happened. That fits with the employment patterns that exist in the country. The employment growth in the NHS has been most rapid in East Anglia, an area which has had the biggest deficits or some of the greatest concentration of deficits have occurred in East Anglia and they have also had the biggest growth in NHS staff over the relevant period. It is very hard, I think, to attribute this relationship which is interesting and which, I will acknowledge as Chief Economist, appears to emerge in 2004–05 between age/needs and deficits to the income side of the budget, but I suspect it is rather more accurately attributed to the expenditure side of the budget.

Q418 Sandra Gidley: I was actually talking about rurality rather than age/needs which is a slightly different thing because other government departments do actually weight that factor much more strongly. They do in Scotland, they do in other countries. Why is the Department of Health different? Why does it not seem to accept that it is more expensive to deliver services in the rural areas?

Professor McCormick: I think the Department of Health believes in taking advice from recognised authorities, and it has set up an independent panel that comprises senior clinicians, economists and statisticians to advise it. It has looked at the rurality matter on many occasions and we are presently in the situation that we are, taking advice from that panel.

Q419 Sandra Gidley: But, as we move to more community-based services, is this not going to become a greater factor? Our Health, Our Care, Our Say is all about delivering in the community.

Professor McCormick: I would hope, if this is going to deliver increased costs of delivering that kind of care in rural areas, that the model would pick that up.

Q420 Sandra Gidley: You would hope?

Professor McCormick: I would hope so, but this is an issue that has been referred many times to that body of independent observers and they have recommended what we have at the present time. This is not something that has been politically imposed, except as a consequence of taking the advice of the independent body.

Q421 Sandra Gidley: Does anybody else want to add anything to that?

Professor Asthana: I think I would stress that this word “independent” covers a multitude of varieties of independence and that really what we have not found is a recognition that there has been a continuous, unresolved disagreement now for decades in relation to the allocation of resources to the National Health Service right from the days when Crossman introduced his simple formula for the number of beds and things like that. Every so often the Department of Health changes the team that has to produce the formula. Actually the Advisory Group was changed in 1998 and it is rather interesting, I have it here, the report of the 1998 Committee, if I can find it. This is the Report of the Advisory Committee on Resource Allocation published in 1999. Appendix I is by the Technical Advisory Group, I think. They have this technical group of specialist people and the appendix here is very interesting as it lists six criteria that are essential that a resource allocation formula should satisfy and some that are desirable. Some of these pass the criteria, but the majority do not and, if I were to read them out, I think you would begin to feel a little amused by the language that is used. I recommend that anybody studying those criteria that were laid down in 1998 by the Committee that was looking ahead to what this group, based in Scotland, would achieve and, as far as I can see, it would be nice if we had some further debate on whether or not the current formula has met those criteria, which it has not!

Q422 Sandra Gidley: We had rather guessed that.

Professor Asthana: I would just like to pick up on several of the points just made. The first one is your question about additional costs, and basically
looking for deprivation in rural and urban areas does not address the additional costs of providing rural services or associated rurality and they are simply not dealt with in the formula, so let us just be clear about that. The second is that I am really surprised that you are saying, “Let’s get away from looking at PCTs because there is a balance between hospitals and PCTs. Let’s look at the whole economy”\textsuperscript{1}, and that there is no relationship, no geographical pattern here with regard to looking at the broader economy. I have the list here of 2005–06 and this is at the regional level: North East, in surplus; North West, in surplus; Yorkshire and Humberside, in surplus, with the exception of key rural areas which are in deficit; East Midlands, in deficit; West Midlands, in deficit; East of England, in deficit; London, in deficit overall; South East, in deficit; South Central and South West, in deficit. Am I alone in seeing a slight north/south pattern here? 

Professor McCormick: What year is that?

Professor Asthana: It is 2005–06.

Professor McCormick: Well, did I not acknowledge that in 2004–05 was when this relationship began?

Professor Asthana: Yes, but why did it begin? It began because we saw an end to brokering. I think there are several parts of the country which have had longstanding financial problems. Cornwall is one, East Anglia is another, Cumbria has managed to get in and out of its problems, but the reason that these problems have emerged is not because they are suddenly being profligate users of health services, but because they can no longer broker within mixed areas to cover their financial problems. I think to blame sudden profligacy is misleading. I am also surprised that your research has suggested that there is no relationship between funding increase and risk of deficits. We looked at this and we found that only four of the PCTs with the greatest funding increases between 2003–04 and 2004–05 were in deficit compared to 34 out of 60, so 7% of PCTs with the greatest funding increases were in deficit compared to 57% of PCTs with the smallest funding increases. In other words, there is a relationship between funding increase and risk of deficit and, moreover, this relationship is going to get worse because, with the progressive shift of funding. One of the things I will agree is happening is that things are changing year on year and the reason I think they are changing year on year is because there is a progressive shift of funding away from the very areas that are getting the least and are at risk of deficit towards the areas which are at least risk of deficit and getting the most. In other words, to them that have comes more. The whole thing is completely bizarre. You said there is a balance here, that it is misleading to look at PCTs alone because sometimes hospitals are mopping up or taking up the slack, but let us cut it a different way and let us look at waiting times. There is a significant association between the time that a patient has to wait for an inpatient appointment and deprivation by region (and this range is enormous), deprivation by ward, et cetera. I think in Caradon, a patient in 2004—I cannot remember which year we used, it could be a later year—had to wait for 145 days compared to 54 in Hackney. We are talking huge, huge differences. Moreover, there is a very, very significant geographical pattern in waiting times, so, regardless of whether hospitals are taking up the slack or whatever, let us look at the key outcome in terms of access to services. Perhaps I should not also point it out, but there is also a significant difference according to political constituency.

Mr Amess: Game, set and match to Professor Asthana!

Chairman: I think the debate we have just had covers about the next four or five questions!

Q423 Mr Campbell: The Department has issued an invitation for work to review the funding formula and the question is why now and why this particular time and what is the real concern of the Department?

Professor McCormick: The reason is very straightforward. I think the Department is continually concerned to make sure that it is bearing in mind or that the independent committee’s advice is bearing in mind the best possible research that is available. As Professor Asthana has said, evidence on the availability of information on morbidity at a local level is improving and that makes feasible different estimation models that were not feasible when we did not have the data sets available 10 years ago, so I think the Department is merely trying to make sure that it is making the most of the data that is available and the best thinking at the time on how to construct the models. I think the Department is mindful that there is more than one way of constructing models of this sort and it is merely interested in constructing the models which are most appropriate on the basis of fairness and efficiency.

Q424 Mr Campbell: What do you think is the most important thing they should be focusing on, basically the big issue? What is the big issue for the Department? What should they be focusing on?

Professor McCormick: That is almost a political question which I am tempted to pass back. It is almost a political question because I think the maximand for healthcare, what we are trying to achieve in healthcare is something that deserves to be considered deeply by politicians and offered to their civil servants to implement, but in some broad sense we are trying to enhance the health gain that comes from the large sums of money we spend in the health arena and that will be perceived through a different prism in different ways by different parties.

Q425 Mr Campbell: Professor Stone?

Professor Stone: We have just heard that there are many ways of constructing models and I think it is a point I made earlier, that within the framework of the fitting that was carried out by the area study group, there are many models and there is a lack of imagination. All that was done was to say, “We’ll have a little bit of that, plus a little bit of that, plus a little bit of that” in relation to the thing that was then being fitted. Such models are highly specific. How can you believe that the reality does simply oblige you in that matter? It is all right in a scientific investigation and epidemiological studies where we like to say, “The risk of taking that kind of fat when
you take account of these other kinds of fat gives a clue, but no one really believes it because next month there is going to be another epidemiological study that will turn that thing around completely. They provide indications. There is a difference between scientific investigation where we do things like that and then follow up clues, but producing a financial formula that has the serious job of dividing 60 billion on the moment roughly among 303 Primary Care Trusts, I think it is a scandal that the present formula is even as influential as it is, and it is influential because the gap between target and the allocations is narrow. I think it is a national scandal which the Department of Health does not face up to. We have talk of independent advisers, but the chief statistician in the Department of Health is not involved in this. Why not?

Q426 Mr Campbell: Is there an easier way out of this formula problem?
Professor Stone: No, I think it is—

Q427 Mr Campbell: There is no easier way it can be done?
Professor Stone: I think it is a long-term task. It is a serious task, a serious statistical analysis. The methods used, by the way, they are called ‘econometric’, but these depend on methods which were invented in my own department or developed in my own department up to 100 years ago. They are classical statistical techniques. There is no wonderful thing associated with economics that validates these things. We have got to go back to basic principles and involve a much wider discourse than we have at the moment. I do not accept these claims that we have sufficient independence, I think that is not the case.
Professor Asthana: Can I just add to that, that I agree, I think it is a serious task. I should declare a conflict of interests here because I have put in an expression of interest to do this piece of work, although I think it is very unlikely that I will get it! However, my concern, I think, about this process is that, first of all, two and a half weeks’ notice was given for the expression of interest and then they are envisaging the work being done within six months and really this is a serious, ambitious task. That said, I think that my team is capable of doing a very ambitious piece of work and exploring the potential of a morbidity-based approach. It may be that a reformulation of the current utilisation-based formula would attain greater fairness, but I think one could test that against a morbidity-based approach, so one does not necessarily need to radically change. I think one also needs to be aware of the kind of danger of turbulence within the system and it would be highly turbulent to suddenly and radically shift resources back again. You ask what is the big issue, and the big issue for me is getting away radically shift resources back again. You ask what is the big issue, and the big issue for me is getting away from this constant refrain that we have a fair funding formula based on an independent set of advisers. It is a murky, unfair formula. It can be criticised on so many different levels and I think that if we could just have a little bit of honesty about that, that would be a great start. Actually I am puzzled and a little worried about your phrase “enhancing the health gain” because effectively there are different ways of looking at this. I know that there is interest at the moment, for example, in allocating resources in a way that we try to address health inequalities, even if that means giving less resources for overall morbidity until we close the gap. That is a very, very different principle from the current principle of equal access to equal needs. It means we are shifting from the principle of health care equity to a principle of health equity, and indeed I think that is what has been happening in a way already, but we need to be open and honest about this and about which principle we are actually following and perhaps we can be clear about the principle and the implementation of the kind of danger of turbulence within the system would be highly turbulent to suddenly and radically change. I think one also needs to be aware of the potential of a morbidity-based approach. I think you said that the formula already has a morbidity-based approach, but it uses it in its unmet need area in the most bizarre way, sort of standardising, de-standardising, standardising again. It makes very little sense to me the way in which that part of the formula is used. It is perfectly feasible to actually replace the current formula with something far more transparent and far more direct. Six months is challenging, but we could do it.

Mr Campbell: You have got the job!
Anne Milton: Chairman, we are presumably completely off script now, are we, as we have sort of covered it all?
Chairman: We normally are, but I think this morning we certainly are, yes!

Q428 Anne Milton: Professor McCormick, I think you should cheer up actually. You look very miserable because you have got to two people who are left who could give you lots of independence and add independence to the Department with whom clearly it would be very challenging and stimulating to work. I just wanted to pick up on a couple of things. I appreciate Professor Asthana’s comments. Words like “health gain” and “needy” which, Professor McCormick, you used an awful lot, I think, do skew the picture somehow because needy is obviously something that we need to address. You talked about suppressing demand and suppressed demand, that you feel there is a lot of suppressed demand. I would be interested in your comments on the fact that we are to lose around 60 acute trusts around the country over the next few years. My concern is that actually what that will do is actually suppress demand and there is talk of suppressed demand, so rather than seeking out the existing suppressed demand, I would appreciate your comments on whether you would share my concerns that actually there is now an active programme of suppressing demand even further, particularly in the rural areas?
Professor Asthana: I absolutely agree with you. My feeling is that I have so far to be convinced that we have a fair funding formula; I think it is extremely unlikely that we have a fair funding formula. I think the funding formula discriminates against particular types of areas, rural areas, rural affluent areas being particularly the case, and if we are going to base hospital closures, et cetera, on deficits which are actually as the result of an unfair funding formula,
then that has to be stopped. It has got to be stopped now. I think we need to address this issue before there are any more closures, particularly in paediatrics, maternity services and A&E services. All of these areas are being cut. What of the vulnerable, the needy, the elderly in areas which are already under resourced? There is a big equity issue out there and we need to wake up and address it.

Q429 Anne Milton: Have you done any work on looking at what would happen on deprived areas if those more rural areas got more funding?
Professor Asthana: No, I have not. Again, I have alluded to this. In the forthcoming review of the Resource Allocation Formula I think anybody who would do that needs to accept the fact that turbulence needs to be reduced, because it is not helpful to suddenly strip areas of resources in a fundamental sort of way, and that would lead to immediate problems in those areas, but I think that we need to move towards a stable solution and away from what we have got at the moment.

Q430 Anne Milton: Your comments, lastly and briefly, on funding public health. Public health is where you will do something about deprivation, and there is an argument to say that actually putting the money through a public health budget that is separated from the budget that supplies services would be a better way of addressing deprivation. I would appreciate all your views on that, briefly, or I shall be cut off by the Chairman?
Professor McCormick: I think that is something I would prefer to have the Chief Executive of the NHS answer, or the CMO. I do not think that is my area of speciality, to be frank.
Professor Asthana: I have just written a book about health inequalities! Basically, it is generally agreed that for curative services, the issue of health and equality is tantamount to shutting the stable door after the horse has bolted. What we ought to be doing is preventative measures, public health measures. Basically, the vast bulk of hospital community services go to curative care. In other words, it is an ineffective solution to pour additional resources at deprived areas. You are absolutely right; we should have a separate public health budget.
Professor Stone: I have no comment. I defer completely to even both of my colleagues.

Q431 Dr Taylor: You have mentioned brokerage as the only thing that has kept the system working over the past few years. Is not the Government’s suggestion of a buffer in fact bringing back brokerage?
Professor Asthana: I do not know what the Government’s suggestion of a buffer is, I am afraid.

Q432 Dr Taylor: It is a suggestion of a reserve held centrally which can then be fed out to trusts in deficit?
Professor Asthana: I suppose that central brokerage would be better than nothing.

Q433 Dr Taylor: About your redesign of the funding formula, is this paper from you?
Professor Stone: No, I am afraid I am responsible for that. That was to illustrate. People asked me, “What is the formula?” and I could not tell them because it is a very complex piece of algebra, although it is not really complex, but it appears to be very complex. This is a simple graphical way of seeing how these little things that are put into the formula would change the result.

Q434 Dr Taylor: Am I right in interpreting it that the age profile has relatively little effect?
Professor Stone: That is right, yes. It is overwhelmed by it, and this came out in my comment on the Finance Director’s claim that, if we went to equality, then the aging populations would suffer.

Q435 Dr Taylor: The things that really drive it are the market forces, the ambulance service and HIV?
Professor Stone: You can see the big jumps there, yes. I think the point to emphasise in connection with that, if I were to talk to it briefly, is that there appear to be variables along the way which appear to be direct health measures. They are not. They are combinations of socio-economic variables that were found to correlate, by some kind of correlation analysis done years ago, based on self-reported health largely, though one aspect of it, mental health, was nurse controlled. So it really is all socio-economic. I would describe all those variables as proxies, and we are not using direct measurement in constructing such a target.

Q436 Dr Stoate: Professor Asthana, you argued that it is the PCTs with lower than average capita funding that are likely to be in deficit; you have also argued that it is the areas with the smallest increases that are facing difficulties at the moment. Could you not look at it as just the case that it is those areas that are having the biggest transition from over-funding to fair funding that is causing the real problem?
Professor Asthana: That is assuming that the funding formula is fair. As I said, if you look at the principles, if you look at the technical design and you look at the outcomes in terms of waiting lists, in terms of all sorts of things, particularly the relative balance given to age and additional links which we have just been talking about, there are a number of grounds to suggest that the funding formula is very unlikely to be fair. So, no, I would not assume that.

Q437 Dr Stoate: You are genuinely satisfied that these areas are simply short of money and that is the simple reason why they are having difficulties?
Professor Asthana: I think that is also too simplistic an explanation. I suspect there is a whole range of different factors. Local management may be a factor; I would not argue it was a systemic factor. I think we have got a complex picture going on, but there is a significant association between level of funding and likelihood of being in deficit for a PCT, and that would suggest to me, in conjunction with

1 See supplementary evidence from Professor Stone (Ev 171).
the population characteristics and what we know about the way in which age determines disease risk, that, yes, those areas are under-funded.

Q438 Dr Stoate: If you look at the map of PCTs, which we obviously have looked at, the deficits seem fairly random?

Professor Asthana: Is this the map?

Q439 Dr Stoate: Yes.

Professor Asthana: I was intrigued by this map, because this map was produced by the King’s Fund, I think, in black and white. One of the problems with the map is that you will notice that the same colour is used for overspend here and surplus here in the middle line, so we reproduced the map in colour. I think there is quite a strong geographical pattern there. For example, if we look between the north and the south, 72% of PCTs north of that line from the Wash to here are in surplus compared to only 47% of PCTs to the south of that line.

Q440 Jim Dowd: What is the proportion of the population covered by those?

Professor Asthana: I think it is roughly equal.

Q441 Jim Dowd: So you do not know?

Professor Asthana: I do not know. What I was effectively saying is that this map is a misleading map. I do not understand that map at all.

Q442 Dr Stoate: Fair enough. How much do you think managers are partly to blame for the difficulties or do you think it is just the funding?

Professor Asthana: I have no idea how much managers are to blame for it, but what I would suggest is if you have as strong a statistical relationship between level of funding, age characteristics, all of these types of things, population characteristics and deficits, it is highly unlikely that local management is to blame because if it was local management you would expect a random pattern, you would not expect such a systematic pattern. The other thing that makes me wonder is that among those interested in the inverse care law with regard to access to primary care, there was always the idea that doctors, as middle-class professionals, liked to settle in leafy, rural areas and urban deprived areas lacked these professionals. It seems to me that financial accountants are extremely altruistic in their choice of location. The most competent ones seem to want to go and work in the most urban deprived areas! It is very, very unlikely.

Q443 Dr Stoate: Professor McCormick, do you share that view or do you think there is an alternative explanation? Do you think it is nothing much to do with management, it is all to do with funding, or do you think there is a significant management element?

Professor McCormick: I think there is an interface of them both. I think in certain parts of the country, in 2004–05, not earlier, and quite possibly on-going into 2005–06, managers have been under greater strain to balance their books than in other areas. I think the question is why has that arisen. I am not at all convinced that it is due to the funding side of the budget equation.

Q444 Chairman: Professor McCormick, is it due to the ending of brokerage as we knew it? Brokerage has been the least transparent thing in terms of National Health Service funding that I have ever known. I have been in this House for 23 years. This is a new phenomenon. I knew a little about brokerage. I knew on the odd occasions my health authority had problems in the past, but what we are talking about here is a transparency of brokerage that we have never had in the past. Is not that one of the issues, that the actual spending patterns, as opposed to allocations, have put pressure on individual Primary Care Trusts and hospitals?

Professor McCormick: I think the problem with the argument that brokerage is key to all, which Professor Asthana may share with you, is that if we are observing whole regions that are having more of a deficit problem than other regions, since brokerage would have been on a local basis between adjacent authorities, it is hard to explain the emergence of regional patterns with an end to brokerage. I do think that ensuring that we have got appropriate continuation of the brokerage arrangement through some form of transparent banking facility is important, and that is something that the department is very mindful of.

Q445 Chairman: But on paper is it not that which has caused the current issue, the deficit/overspend, whatever you want to call it? Has that not caused the current problems in terms of NHS finance as far as the general public is concerned?

Professor McCormick: I am not convinced that brokerage is as key to the general financial problem as you fear. There may be other accounting issues that have yet to be fully clarified, and I know the Committee has been mindful of the role of the ending of capital revenue transfers which occurred in 2004–05 and issues surrounding that, but there are a variety of other issues that, I think, lie deep within the working of the system that we are still trying to understand why the pattern of deficits emerged, as it did, in the middle of a spending review period.

Q446 Chairman: It has a relationship to patterns of historical expenditure, does it not, in simple terms?

Professor McCormick: It does to some extent, yes.

Q447 Chairman: Some people would argue that that was probably a better formula than the one that has been made transparent in the last few years, or is that too simplistic?

Professor McCormick: I am reluctant to say too much in anticipation of a report I am producing for the Finance Director, which he does promise to publish at some stage in due course.

Q448 Dr Taylor: We have missed out the other causes of deficits, which seemed to us to have been really very bad management by the Department of Health of estimates of future costs. We know that
the consultant contract agenda changed, the GP contract, all have cost far more than was estimated. What is the explanation for that?

**Professor McCormick:** I think it is a matter of record. The Finance Director has acknowledged that these contracts have cost more than was originally scheduled.

**Dr Taylor:** Should this not have been forecast and got better?

**Q449 Chairman:** Maybe you can ask that question in a few minutes time, if we ever get there. Professor Asthana, the map that you have now brought out in colour, would you mind leaving that with the Committee?

**Professor Asthana:** Yes, of course.

**Q450 Chairman:** That particular issue I feel is very important. Could I thank all of you for coming along and opening up this morning’s session. It has been quite fascinating. We will have to reflect on everything that has been said. Professor McCormick, you say you are drawing a report up in these areas?

**Professor McCormick:** Yes.

**Q451 Chairman:** When it that likely to be in front of the, I think you said, Financial Director?

**Professor McCormick:** I am expecting to complete it in the next six to eight weeks.

**Q452 Chairman:** That is a bit beyond our timetable. Perhaps we will have to wait and see. Thank you very much indeed for that opening session.

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**Witnesses:** Mr Andy McKeon, Managing Director of Health, Audit Commission, and Mr Phil Taylor, Chair of the Healthcare Financial Management Association, gave evidence.

**Q453 Chairman:** Good morning. Could I, first of all, apologise for the lateness of the hour. I do not have to explain why you have been in the room. I hope you have found the last hour and 19 minutes as informative as the Committee has done. Could I ask you to introduce yourselves and the positions that you hold for the record, please?

**Mr McKeon:** I am Andy McKeon, Managing Director of Health at the Audit Commission.

**Mr Taylor:** I am Phil Taylor. I am Chairman of the Healthcare Financial Management Association.

**Q454 Chairman:** Welcome once again. A question to both of you really. Only 3% of trusts received a score of “excellent” by the Healthcare Commission for their use of resources. Is poor financial management the real cause of the debate that we have just had for the last one hour, this issue of deficits, overspends, or however you currently phrase it?

**Mr McKeon:** Perhaps I can answer that question first. Only a very small number of trusts did, indeed, get a score of “excellent” for use of resources. As far as the scores for NHS trusts were concerned, only two trusts got an “excellent” score and they are now both foundation trusts. Poor financial management has played a part in producing deficits, and the Commission has gone on record in demonstrating that through various reports we have published, for example, a report on *Learning from Financial Failure in the NHS*. But it is not the exclusive cause, by any means, of the current problems and it is quite possible that you can get somebody with difficult financial circumstances and poor financial management which come together. When we published the scores last week, in some detail, and the auditors’ local evaluation summary results, we took some care to try to distinguish between those organisations which, although in deficit, scored a one for financial management, ie were weak, and those who did not. There were 37 organisations which scored a one for financial management, financial standing and value for money and, of those, six scored a one across the board in all five domains that they were scored in by their local auditors. In those circumstances, it is possible to say that poor financial management may well have played a part in their circumstances, but there were other trusts whose financial management was scored as “adequate” and who perhaps had other problems that they had to cope with as well.

**Mr Taylor:** I think the results of the Healthcare Commission and the Audit Commission’s report last week on the ALE scores were disappointing to the finance profession. If you look at the individual measures, on financial reporting 85% were adequate or above. Adequate does not sound that good, but it was at least adequate. On internal control 96% were adequate or better. On value for money, 91% were adequate or better. Those are not good results, but I think you have to bear in mind that this is the first year of a new system, a system which I think has been welcomed across the profession. We do like to have very clear measures, and I think the system invented by the Audit Commission does very clearly set out the financial standards within an organisation, but it being the first year of a new system, inevitably it takes time to learn that system and the individual practitioners who are putting their evidence forward need to learn how to put that evidence forward in order to improve their ratings. Undoubtedly, over future years that will improve and it will drive improvements in the standards of financial management across the system.

**Q455 Chairman:** How big a factor is the funding formula in explaining deficits?

**Mr McKeon:** We have had a very interesting debate in the previous session, and I am by no means an expert on the funding formula compared with your previous witnesses. We have not done a great deal of work in the Audit Commission on the funding formula. What little work we have done actually supports the point that Professor Barry McCormick made. We were only able really to look...
at PCTs and their financial position compared with their formula because it is a very complicated business to try to get the health economy picture overall, but 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. I think there needs to be more in-depth analysis than we have been able to do of the kind that Barry McCormick was talking about before you could get to the bottom of the position.

Mr Taylor: I afraid that we in the Healthcare Financial Management Association (HFMA) are not really experts on the funding formula. My colleagues in the field tend to complain about it when they feel it is unfair to their local health community. There are, I think, following from the debate this morning, many different weights that you can put on the various factors involved which will all come out with different answers at the end of the day. I think from the HFMA’s point of view we would accept that whatever formula you choose it is going to be beneficial to some people and less than beneficial to others. From that point of view the starting point for us is that, when you look at it organisation by organisation, your income is determined at a certain level and it is that organisation’s responsibility to deliver within the resources that are allocated to it.

Q456 Chairman: Did both of you see the Health Service Journal survey of Chief Executives and what they found about the current affairs? I will give you a couple of examples. I will not go through them all, but I assume that you saw them. 84% thought the Government was trying to dodge its own culpability for the financial problems by blaming it on small numbers of poorly performing trusts, 99% said the Agenda for Change and the consultant and GP contracts were not costed effectively by the department and that this had a big impact on the financial state of the NHS. Do you generally agree with what these Chief Executives have said? What assessment do you make of their views, as it were?

Mr Taylor: Yes, I think the members of the HFMA have told us for a long time that those contracts were under-costed. and, as we know, Richard Douglas has been along to this Committee and agreed that they were under-costed. I think he talked about a total figure of round about £560 million. So, yes, they were under-costed. I think there is a behavioural element possibly here in that when new things are costed in the department the costing might be a little bit optimistic because people want those new initiatives to be put into place. When it goes out to the field, the costing might then be a little bit pessimistic because the people in the field have the problem of implementing them. So, perhaps there is always bound to be a little bit of difference between the department’s costings and the NHS’s costings, but probably not to the extent that we have had on those contracts.

Q457 Dr Stoate: Several of us this morning had a meeting with Ian Kennedy, who looks after the Healthcare Commission, and he was talking about his annual health check figure. Looking at the figure that he presented, over a third of trusts were declared weak on use of resources, a tenth of trusts were said to be weak on quality of services, but half of all trusts had misrepresented their true performance against standards about health checks. Can I ask you as a representative of the finance directors of health services and trusts, how come a third of them were weak on the use of resources and yet you say that financial management is only a part of the problem?

Mr Taylor: The score on use of resources relates mainly to whether the organisation has a deficit or not. That is the main factor in determining that key line of inquiry. If you have got a deficit you are going to score a one on that factor, and 31% of organisations had a deficit.

Q458 Dr Stoate: It is still pretty concerning that a third of them were declared weak. Not adequate, not fair, not good, but weak, a third of all trusts. Does that not give you cause for concern. Are your members not somewhat alarmed that that is the standard of management that we are seeing?

Mr Taylor: I think the results are disappointing, but I think you need to understand the environment in which the NHS operates. We are asked (I think it was Sir Nigel Crisp who said this) to land a jumbo jet on a postage stamp. You do not want the NHS to overspend, you do not want us to underspend either. You could equally be asking me questions here if we had underspent last year, saying, “Why did you not use all the resources that were available to you?” It is a difficult task, managing the finances of the NHS, it is a complex task, and I do not think we should underestimate it. We have in the NHS a highly skilled and well trained finance function who I think overall are highly competent, highly trained and thoroughly dedicated to the job that they are doing and those people do not want their organisations to be in deficit and they do their very best to make sure that they are not. The fact that so many of them are scored as weak, I think, is a reflection of the very difficult environment that we operate in.

Q459 Dr Stoate: I am not suggesting they do it deliberately, I am saying it is an alarming figure.

Mr Taylor: Yes, it is disappointing.

Q460 Dr Taylor: The audited NHS accounts have gone up, I think it was, from 512 to 547 million. Where did those increases come from? Is that the sort of thing you would expect? Would you not expect greater accuracy? Have you any comments on that?

Mr McKeon: We would expect there to be some variation between the unaudited and the audited accounts because there will be differences in judgments. There was in 2004–05 a very significant
variation between the unaudited and the audited accounts, and that was due very clearly to two or three systematic factors, which I think were explained by Richard Douglas when he came to give evidence in July, and with which we concur. Since then there has been a systematic effort by us and the department and the finance professionals to improve the position. What we saw in 2005–06 was an improvement. Having looked at the figures, where there was a difference of about £35 million, one organisation accounted for a third of that. There was a difference of £12 million between its unaudited and audited accounts, and that was due primarily, as far as we can tell, to some of the actions of an executive director who is now under suspension or investigation. Five organisations, including that one, accounted for two-thirds of the difference, and a further 10 organisations accounted for the remainder. I cannot give you the detail of why each of those had a difficulty. Nonetheless, there were some individual performance issues which I know the department and people locally are pursuing, but overall what you had is something like five organisations, which is something less than 1% of the total, accounting for two-thirds of the difference between the unaudited and the audited accounts.

Q461 Dr Taylor: I want to go on and try and sort out a suspicion that we have all had. These are that the gross deficit was cut from 1.27 to 512 largely by the use of training budgets. I wonder if you have had a chance to look at this. The figure that was taken from SHA surpluses (and these are the unaudited figures) was 524 million. A complicated letter we got from the Department of Health trying to explain this said that just 133 million of that came from education and training, 145 came from underspends on SHA running costs and the last bit (which is 246 million) really needs to be investigated. I think, because it said, “The third source, we understand, is being held by the SHA as some organisations pass their surplus income to the SHA rather than record it in their own accounts.” That sounds absolutely unbelievable when they have spare money that could make them look to be in surplus, that they have passed it on. Have you looked at where that figure of 524 million comes from, because we suspect a lot more of it is education than the 133 million?

Mr McKeon: No, we have not looked in detail at that, but I can say, and Phil Taylor might wish to comment on this, that some SHAs have traditionally acted as banker for surpluses from PCTs in particular and also sometimes from trusts, and so it is not surprising that they end up with a large figure from PCTs and trusts, as that letter from the department says. I do not know whether you wish to comment on that.

Mr Taylor: Yes, I can confirm that SHAs do carry forward funding for PCTs when it is earmarked for spending on particular items that they could not spend in one year. So, if the PCT is unable to spend the money in one year, the SHA will carry it forward for them to the next year so that they could spend it on those issues in the next year. That is called deferred income and it is transferring income from one year to the next by the SHA.

Q462 Dr Taylor: This would not just be the sorts of services that SHAs commission themselves?

Mr Taylor: No, it could be for any sort of service that a PCT was purchasing.

Q463 Dr Taylor: Is it not rather odd that they were not allowed to reduce their own deficits by that amount rather than passing it on?

Mr Taylor: It would generally be from organisations that were in surplus, not ones that were in deficit.

Q464 Dr Taylor: But there are not many that are in surplus?

Mr McKeon: That is partly because those in surplus have handed the surplus to the SHA to be kept for them.

Mr Taylor: Two-thirds of the organisations are not in deficit.

Chairman: Is that not part of the mechanism of the old brokerage system, Richard. I think the answer to that is, “Yes”.

Q465 Mr Amess: Mr McKeon, just remind me what your previous job was.

Mr McKeon: My previous job, which I left three years ago, was Director of Policy and Planning at the Department of Health.

Q466 Mr Amess: We have got the right man here! In the Health Service Journal you wrote that, “Over time there has been less of a focus on financial management both nationally and in some organisations.” Would you like to expand on that? Presumably this is within the last three years.

Mr McKeon: I think it has been clear that, although achieving financial balance has always been an important issue, greater emphasis has been given to actually achieving targets rather than to achieving financial balance. The performance management thrust has been to achieving targets rather than to achieving financial balance. Nobody said that it was not important to achieve financial balance and nobody said that you should not achieve financial balance at the expense of targets, but the focus of performance management has been on the achievement of outputs for the benefit of patients.

Q467 Mr Amess: I do not think you could be clearer in what you have just said. Are the department and the NHS taking the right steps, and what else do you think they should do improve financial management?

Mr McKeon: I think the department is taking the right steps in the way in which they have targeted a number of organisations with turn-around teams, and so on, in order to help rescue their particular financial position. I think they are taking the right step by reinforcing the focus on financial management and financial balance in the last 18 months, perhaps the last year or so now, and I am hopeful they will take the right steps in considering
the report that we gave them in late July, the Review of Financial Management and Accounting Regime. I think the recommendations in there would further bolster financial management within the NHS.

Q468 Mr Amess: You were not working for the organisation three years ago, so would you like to give your thoughts on it, Mr Taylor?

Mr Taylor: I thoroughly support what Andy has just said. I think the Audit Commission’s recommendations on the changes to the financial regime will make things a lot more transparent and a lot clearer. If the department accepts those recommendations and removes what has been called the RAB double whammy, it will make the accounting system much more transparent and clear to people who are not specialised NHS accountants. The general principle, I think, of making the NHS accounting rules much more like UK generally accepted accounting practice (UK GAAP) will improve the understandability of the system to the public and to all commentators. I think that will be a good move in the future. You have also made a very good point about getting the priorities right. From the finance profession’s viewpoint, finance has to be at the top of the list; financial balance has to be what you achieve first, but, of course, being the NHS, there are lots of other priorities. People who work in the NHS are actually there to improve the treatment of patients, including the accountants and the finance people who work there. They have those same objectives in mind. It is always a very difficult decision when you are talking about spending a little bit of extra money on patient services that might just push you into financial deficit. You have to have sympathy for boards and individuals who have to take those kinds of decisions about spending at the limit of resources when there are clear benefits for the patients. I think also what is happening at the moment to improve the quality of NHS boards is very important. The financial position is ultimately the responsibility of the board of that organisation, and that board has to have the right skills and expertise in order to be able to ensure that everything is in the organisation to make sure that finance is delivered as well as all the other targets. One point I would quite like to make is that I am not sure that anybody else has made: we talked this morning about the distribution of funding through the allocation formula. Another question we have to ask is that, despite the huge increases that there have been over the past five years, averaging out at about 10% a year, are we investing enough in health services in this country? We are still lagging behind other countries, in terms of the investment we make in health services, when we aspire to deliver the same standards of healthcare as other countries. Can I quote you some figures. These are OECD figures. They are a little bit out of date. For example, in France in 2004 they were spending 10.5% of GDP on healthcare. In Italy it was 9.2%, in Portugal it was 10%, in Switzerland it was 11.6%, in the United States it was 15.3%. In the UK in 2004 we were spending 8.3% of GDP on healthcare, and, although we have been increasing at a significant rate, those other countries have been increasing, in some instances, more quickly. Over the five years’ figures that I have got here the UK investment increased by 1% of GDP, in the US it increased by 2% of GDP, in France it increased by 1.3% of GDP. So, although we are increasing our investment quite significantly in the UK, so is everybody else and the demands of an ageing population, high cost drugs and all the other factors that come into healthcare are pushing the cost of healthcare up across the world, and so we need to consider whether actually we are pumping enough money into healthcare in the first place.

Q469 Jim Dowd: On that very point, because we have been through this plenty of times and healthcare expenditure has gone up sharply, more sharply than ever before over recent years. You double the expenditure and create a crisis. I am not quite sure how that works, other than that it seems to be a general fact of public spending that the more money you spend on a problem the bigger the problem gets, which I think is a structural issue. You mentioned the US. On the occasions we have been recently to the US the one thing we are almost unanimously unfailingly told is the amount of money they waste. They spend 15%, the largest GDP in the world, and yet waste at least a third of it. Why on earth should we aspire to that?

Mr Taylor: I am not suggesting that we aspire to the levels of waste in the US system. I too have visited the US this year as part of my role as HFMA Chairman, we have an annual exchange with the US, and the investment in bureaucracy in the US system is huge. They spend a fortune. The system I went to ran a similar size hospital in the UK we had 30 people in the finance department. When I ran a similar size hospital in the UK we had 450 people in the finance department. When I ran a similar size hospital in the UK we had 30 people in the finance department, so that gives you a measure of the enormous bureaucracy in the States, but we should aspire to the levels of access that they have in the States whereby you can get immediate, high quality treatment with the latest high-tech equipment.

Jim Dowd: Sixty million people are not even covered in the United States.

Chairman: I am going to end it here. I have to say that doing a comparator between GDPs of the United States and the United Kingdom on the issue of equity alone, you cannot make a comparison. We heard some horrendous stories last time we were in California about what a self-employed plumber would be able to afford in terms of healthcare, and the answer is very little. It does not matter in the UK, thank God. If you keel over in the street when you leave here, Mr Taylor, someone will come and whisk you away no questions asked. It is difficult to measure that against GDP.

Q470 Sandra Gidley: A question to Phil Taylor. The Audit Commission’s Learning Lessons from Financial Failure in the NHS was probably quite damning, and that would have a particular impact on members of your organisation. Some of their conclusions were inadequate leadership, particularly in the post of Chief Executive and Finance Director,
limited cohesion among Board members and lack of concentration by the Board on breaking even. How have your members responded to that?

Mr Taylor: I would have to say, first of all, that we think it was a good report, the Audit Commission’s report on financial failure, and had some good work in it. I think we do have to recognise that very occasionally the function does fail in the NHS and some of the particular instances that were in that report indicated where there had been financial failure, those 25 public interest reports that were examined as part of that showed that we are not perfect and sometimes we get it wrong.

Q471 Sandra Gidley: That was a fairly small snapshot as well. You say it happens occasionally. If it is picked up in a fairly small snapshot, it would indicate a bigger picture than you are indicating here today.

Mr Taylor: You must remember that those were the 25 organisations where public interest reports have been issued. In the remaining 575 organisations they have not got into that state. These were the poorly performing organisations. What we have to recognise is that financial failure is operational failure, it is generally a whole systems failure, and it is weak management, it is not having the clinicians on board, it is a whole series of things that all add up, and when you get all those factors in the same place at the same time, then you end up with a failing organisation. We recognise within the HFMA that our members need to be continuously updated and need to have continuous professional development, and we provide all sorts of courses for them to do that and try to help them with those processes. We also try to provide financial management skills to non-financial managers in the NHS, which is one thing that is important. At the HFMA we train a lot of non-executive directors in financial issues and for other people who have to deal with financing the NHS, we have just introduced a new e-learning package whereby they can learn financial skills through the new learning system. We are all the time trying to improve the skills of the members of the association and improve the financial skills throughout the NHS, not just in people who work in the finance function.

Q472 Mr Campbell: Can I ask first a question on foundation hospitals. In the last report on this issue Monitor had said that the foundation trusts were delivering a strong financial performance. Is it your view that these trusts, set up by a Labour Government, have been getting more money pumped into them than other organisations in the Health Service?

Mr Taylor: My answer to that would be, “No”, my view is that they are not getting more money pumped into them. What happened was that the Payment by Results regime was introduced for foundation trusts first and was extended to all acute hospitals this year. Perhaps they were able to take advantage of that system earlier than the rest of the NHS, but I do not believe that means more money was being put into them, I believe that they were being reimbursed in a fairer way than the NHS hospitals for that one year.

Q473 Mr Campbell: So it is not an imbalance. That is the main thing.

Mr Taylor: I do not think so; not in my view.

Mr McKeon: I think in 2004–05, as Phil Taylor has said, the first foundation trusts did make a gain out of the implementation of Payment by Results. I think, from memory, the overall income of foundation trusts went up by something like 14% compared with 11 or 12% for NHS trusts. Of course Payment by Results has now been introduced across the board. We have not done the analysis for 2005–06.

Q474 Mr Campbell: The other question is: how has your organisation responded to the deficits and, in particular, how have the financial managers responded to the deficits of the Health Service?

Mr Taylor: You will know that in the current year local NHS banks have been introduced at SHA level. Those banks are moving funding around the system, if you like, to try to bring the whole system into balance. I think that puts pressure on the whole system to deliver, because it puts pressure also on those organisations that are in balance to deliver additional funding, but through that mechanism there is a very good chance, I believe, that we will bring the system back into balance, and financial managers around the system are responding to that need to make contributions to the NHS bank at SHA level.

Q475 Dr Naysmith: What is the difference between that system and the old brokerage system that is supposed to have been dispensed with?

Mr Taylor: I think the new system is much more transparent, and the movement of funds will be declared in accounts and the funds that are collected at SHA level will remain with the SHAs rather than being distributed out across the system; so this year we will end up with surpluses in SHAs to offset any deficits that there are in the system. Brokerage is a difficult question, because I think the Committee has said it made the system less transparent because you did not know where money was moving around the system, but I think always with the very best intentions. Brokerage was used to remedy a number of problems, one of them being the effect that we have talked about of the RAB double whammy. If you gave brokerage to an NHS trust it avoided that problem of the double whammy, so that was one reason for giving brokerage out. You might have used brokerage for other things as well. 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.
Q476 Dr Naysmith: My experience of that system was that it was sometimes used to cover up deficits and then, at an appropriate time, the money was moved back again to where it had come from without any real effort being put into sorting out why the deficit arose in the other organisation first. You are saying it is now transparent enough for people to make sure that that does not happen in the future.

Mr Taylor: In the new system it is much more transparent, yes.

Q477 Dr Stoate: Certainly, in my experience, transparency has not been the strong point of the NHS. One of the things I would like to see is that financial directors, generally speaking, know where the bodies are buried, if you will pardon the pun. Are there any bodies that are still buried that the financial directors have not yet owned up to?

Mr Taylor: I cannot answer that question, clearly, but what I can say is that we do run a very tight system here. We are under pressure to spend every penny; it is a very tight system. If you are running a system like that where you are aiming for absolute financial balance every year—

Q478 Dr Stoate: I am not concerned about that. What I am concerned about is there any underlying financial nasties to come out of the woodwork, or do we now know the full transparent picture?

Mr Taylor: I am afraid I cannot answer that question.

Q479 Dr Stoate: That is even more worrying, because if you cannot answer it, what is going on? You mentioned several times during your evidence that you want to improve financial transparency. I am asking you: is it transparent, is it in the open, or are there any things waiting to come out? If you say you do not know, it does not do much for my confidence in the transparency of the system.

Mr Taylor: I am here as a representative of the HFMA. I do not receive the information that the Department of Health receives every month on the financial position in individual organisations.

Q480 Dr Stoate: Can I ask the Audit Commission if they are concerned about more facts and figures that are yet to hit the headlines, or do we have the full picture of the deficits?

Mr McKeon: I think a lot has been done over the past year and now this year to flush out the financial position of individual organisations. All the trusts have now gone through the trust’s diagnostic programme to see what their financial position is, to see how quickly they can get to foundation trust status. All the PCTs are going through a fitness for purpose assessment which is looking at their financial future as well. Existing PCTs which did not change on 1 October have now been done. The ones that changed on 1 October, the new ones, are being done over the next six months. At the end of that period I think we will have a very good idea of all the financial problems in the NHS. Could I guarantee it is 100% transparent? No, I could not guarantee it is 100% transparent.

Q481 Anne Milton: I wonder if I could ask you both what you feel the NHS needs to do to get back into financial balance?

Mr Taylor: We have mentioned a number of things. First of all, we need a clear, transparent financial system so everybody can see what is happening and so it is clear to all involved where financial problems arise. I think we need to do some work on strengthening the boards in NHS organisations. I think we need in organisations to make it very clear what the priorities are. The Department of Health needs to make it very clear what the priorities for the NHS are. We need to have early guidance on what we are going to do for any particular year, and I think we need to recognise that it is a difficult system. As I have said on a couple of occasions, it is not easy to work in that complex system and produce the exact zero answer every time.

Mr McKeon: I agree with that. I think there are two issues: one is to recover financial balance and the other is to have a financially sound position for the future, not just recovering financial balance. I think the department is doing the right things, as I said earlier, in terms of getting into financial balance in individual organisations, in providing the support and help that is going on and providing the right focus on this issue and also the way in which they have curtailed some of their priorities to make sure that financial balance is achieved. I think for the longer term, we need to do the things, as Phil has said, in terms of strengthening boards. I think the department needs to make sure that it issues guidance at the right time, earlier, so that people have enough notice of what is going to happen. I think they need to be more transparent and open in their costings. I am not saying that their costings are poor. I think they need to be more open to challenge about those, also to identify the inherent risks in those costings so that people can be aware of those and work to mitigate them. I think they need to do something on resource accounting and budgeting. All I am saying has been set out in our review. I think these are the sorts of things that we need to do for the longer term. Equally, the finance profession needs to up its skill levels in some particular areas, as the results of our auditors’ local evaluation has shown, and to use that as a framework to improve.

Q482 Anne Milton: Somebody said to me recently, and I will ask you whether you think it is valid, that if they were asked to put the cost down for, say, an x-ray department they could make it 300 or 3,000 depending on how they accounted for it. Would you dispute those comments? Undue hesitation, Mr Taylor and a smile!

Mr McKeon: I would dispute that they could do it quite that way. In terms of costings, there is a costing manual that is set out by the department which sets out how the cost should be derived for individual units and individual procedures. So there is a rule book which should be followed. Some of this, I have
to say, is a matter of judgment and not necessarily an absolute rule that you have to follow. There is variation and there are things to do with how you allocate overheads, for example how the cost of the finance function should be attributed to the pathology department or the x-ray department. The costing manual sets out how that should be done, but in the end there is still a matter of judgment about that.

Q483 Anne Milton: So it is not an absolutely rigid structure; there are opportunities. I do not mean this in a prejudicial way. There are opportunities to be imaginative in your accounting. What you charge up to what department and what you end up with will define the figure then, presumably?

Mr McKeon: There are opportunities to take different judgments about where costs should fall, but one of the points about Payment by Results is it matters, in a sense, not what your costs are, because you are paid the average cost, if you like. What matters is the income that you get. Where there are services which are not funded by Payment by Results, then clearly PCTs tend to look very closely at what the costs attributions are and what they are actually paying for in those circumstances.

Q484 Anne Milton: Mr Taylor?

Mr Taylor: As always costing is not an absolute science. There is always a degree of art about it and there is always, at the margin, a possibility of taking different views on how you allocate costs. There will always be some variation between two different accountants costing the same thing, but what we aim to do, through the costing manual, through procedures, is to reduce that degree of variation and try to get everybody doing it the same way.

Q485 Anne Milton: Do you think the first priority of the NHS is to achieve financial balance?

Mr Taylor: No.

Q486 Anne Milton: Mr McKeon?

Mr McKeon: I think the first priority of the NHS is to treat the people within the resources available. Provide the best service within the resources available.

Q487 Anne Milton: So the answer is, “Yes”, then?

Mr McKeon: No, the answer is what I said.

Q488 Dr Taylor: I want to go back to brokerage and buffers and things like that to make sure I have understood it, because it strikes me that we are returning to brokerage with different titles and with more transparency. Mr Taylor mentioned the local banks at SHA level, so that is one reserve being held. We also gather that there is going to be a central buffer held by the department and the Treasury amounting to something like (I have read somewhere) 350 million. Is this not just a return to brokerage and is not this going to let trusts off the hook?

Mr McKeon: Perhaps I can start by talking about the buffer, which is a recommendation in our review which we presented to the Secretary of State in July. The department has not decided on that recommendation and, as far I know, no figures have been attached to what the buffer will be. People may have made guesses, but there is no final figure. As I say, it is still up to the department whether they accept that recommendation. As we set out in the report, the buffer is not a reserve that is meant to be handed out to trusts in trouble. It is not there to be spent on individual trusts in deficit. The need for the buffer arises because one of the problems the department has had through resource accounting and budgeting is that, if the NHS overspends, the Treasury take back the equivalent of that overspend for the next year’s allocation. That is then passed down. Effectively, the consequences of that are then passed down to the individual trusts who have overspent, and that has resulted in what Phil Taylor referred to as the RAB double whammy. The point about the buffer was, in a sense, to isolate the NHS from the effects of that so that, if there was an overspend by the NHS in aggregate, the department could meet its responsibilities to the Treasury but not have to pass the consequences of that down to trusts in the way that they have. The trusts would still be in deficit, they would still have to recover, but they would not have the double whammy.

Q489 Dr Taylor: Is it there particularly to protect foundation trusts if they get into trouble?

Mr McKeon: There is a point about foundation trusts, because the department is also responsible to the Treasury for the aggregate overspends or, indeed, underspends of foundation trusts. So, if foundation trusts overspend in aggregate, that is taken into account by the Treasury as to whether the department has overspent its allocation or not. If the foundation trusts underspend, that is also taken into account and the department gets the benefits of that. The department has no way, as it has with NHS trusts, of passing on the consequences of those overspends directly back to foundation trusts, as they have done with NHS trusts. The buffer is a way of ensuring, as I say, that the department can meet any potential overspend and meet its obligations to the Treasury without having to pass down the consequences of that in the way they have to NHS trusts and foundation trusts. The individual organisations will still be left with their financial problems, but they will not have been said to have been compounded with the operation of the system.

Q490 Dr Taylor: Would you go so far as to agree with Professor Asthana? You may not have heard her, but in her written evidence she says, “Brokerage offers the only means of moderating the pernicious effects of the funding formula”?

Mr McKeon: A way, in her view, of ameliorating or affecting the funding formula is to pass money from one organisation to another. That must be true, but I do not necessarily agree that is the right approach to do it. As you, I think, agreed, the way in which that is done would not be the right way. If there were
to be a problem with the funding formula, surely the way is to address the funding formula, not to move money between organisations.

Q491 Dr Taylor: Is it fair to ask if the Audit Commission has a view on the funding formula?  
Mr McKeon: No, I think I have said all I can say on the funding formula as far as we are concerned.  
Dr Taylor: Thank you.

Q492 Chairman: Mr McKeon, could I ask you about your review. Do you have a timescale when the Government are going to respond to this review?  
Mr McKeon: They have not given us a definite timescale but I understand that the Director of Finance is hopeful they will be able to respond next month.

Q493 Chairman: That might be helpful to this Committee in terms of that response. In your review, you conclude that RAB (resource accounting and budgeting) needs to be radically relaxed in the NHS and that accumulated deficits should be written off.  
Mr McKeon: No.

Q494 Chairman: Is that a misinterpretation?  
Mr McKeon: That is definitely not what we said.

Q495 Chairman: You do not compliment RAB anyway. Let me put it this way: by implication—and I am looking at table 1, which you will be familiar with—if a trust overspends by £10 million, the following financial year it loses that £10 million and also has to pay it back at the same time. That is the double-whammy which Mr Taylor described.  
Mr McKeon: Yes.

Q496 Chairman: Who is responsible for that? You suggested in answer to Richard that it may not have been the National Health Service accounting but the Treasury that is responsible for that? In your view, who do you think is responsible for it?  
Mr McKeon: The Treasury have laid a requirement on all departments in resource accounting and budgeting. The way in which the Department of Health has met its responsibilities, in the sense of the Treasury’s, is to pass that responsibility down directly through the NHS, on the grounds that the individual organisations are overspending or underspending, but if they are overspending they should bear responsibility for that action.

Q497 Chairman: That is then decided by the NHS to pass it down to the individual trust.  
Mr McKeon: Yes. This has not always been applied by individual SHAs to all trusts. There has been a variation in the way that has happened.

Q498 Chairman: Mr Taylor, do you agree with that?  
Mr Taylor: Yes, I do. We have a conflict between two different forms of accounting. Resource accounting and budgeting is entirely appropriate for government accounting, and as applied to government departments is a very suitable system. When you move down to NHS trusts, we have a system which is much more like normal, commercial UK generally accepted accounting. Those two systems work differently and that is why we have this problem with the clash between RAB and normal accounting. When you apply RAB to an organisation that is doing ordinary accounting as well, you end up with this doubling of the effect. I think the recommendations that the Audit Commission has made, that you protect NHS trusts from the effects of RAB by having a central contingency, provision, whatever you want to call it, is a very good suggestion.

Q499 Chairman: Did the auditors predict a likelihood of what would happen with the introduction of RAB?  
Mr McKeon: No, I do not think we did predict this is what would happen with the introduction of RAB.

Q500 Chairman: But we knew the Treasury would not allow any Department to overspend.  
Mr McKeon: Yes.

Q501 Chairman: They got inside a mechanism that if you do overspend we will punish you the following year. That was known.  
Mr McKeon: That was certainly known and I think it has been the effect of the way this has worked out, as is set out in table 1, in terms of the NHS trust accounting system and the way in which the resource accounting and budgeting process has affected that. As we said in the report, however, not all trusts have this applied to them by any means.

Q502 Chairman: Even if they have overspent?  
Mr McKeon: Even if they overspent, they did not necessarily have the RAB adjustment applied to them.

Q503 Chairman: Who took that decision then?  
Mr McKeon: That decision would have been taken locally.

Q504 Chairman: Taken locally?  
Mr McKeon: Yes by the SHA or sometimes by the PCT. Because the way in which this system works is that it is actually the PCT’s allocation that is deducted and they technically pass that deduction on to the trust if—if—they decide to do that. Some people decided not to do that. Some trusts were given financial support in order to ameliorate the effects of RAB, as we set out in our report Learning the lesson from financial failure. You cannot lay all the problems of deficits at the door of RAB by any means.

Q505 Chairman: I accept that, but we are looking at a piece of accounting that changed a few years ago now and its effect on a trust, given that the buffer zone, or whatever we want to call it, that has been put in place now was not there at that time. If my trust had spent £10 million more than it should have spent, it not only has to rein back on that £10 million...
but it also loses £10 million the following year. What are the implications for any organisation of that happening?

Mr Taylor: It is a very punitive regime. The organisations are being punished, if you like, twice for their deficit.

Q506 Chairman: It is not quite capital punishment, but not far off! What are the implications for “the business”?

Mr Taylor: One of the things we do know is that the best indication of whether an organisation is going to have a deficit in the future is whether it had a deficit in the past. We have learned—and you have quoted in your studies—that once an NHS organisation gets into deficit, it is very difficult for it to get out of deficit.

Q507 Chairman: Without . . . ?

Mr Taylor: Without help.

Q508 Chairman: Without help or cutting back on its business.

Mr Taylor: Yes. Without help and a suitable cover period.

Q509 Chairman: Stopping the over-expenditure. Do you agree with that Mr McKeon?

Mr McKeon: If it has a deficit, then it will have to claw back on its expenditure the following year. That is very clear. There are two points I would make. Where the RAB effect has been applied, it is variable. Where it has been applied, there is no doubt trusts have found it harder to get out of their financial deficit, but clearly that does not apply where it has not been applied. It is also clear, as I think has been said before, that some organisations have had underlying problems for some time which were there possibly before the introduction of RAB and have now come to the fore.

Q510 Chairman: Presumably the implications of the introduction of RAB were not taken into account by (a) the local overspenders or (b) the National Health Service itself. Is that a fair comment to make? The implications of this change of accounting for some trusts who are currently overspending—and some of it may be historical overspending in terms of judgment against the formula—was not looked into in a proper way, the likely effect of this introduction.

Mr McKeon: For some organisations, the effect of it did come as a surprise, yes.

Q511 Chairman: We will pursue this with other people we will have in front of us on this particular inquiry. It seems to me that this was an area that was walked into without looking at the implications of it. How do we get out of it?

Mr Taylor: The double effect when you are going in does actually become a double effect when you are coming out. If the organisation can get over this overspending problem and restore financial balance, when they are coming out they get a double benefit at the other side.

Q512 Chairman: What about the issue of top slicing. Mr Taylor, you are dealing with people on the sharp end of all this. What are the implications for that?

Mr Taylor: Are you referring specifically to the top slices that are being applied this year in order to restore the system to balance?

Q513 Chairman: Yes. Mr Taylor: I think HFMA members are very keen that the whole system is brought back into balance. It is a very difficult time being in the finance function in the NHS at the moment with the deficit problems. 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.

Q514 Chairman: Returning to financial balance over the short term or the long term? My local trust has been top-sliced. It is not overspent, in deficit, but it has lost about one-third of its growth money this year. That is not devastating for health care in my area, but we could have improved it if we had had all the growth money and not lost one-third of it. For these trusts which are grossly overspent—certainly in the wider region that we have now in Yorkshire and the Humber—that is not going to go away in the next six months, is it? What are the implications, do you think, for your members and budgets for the next financial year after this? Will we see an end to top-slicing?

Mr Taylor: I cannot predict whether we will see an end to top-slicing or not. That is a decision for the Department of Health. I think many of my members are concerned that they have a reasonable period in which to recover. If you do have an organisation which is in deficit, you need to produce a financial recovery plan, and that will set out how you will recover the financial position over a period of time so that you can continue to deliver the services to patients in the period whilst you are in financial recovery.

Q515 Chairman: We have been told that the top-slicing money will go back, with interest. The real question is when? Do your members have any understanding of when that is likely to happen?

Mr Taylor: I think the Department of Health’s position is that it will be repaid over three years.

Q516 Chairman: The other thing, of course, is that the top-slicing on this year’s budgets equates with the overspend—or we are led to believe that it equates with the overspend, but now we have the real figures I am not too sure about that. If that is the case, would you expect—and I know you have said you do not know—there to be any top-slicing on next year’s budget on the basis that this money equates with the overspend this year? Is that a bit complicated?

Mr Taylor: I cannot really comment because it is a Department of Health decision as to whether there is a top-slice next year.
Q517 Chairman: We were told that they will not pay the money off, that people who have overspent will have to get themselves back into financial position, but if they do not pay the money off then there is still overspend next year and the year after, at least, I would have thought, and some of these trusts could go on for ever. Your members have no feeling about when this type of reaction—and I am not saying it is not justified, do not get me wrong—of top-slicing will end while we have overspend. We have no concept of that at this stage. 

Mr Taylor: The view of the HFMA would be that this is a short, sharp year of correction and that hopefully we will be back in financial balance in the future. That is certainly what all my members are working towards.

Q518 Chairman: What has happened to this year’s budgets, in areas, not necessarily of surplus but, let us say, of underspend, you would not expect that they will be hit again next year.

Mr Taylor: Again, I cannot answer that question.

Chairman: I know it is dangerous ground. I will try it with one or two other witnesses we will have in front of us in the next few weeks.

Q519 Dr Taylor: The Chairman just asked about cumulative deficits, but you rather skated over those. Is it the Audit Commission’s view that cumulative deficits should be written off?

Mr McKeon: No. It is not proposed that cumulative deficits should be written off.

Q520 Dr Taylor: I think they amount to £1.3 billion. Mr McKeon: That is correct.

Q521 Dr Taylor: However are we going to recover those? Or is it, sort of, joke money—does it not really exist? Or where is it?

Mr McKeon: Or where is it? Just to be clear, the proposal we made in our review was that those trusts who had RAB adjustments made to their budgets should effectively have the money returned to them. That is not the same as writing off their cumulative deficits.

Q522 Dr Taylor: What percentage of the cumulative deficit is due to RAB? Mr McKeon: I cannot tell you that because I have not been able to look at all individual trusts’ accounts and financial performance to see in what way they have had financial support. Because you have to dabble around in quite a lot of the detail, with the SHAs as well, to find which trusts have had financial support in order to remove or ameliorate the effects of RAB, and which have not. It is a very complicated exercise that you need to go through to do that. As far as cumulative deficits are concerned, we said that the first thing was to deal with the consequences of those deficits, and certainly not to write them off but to make sure that the trust was in a proper position going forward. One of the consequences of having a significant cumulative deficit is that you may have a cash problem and therefore you have to have a way of funding the cash and making sure the trust is in a sensible position in order to do that. You then have to look at the ongoing position of the trust and how that is going to perform in the longer term. There was an example in 2004–05 where a trust’s cumulative deficit was written off locally—

Q523 Dr Taylor: Locally? Mr McKeon: No, by the SHA—to the tune of some £15 million. The next year, it had a deficit of £15 million. It did not seem a very sensible exercise to spend £15 million to write off the cumulative deficit only to find that the trust in the next year had a further in-year deficit. One needed to look at the structural position of the trust and its spending. Our recommendation is essentially to say: deal with the consequences of cumulative deficits where there are those in cash problems, and, secondly, have a serious look at the trust’s ongoing financial position and make some decisions in the light of that.

Dr Taylor: Thank you.

Q524 Dr Naysmith: Mr Taylor, in your written evidence you said, “It would be reasonable to expect 70% of the required savings to come from the staff budget.” Does that mean widespread staff cuts inevitably?

Mr Taylor: The point we were trying to get across there is that between 60–70% of NHS spend is on staffing: it is therefore a fairly logical step to take one step back from that and say that if we are going to cut expenditure then probably 60–70% of that cut is going to be on staffing. Of course there are various ways of doing that: you can cut back on bank and agency spend; you can get rid of people who are on temporary contracts; you can not invest in the new staff that you would have invested in. Only at the end of the day would you come to having to make people redundant. Hopefully in very few cases, only where there are severe financial deficits. I think you have to have control of your staff expenditure if you are going to have control of your budget in an NHS organisation.

Q525 Dr Naysmith: What you have said sounds very sensible but some of the things that have been said have been really ridiculous. We have had people emerging from meetings saying, “We are in deficit so-and-so and that means 10,000 people are going to be sacked or lose their jobs.” There has been quite a lot of that from some of your members—not necessarily from the ones you represent, but organisations.

Mr Taylor: I think we have all read the press coverage of various organisations around the country saying that they are going to have to lose large numbers of people in some instances, and I am sure that is true. It is just a matter of how much you lose through natural wastage and the other mechanisms that I have mentioned. It has to be put in the context of the huge increase in numbers of staff that have been recruited by the NHS. I read some NHS employers’ figures that were out last week that
said the NHS had recruited an additional 268,000 staff over the last six years. Perhaps some organisations recruited too many too quickly.

Q526 Dr Naysmith: If it does come down to some people losing their jobs, what sort of categories of staff do you think it will be? Or is it impossible to say? You mentioned agency jobs. Obviously that would be part of it in some places.

Mr Taylor: Yes. I would imagine that staff reductions would come across all categories of staff.

Dr Naysmith: Thank you.

Q527 Jim Dowd: I have one brief question for Mr Taylor in particular. The Chairman mentioned in his opening the questions the survey in the Health Service Journal. One item adduced here is that “39% of chief executives believe that the calibre of finance directors was a major contributory factor to deficits.” Does it concern you that two out of five chief executives do not trust their finance director?

Mr Taylor: I would not put it quite that way.

Q528 Jim Dowd: I do not have the figures for the reverse, of course!

Mr Taylor: No. I do not recognise that figure, to be quite honest. I saw it in the article you are referring to and I find it difficult to believe that is the case, two out of five. The relationship between the chief executive and the finance director has to be very close. I would be extremely concerned and disappointed if that was the true feeling of all chief executives.

Dr Naysmith: I think you are misinterpreting that. Really it is other finance directors talking about finance directors in other trusts. I myself have heard chief executives being critical—especially if they are being top-sliced because of something that has happened somewhere else.

Jim Dowd: No, I think, Mr Taylor, you got it exactly right.

Q529 Chairman: If you have nothing further to add, could I thank both of you for coming along this morning and helping us with this inquiry. We may at some stage be seeing the wood, though I do not know exactly at what stage. Mr McKeon, if there is a response, is it normally published publicly?

Mr McKeon: I understand their intention is to publish the response, yes.

Chairman: We may be in touch with you or dealing with it ourselves in trying to find out when that is likely to happen. Thank you very much indeed.
Thursday 2 November 2006

Members present:

Mr Kevin Barron, in the Chair

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

Witnesses: Mr John Rostill, Chief Executive, Worcestershire Acute Hospitals NHS Trust, Dr Ros Keeton, Chief Executive, Worcestershire Mental Health Partnership NHS Trust, and Mr Mike Ridley, Former Chief Executive, South Worceashire PCT, gave evidence.

Q530 Chairman: Good morning. Could I welcome you and apologise for the few minutes' delay that we have had. I wonder if I could ask you to give us your name and position, please, for the record.

Mr Rostill: John Rostill, Chief Executive, Worcestershire Acute Hospitals Trust.

Dr Keeton: Ros Keeton, Chief Executive, Worcestershire Mental Health Partnership NHS Trust.

Mr Ridley: Mike Ridley, I retired from the Health Service two days ago. Before that I was on a year's secondment to Stoke PCT and before that permanently in Worcestershire PCT.

Q531 Chairman: Thank you very much for coming along. This is our fourth session now taking evidence in relation to NHS deficits. Opening with a question to all of you: 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? Could I ask Mr Rostill?

Mr 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.

Dr Keeton: I would just confirm what Mr Rostill said. You can see how the deficits had shifted in this particular year from sitting previously with the acute trust and now sitting primarily with the PCT and my organisation.

Q532 Chairman: Do you agree with that, Mr Ridley?

Mr Ridley: Yes, I do. I think it is essentially a health economy-wide issue that needs to be considered within the health economy, and it is a mechanism that is employed from time to time where the actual deficit sits between the PCT and the acute trust. My personal view is that it is more important to look at the overall financial position is.

Q533 Chairman: We are interested in how it moves around inside the health economy. Obviously we are looking at Worcestershire today. You said, Mr Rostill, this is by agreement with the SHA. Was it by direction of the SHA?

Mr Rostill: Direction might be too strong a word. They certainly influenced us. This was West Midlands South, not the NHS West Midlands, as now the Strategic Health Authority is called. 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.

Q534 Mr Amess: This is a rosy picture which the three of you are painting, and you work very closely with the leader of the independent group of members of Parliament, Dr Richard Taylor?

Dr Keeton: We work closely with all of our MPs, but that is true.

Dr Taylor: Well said!

Q535 Mr Amess: How have you communicated with each other and combined your efforts to reduce the deficit?

Mr Rostill: First of all, we need to understand that halfway through this financial year (1 October) we actually had a merger of the Primary Care Trusts, so we now have one: Worcestershire Primary Care Trust. Life was more difficult before that when there was a need to communicate with three Primary Care Trusts and a Mental Health Partnership Trust. I am not saying it was impossible, because that would be inappropriate. It certainly was difficult, because, inevitably, the Primary Care Trusts, which had complete responsibility for commissioning services for their patch, would not necessarily always agree for a Worcestershire-wide approach. Two years ago we did get our act together in one year and actually worked very well together. I have to say, though, that the problems and the financial issues within the county meant that that gradually broke apart. To answer your question: how are we going to liaise with the one Primary Care Trust? I am full of confidence that, as a result of one organisation looking after the needs of the whole of the population, we will get consistency of approach. Inevitably though, they are currently a very stretched organisation in that they have a chief
executive, a chairman and I believe they have now appointed some non-executives, but they do not actually have a full board of directors yet, so it will take some time. The early signs, though, are very encouraging, and both the Chief Executive of the Primary Care Trust and myself have made it clear to our staff that this is a co-operative, collaborative approach, not one of competition.

**Q536 Mr Amess:** In your judgment then, combining your efforts is benefiting, ultimately, healthcare in Worcestershire?

**Mr Rostill:** I believe so.

**Q537 Mr Amess:** And the deficits are being reduced?

**Mr Rostill:** Our plan for this year is to break even.

**Q538 Mr Amess:** You have got to break even, have you not?

**Mr Rostill:** Yes.

**Q539 Mr Amess:** You have got no choice, but my question is: are deficits at the moment being reduced?

**Mr Rostill:** I do not think the whole deficit within Worcestershire will be reduced significantly in this year, but over the next two to three years they certainly will and there will be a plan for the health economy to get into sustainable balance in two to three years’ time.

**Q540 Mr Amess:** Dr Keeton and Mr Ridley, do you have any observations to make?

**Dr Keeton:** I think I would concur with what John says about working with one PCT as opposed to three. It was very difficult previously, with three PCTs, to get ownership of mental health issues any more than one of them. One of them used to take the lead, which let the other two, in some ways, take their eye off the mental health ball, and that, I felt, was not helpful and, therefore, a single PCT would be much easier to work with and looking at the whole of the population. We are working together to reduce deficits, both as individual organisations and trying where possible to work jointly on county-wide approaches. Like John, I am confident that we are reducing the deficit, but we will not reduce it and get rid of it this year—certainly I will not—but I have a plan that will get us back into balance in three years’ time.

**Q541 Mr Amess:** What is your view, Mr Ridley?

**Mr Ridley:** My view is that Worcestershire is probably a catalyst for the rest of the country. Over the last six years, since I have been in Worcestershire, there have been peaks and troughs in terms of relationships between the different organisations, and that is definitely down to individuals and how they work with each other. I am not even talking about the Health Service but other partners in social care and the independent sector. So, it has gone up and down, depending on the level of co-operation that has been available between the organisations, but each organisation has its own specific responsibility, and I think that is a particular issue that, as well as each organisation having to balance its books, they also have very clear responsibilities to hit particular targets and a whole range of other issues that arise during the year. As John has said, a couple of years ago we probably peaked in terms of the organisations working together, and that helped. It is still dependent and one single PCT from Worcestershire will, I am sure, help that position. In answer to your final question, the PCT deficit in the current financial year is not going down. We projected a deficit at the start of the year of £11 million, we are currently projecting a deficit of £16 million, so you might say we are going in the wrong direction. That is entirely due to in-year issues and I think the problem of the financial position within the Health Service is on a day-to-day, week-to-week basis. There have been a number of extra pressures identified over the last six months which we have to cope with and almost alter savings plans meeting by meeting, month by month, so the whole financial position of Worcestershire probably has not changed significantly. John is projecting a better financial position. It is perhaps the PCT’s turn this year to project a deteriorating financial position.

**Q542 Mr Amess:** We thank you for your honesty. It is clear then it is not such a rosy picture really?

**Mr Rostill:** I need also to add, if I may, that it will only balance by being the beneficiary of a loan from the Strategic Health Authority.

**Q543 Mike Penning:** And by cut-backs?

**Mr Rostill:** Yes, definitely.

**Q544 Mike Penning:** How big?

**Mr Rostill:** This year we are looking at an £18 million, and a bit more, deficit that we need to recover, and that will certainly lead to reducing the number of staff that we employ by 600 or 670 or so, and that is inevitable.

**Q545 Mr Campbell:** Would that be front-line nurses?

**Mr Rostill:** Some will be front-line staff.

**Q546 Mr Campbell:** Do you not know the exact number?

**Mr Rostill:** I cannot give you the exact number now, but I can certainly send it to you. I know that we have reduced the number of nurses that we employ by over 130 this year. We currently have over 450 vacancies and we are currently predicting a balance, but having said that, what that means is that we are currently doing the same amount of work with less staff, and you can only continue that for a period of time. We need to do more work with even less staff but we need to do that work differently and smartly.

**Q547 Mr Amess:** How is morale?

**Mr Rostill:** It depends who you are talking to in the Health Service. I think we have a particularly good relationship with our staff side and trade unions. Clearly, they are opposed to what we are doing, but they see the sense of co-operating and getting involved in the process so that it reduces the impact wherever possible. The morale of the National
Health Service, you will be told in the papers, is the worst it has ever been since it was introduced in 1948, and we have been hearing that since 1949.

Q548 Dr Naysmith: You talked about the reduction in staff posts. I suppose you mean really, of about 600 or so. Over what sort of period are you talking about?
Mr Rostill: We are trying to do it in the current year. That would be difficult, so we need to do it over a two-year period.

Q549 Dr Naysmith: That is not filling posts as they become vacant, or what do you mean by the 600?
Mr Rostill: There are all sorts of things, not filling posts, but, of course, you cannot not fill every post, and inevitably—we have a restructuring plan—the people who leave are not necessarily in the right places, therefore some replacements have to take place. I think the answer that you are requiring now is, we have had some voluntary severance, some people have taken voluntary redundancy, and I think it was 23 at the last count, we have also had to make some people compulsorily redundant. At the moment, at the end of October, we had actually made five members of staff compulsorily redundant.

Q550 Dr Naysmith: That was not really what I was getting at, although that is interesting. What proportion of the 600 (and I know you have said that it is not the same people necessarily) have been posts that have been created or filled that were previously empty, say, two years ago because there has been a big growth?
Mr Rostill: There has been a growth. 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, and I think the National Health Service generally, and Worcestershire in particular, has done exceedingly well to meet those targets, but that has had a necessity of taking on additional staff.

Q551 Dr Naysmith: We are getting down backlogs. Presumably, now that you have got down backlogs, you will not need quite as many staff in the future?
Mr Rostill: I understand the comment. The targets, or the objectives, get no easier. We are currently working at a situation where nobody waits more than six months for an operation, nobody waits more than 13 weeks for an out-patient appointment. By the end of 2008 the whole of the patients' experience should be no more than four and a half months. We have got to go from nine months to four and a half months, so we have not, if you like, got rid of the backlog or the tail yet.

Q552 Dr Naysmith: Finally, how will the proportion of the people you will be employing in 2008 compare with the proportion of people you are employing in, say, 2005? Will it have gone up?
Mr Rostill: It cannot go up significantly and balance the books. We are going to have to make sure that we introduce new systems, new procedures and new processes to actually meet the ever increasing demands. It would be difficult for me to predict exactly how many staff. It would be less than we have currently got.

Q553 Dr Naysmith: It could still be more than you had in 2005?
Mr Rostill: I think it is unlikely.

Q554 Anne Milton: Can I come in and ask you. You are the highest spender on agency staff. You employ more agency staff than anybody else. It seems odd to be cutting jobs and employing agency staff.
Mr Rostill: You are talking about the productivity matrix.

Q555 Anne Milton: I am talking about the fact that you are the highest in the country.
Mr Rostill: Yes.

Q556 Anne Milton: And they are expensive.
Mr Rostill: I entirely agree with you. I have to admit that that is an error. In actual fact the figure that we put in did not just include agency staff but people we got from NHSP, which is the NHS bank, so that figure is inflated. When the second quarter’s figures come out you will see that it will be a lot less. Indeed, and you are quite right to point it out, one of the things you have to do is not take people on at inflated rates to do jobs often at short notice, but sometimes you have to do that. If a senior house officer does not turn up at 10 o’clock at night, you need a senior house officer, so you are inevitably going to get a locum in, but you should not have long-term locums. We have spent a lot of time in the last two years reducing our agency staff, particularly for nurses. We still have an issue with medical locums.

Q557 Anne Milton: So you are not the highest user of agency staff; you put in the wrong figures?
Mr Rostill: We will not be when you look at the second quarter’s figures.

Q558 Anne Milton: You put in the wrong figures?
Mr Rostill: Yes.

Q559 Mike Penning: Can I ask you two quick questions. You said morale has been bad since 1948. Can you in your career remember having these sorts of job losses in the NHS across the board?
Mr Rostill: My career stretches 42 years.

Q560 Mike Penning: When was the last time you arranged 650 job losses?
Mr Rostill: Never.

Q561 Mike Penning: We probably agree that is why morale is pretty bad at the moment?
Mr Rostill: I think, though, that morale will get better.
Q562 Mike Penning: For those that stay?
Mr Rostill: As, in fact, the new processes and procedures take off. There is still an awful lot of pride by members of staff, not just the medical and nursing staff but everybody else that works in the Health Service, in what a good job they are doing and are continuing to do.

Q563 Mike Penning: There is an awful lot of pride for people that need to go home with a wage packet and pay for their everyday living, and 650 job losses will naturally cause morale to be very bad. It was not quite like in 1948 because we have not had these job losses since 1948. I accept what you have said there. That is why morale is so bad across the country probably.
Mr Rostill: I think it is the uncertainty of not knowing there is an actual end to the process.

Q564 Mike Penning: One of the things you said that would end this uncertainty was a new PCT which is covering your whole area. The previous PCTs came in about three years ago. You had deficits then, before you went into the new ones, you had deficits under the new ones; so why should we think it is going to get any better this time, because you have had exactly the same system of forming deficits before?
Mr Rostill: One of the issues that besets the NHS is continually changing organisational arrangements (which inevitably, in some areas, means that people take their eye off the ball) and concentrating on restructuring. I think with hindsight people other than me, but it includes me, would say that introducing the number of primary care trusts three years ago, the actual number, was not a particularly good thing to do.

Q565 Mike Penning: You had deficits before you introduced those under almost the identical PCT scheme that you have now, which you think is the panacea to the problem. Why was it not the panacea last time if you are going to have the problem now?
Mr Rostill: I did not believe it was the panacea last time if you are going to have the problem now?

Q566 Mike Penning: You seem very chirpy about it!
Mr Rostill: I am a naturally chirpy person.

Q567 Mike Penning: I would not be if my job was under threat.
Mr Rostill: Yes, but you have to have some confidence that, in fact, you are building better relationships, you are building better systems, you are building better processes for the benefit of the population.

Q568 Mike Penning: You are building exactly the same relationships you had three years ago and you had the deficits then. Why are you chirpy about it today? It is exactly the same principle.
Dr Keeton: The relationships, we believe, will help but they are not the answer. We have got to change the way we provide services in Worcestershire, and I believe we can demonstrate we are on that road to changing them, but, unless we fundamentally change the way services are delivered in Worcestershire, relationships will not be the answer. They are something that helps us down that road, but they are not the answer.

Q569 Chairman: Just before we move on, Mr Rostill, could I ask you particularly about your trust. We have had quite a long, interactive debate about jobs. How does this impact on patient care in your trust at the moment and any predictions for the future?
Mr Rostill: We have to be sure that the changes that we make have a minimal impact on patient care and, indeed, we do a risk-assessment in the areas in which we think there may be difficulties. We clearly decided, just a few weeks ago, to make a minimal impact on the number of ward-based nursing staff by too many in some areas, and we have decided that we will employ some more in those areas. We now will not reduce the nursing staff in any area by more than 10%, but, overall, to get into balance, we need to make a staff reduction of 15% and 25% in corporate departments, most of which (in the latter category) we have now achieved.

Q570 Chairman: Does any of this have any detrimental effect on patient care?
Mr Rostill: We have to make sure that it does not, because it is entirely unacceptable that we should knowingly impact on patient care adversely.

Q571 Chairman: You do not think it will do?
Mr Rostill: I think that we have to be careful that it does not. It will inevitably make some impact in due course.

Q572 Chairman: You do not know whether that is going to be detrimental or not at this stage?
Mr Rostill: Part of my responsibility, as the accountable officer, is to make sure that it does not have a detrimental effect.

Q573 Dr Stoate: Mr Rostill, I cannot boast 42 years in the Health Service, but I can boast something like 30 something, so I have done a number, and I have worked in most departments within the Health Service at various times, whether it be health authorities, PCTs, primary care, secondary care, and so on, and I can certainly confirm that morale goes down every year, it always does. You pick up the Daily Mail and you realise it is the worst year ever for the NHS, because it always has been since it started, and yet you said yourself that you have seen very significant increases in resources, very significant increases in staffing levels and very significant improvement in patient care, particularly in terms of waiting times. How does that all add up? 
Mr Rostill: It goes back to the National Health Service Plan of 2000, which had some very, very ambitious targets. I do not believe necessarily that people really fully understood the cost implications of hitting some of those targets. I will give you an example. We are supposed to be reducing the number of emergencies by 5%. We have not yet seen that happen significantly. We also have to make sure
that we meet particular waiting times. As more
emergencies come in, the chances are that we will
from time to time have to cancel planned operations.
If we cancel planned operations because we have
already scheduled for the next two to three weeks,
inevitably, to meet the targets, we are going to have
to do those operations out of normal hours and at
enhanced pay. Also, it is quite right that we have
seen a big increase in the numbers, particularly
front-line staff, but not necessarily enough to
realistically hit some of the targets and what I would
call plain time rates.

Q574 Dr Stoate: Certainly in my experience every
organisation is always either breaking even or in
deficit, and always has been. What I want to do is to
try and get behind some of these deficits and find out
how real they are, because we have seen so many
reports in newspapers about deficits of 500 million,
deficits of 1.5 billion, depending on who you ask,
and it seems from the evidence we have been
receiving that a lot of this has been due to financial
mechanisms, things like brokerage, and so on, which
have always been used, I believe, to make the deficits
look different to reality. How much have the new
accounting practices, Mr Ridley, such as RAB
(resource accounting and budgeting) made an
apparently more acute position this year than
previous years or is this a real effect?
Mr Ridley: I think it is a real effect. I think that RAB
is a helpful mechanism in some ways; I think it is
unhelpful in others. The short-termism of RAB, for
example, causes perhaps unfortunate additional
problems in-year and in the year after in seeking to
recover from a deficit.

Q575 Dr Stoate: What I am trying to get at is does
RAB make the situation look worse or is the
situation genuinely worse?
Mr Ridley: I do not think RAB makes it any worse.
I think that RAB provides a possible solution and a
needed solution for how we get out of our deficits
and also brings a very real pressure on getting out of
our deficits more quickly than perhaps we would
otherwise have done, but the stated financial
position (and I take your point about brokerage), I
believe, is as close as we can get at the present time.
Going back to a point that was made earlier, it might
sit in a different part of the Health Service, and I
think we do need to understand on a health
economy-wide basis that this year it will be the
PCT that shoulders the debt for the whole of
Worcestershire, me mainly. Last year it was the
acute trusts that shouldered the debt, so it is moving
around, but as long as all of those figures are
reported consistently, then the bottom line will be a
consistent figure as well.

Q576 Dr Stoate: The point I am getting at is, if we
are now seeing the true figure because the accounting
system is much more transparent and much more
difficult to hide behind, how much in previous years
were things like brokerage simply papering over the
cracks?

Mr Ridley: It was papering over the cracks to an
extent in particular parts of the country. Five years
ago Worcestershire received quite significant one-off
non-recurring support from the then regional office,
and that financial support came down from the
Treasury to the regional office and into
Worcestershire, so it would look as though
Worcestershire was doing better that it actually was.
Somewhere there has got to be an accounting, and
I suspect in those days there was not necessarily the
bringing together of all the local figures and all the
national brokerage. What I am saying now is that
under the brokerage arrangements, under the NHS
bank, under the RAB arrangements, I believe that
we now have a pretty accurate figure for the whole
of the NHS.

Q577 Dr Stoate: I accept that, and I think we are
talking the same language. What I am trying to get
at is simpler than that. If we have now got the true
picture, was it always like this and it is just that the
mechanisms were various, shall we say, book-
keeping arrangements sought to keep them from
politicians’ view or do you think we genuinely have
got a shift in the way the Health Service is now
coping?

Mr Ridley: My good feeling would be that the
current figure is genuine, the current deficit is
genuine and that is a deterioration in the figures that
we have had over the past year.

Q578 Dr Stoate: Do we actually know: because if the
previous arrangements were so opaque, with
brokerage and loans and paybacks all hidden under
the table, for all we know, it has been like this since
1948 and it is only now we have found out about it?
Mr Ridley: No, I think that there have been
arrangements between the Department of Health,
between the Treasury in totality, at the centre and
between regional offices, that have served to produce
the final figure for the NHS, and that is important.
We are coming into the realms of capital
expenditure, PFI expenditure, a whole range of
issues here; so I think the position that we have got
now has deteriorated. I do not think we have had this
position for the last 20, 30 or 40 years, no way, but
it is now a better, more accurate reflection of where
we are.

Q579 Dr Taylor: Thank you very much for coming.
I hope it is not going to be too much of a traumatic
experience. I want to try and explore the causes of
the deficits, which to me is really almost the most
important thing we are talking about. I am very
grateful for the paper (and for colleagues on the
Committee this is Deficits Paper 661; which is John’s
paper from the acute trusts about the size of the
deficit and the causes) and, if we may, I would like to
work through that and get you to explain some bits.
Firstly, the bit about the PFI. You say, “Additional
costs of £7 million from the operation of a new PFI
financed hospital” are one of the main causes. Can
you expand that a little bit?

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Mr Rostill: Yes, that is a calculation that we have done. It is a new hospital, as you are aware, that opened in 2002. As a result of capital charges, et cetera, we reckoned it would cost us now £7 million more than it would have done had we not had it. If we had had a new hospital under the old scheme, it would still have cost us more but not as much as this, and, in addition, they changed the rate of return from 6%, I think, to 3.5%.

Q580 Dr Taylor: That was on National Health Service procured buildings capital charges reduced from 6% to 3.5%?
Mr Rostill: Yes.

Q581 Dr Taylor: You do not benefit from that because it is a PFI?
Mr Rostill: Yes.

Q582 Dr Taylor: Do you think the PFI contract was badly written—I know you were not around at the time—because of the penalty clause, as I call it, for bed occupation above 90%?
Mr Rostill: This was my first experience of PFI, and the contract was one of the first that was agreed in the country. I have to hope that they are better now. I do not believe that there was what I would regard as real transfer of risk in our PFI contract. 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, and I am sure you will have other witnesses from PFI firms who will tell you something different. Where I sit, my hands seem to be tied much more than had this been an NHS funded hospital, public sector funded hospital in the past, and the ones that I have run before I have had much more flexibility in making change, not changes that you would want me to make, but my hands are tied for a proportion of the amount of money that I—

Q583 Dr Taylor: So it is quite a large contribution to your deficit?
Mr Rostill: I believe so, yes. The other point that you were making about what you call the penalty clause, the number of beds that was included in the PFI deal was obviously less than the number of beds in Worcestershire before. It was planned on the basis of 90% occupancy. There are very few acute trusts currently, or for some time, that can sensibly operate at 90% occupancy, so this is what I would call a supplementary charge. It is really no more than a cost and volume, but clearly it is something that we could do without.

Q584 Dr Taylor: Mike, did you want to come in?
Mr Ridley: I was going to support John on that. I was here for the PFI contract, I was working for the Health Authority. It was in the very earliest of days. We did everything we could: we took legal advice, we took Treasury advice, we took regional office advice. There were long, long meetings to agree that, but I think that we were just perhaps a little out of our depth because it was the first year of PFIs and the external organisations had the best lawyers, the best accountants, the best advisers. To an extent, we are paying the price now, but I think we have learned an awful lot from my involvement in later PFI ventures. I think the Health Service has caught up quite significantly.

Q585 Dr Taylor: Those of us on the Committee when we did the inquiry into the role of the private sector will remember that we discovered that risk transfer was an art rather than a science. Going back to your paper, you list some of the changes in the rules you have had to work to that have caused tremendous losses, tremendous difficulties. You say the national efficiency target of 2.5% reflected in the tariff, which was an increase from the expected 1.7%, reduced your income by £5 million.
Mr Rostill: Yes.

Q586 Dr Taylor: When did that happen? Did you have warning of that, or was that suddenly put on you in the middle of the year?
Mr Rostill: It happened before the beginning of this financial year, but only just.

Q587 Dr Taylor: So you had no time to adjust for that?
Mr Rostill: We did not have a lot of time.

Q588 Dr Taylor: Whose fault was that?
Mr Rostill: It is the system.

Q589 Dr Taylor: The system?
Mr Rostill: Yes.

Q590 Dr Taylor: In other words, the Department of Health?
Mr Rostill: If that is what you call the system. We need to be clear. 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 announced at.

Q591 Dr Taylor: When did they introduce the 50% tariff for non-elected growth?
Mr Rostill: I think round about February.

Q592 Dr Taylor: Round about February with the financial year ending in March?
Mr Rostill: Yes.

Q593 Dr Taylor: The same, the 2.5% discount to the tariff?
Mr Rostill: The same time.

Q594 Dr Taylor: Totting up those figures, about £14 million in reduced income suddenly hit you in the February at the end of the financial year?
Mr Rostill: Yes. We were predicting a £20 million deficit. The figures that you have in front of you increased that to 36.9; in other words, nearly another £17 million. I have to say that the NHS West Midlands, or its predecessors, did agree that it was impossible to claw that back in one year.
Q595 Dr Taylor: Can I go to Mike and the funding formula. I think this is the back of your paper. You tell us that at the beginning of 2002, before their contributions to the local NHS bank, each of the Worcester PCTs was funded at a level below its capitation target. We have heard evidence that rural or semi-rural areas by their targets are less well off than some of the urban areas, but now you are saying that you are even below that capitation target. Is that right?
Mr Ridley: Worcestershire is below its capitation target.

Q596 Dr Taylor: The figures that you have given add up to £13.6 million.
Mr Ridley: That is correct, yes, about 2%.

Q597 Dr Taylor: You go on below that and list the things that you have lost because of the contributions to the bank. The bit I do not understand is the PPA, is that purchaser parity adjustment?
Mr Ridley: That is correct.

Q598 Dr Taylor: Can you explain that and how you lost £4.7 million because of that?
Mr Ridley: The intention of the purchaser parity adjustment, when tariffs were brought in, was to ensure that commissioners were no more disadvantaged if we had to pay a different price under the tariff to our local trust. Then, if that trust was efficient and we had to pay more, we got an adjustment to our allocation, we got extra money to ensure that we stood still, effectively our purchasing power remained the same for a two-year period, well, for a period. So, we got that allocation, which would eventually level out as the provider costs balanced with the commissioner’s ability to pay. The problem has been that the extra money that we got, it was decided, would be phased out over a shorter period, over a two-year period, and therefore half of it has been taken away this year, thus requiring us to find that extra £4.7 million in-year in order to maintain our purchasing power.

Q599 Dr Taylor: How much of the total county deficit has arisen because of almost emergency changes by the Department of Health that have impinged on income and cost?
Mr Ridley: If by county deficit you mean the PCT and our provider services. So, the net figures is £16 million, but we have had to find that extra £22 million to give to the bank and to the purchaser parity adjustment.

Q600 Dr Taylor: Those were the acute trusts?
Mr Rostill: Those were the acute trusts. We have also got a number of community hospitals in the county and there is no doubt that the cost of multi-site organisations inevitably are more than single sites, and to resolve the financial problems in Worcestershire we need a much more radical solution than just tinkering with the financial mechanisms. We do need to sit down and have a county-wide plan as to where the services should be provided. The difficulty was, if you like, encapsulated by the primary care trusts that were looking after particular patches of the county, and some of our emerging proposals to rationalise or centralise some services that took services away from one hospital would not gain the favour of that local primary care trust.

Q601 Dr Taylor: Trusts that are in deficits tend to say they are under-funded and trusts that are doing well tend to say they are well managed. Is there any evidence of bad management, before you arrived I hasten to say?
Mr Rostill: Evidence of bad management, not necessarily. I think you need to look at the structure of health services in Worcestershire, and, if you were starting with a blank sheet of paper, you would not draw it the way that it is. It merged three quite disparate organisations in 2000.

Q602 Dr Taylor: Those were the acute trusts?
Mr Rostill: Those were the acute trusts. We have also got a number of community hospitals in the county and there is no doubt that the cost of multi-site organisations inevitably are more than single sites, and to resolve the financial problems in Worcestershire we need a much more radical solution than just tinkering with the financial mechanisms. We do need to sit down and have a county-wide plan as to where the services should be provided. The difficulty was, if you like, encapsulated by the primary care trusts that were looking after particular patches of the county, and some of our emerging proposals to rationalise or centralise some services that took services away from one hospital would not gain the favour of that local primary care trust.

Q603 Dr Taylor: In the inquiry we did into the mergers of PCTs we heard people telling us that the merger was going to set the service back by a number of months. Is the merger of PCTs that has gone on at the moment being well handled or is that setting decision-making, setting management, back?
Mr Ridley: There are always going to be problems. In any merger there is always going to be that point in time where concentration has got to be given to the new organisational structures, and I think that is happening at the moment, and right across the country, I think, that is causing hopefully a fairly short period of, not exactly stagnation, but it takes the eye off the ball for a little time. I think that the benefits after that reorganisation will be clear to see. It goes back to the point that was made earlier. I believe primary care trusts are really good in terms of the primary care led part of the NHS. There were too many in the past, clearly, and now, hopefully, we have got the balance right between single PCTs, which usually cover accounting, and they are able to concentrate directly with provider services in order to commission those services on a much more direct and streamlined basis.
Dr Taylor: Is there anything else you wish to say about causes of deficits that we have not covered?
Chairman: Richard, we have got to move on. It is 10 minutes to 11 here.
Q604 Mike Penning: Can we simplify for all our constituents and your patients’ point of view the spending formula. You say you are not getting the amount of money you need. How much per head do you get? Last year I got about £960 in my constituency. We have got massive deficits. What are you getting compared to the average?

Mr Ridley: I have not got the figure per head.

Mr Rostill: It is about 1,083. Our neighbouring county, Herefordshire, gets about 1,100. We can send you the figures.

Mike Penning: Do you know the national average?

Chairman: Mike, we have got the figures for all the three trusts before they were merged. They are all in the written evidence. I read them last night before I came along here, so they will all be public documents. We have to move on. We have nine minutes to the hour and we have many questions to ask of these witnesses before that.

Q605 Charlotte Atkins: Mike, I am surprised you are not more demob happy to be retired from the NHS. You seem very quiet! What I want to ask you about, you will not be surprised, is your more recent experience in Stoke-on-Trent. Can you draw the parallels between the experience of Worcestershire and your experience in Stoke-on-Trent?

Mr Penning: I can draw very clear analogies. In the relationship end, which I think you are suggesting, back to Richard’s question, about “bad management”. I am not sure about good or bad, but clearly there have been gaps in management down through the years. Some managers are better than others and I think that it is very much down to relationships. I mentioned that two years ago we maybe peaked in Worcestershire in terms of relationships. As far as Stoke is concerned, there have clearly been difficulties, even just with three organisations, two PCTs and an acute trust. I think we have seen changes in senior management in the acute trust at the university hospital in Stoke and in the PCTs, and I think that that has improved the situation and got a greater focus on the overall health problems and financial problems in Stoke. I think the same has happened in Worcestershire. There has been new management coming in, they have worked together, but the bottom line is that they have got to work within a system and, if that system says organisations will change, if that system says that all those organisations will adhere to these targets and this context, then that limits the scope and ability of management to work together. But, yes, there are very, very clear analogies between the two.

Q606 Charlotte Atkins: The issue, of course, was about PCT deficits and the hospital in North Staffordshire, North Staffordshire University Hospital, blaming the PCTs and vice versa over the cause of their particular deficits. Clearly, if the PCTs were trying to, for instance, reduce emergency admissions, then of course that would increase the funding available to the PCTs and reduce the funding to the acute hospital. Is this solution achievable, given that within the system there is automatically a competition between the PCT and the acute trust as to who should be paying for what?

Mr Ridley: Yes, and that is absolutely right. That is why we need clarity, clarity right from the start, in our agreement between the PCT and the acute trust, and that has happened in Worcestershire and that has happened in Stoke and it is really important to identify what is achievable in terms of the finance that is available to the PCT in terms of the activity that needs to be purchased to hit waiting times, waiting-list targets, and not to do anything else. I think that one of the problems is that we have been stretched as PCTs to say not only have you got to hit the acute trust targets but you have also got to hit the teenage pregnancy targets, you have got to hit the smoking cessation targets, you have got to hit the crisis intervention targets, a whole range of other targets, and there has been a real danger that we have pushed out all of these targets. We have gone out on a wing and a prayer to say, hopefully the money will be in the system. I am relying on John and Ros to be even more efficient to deliver the targets within that limited amount of money, and that is where good management comes in, that is where it is vital that we are right on the ball in terms of saying, “That is achievable, Mike, but we cannot do that”, and therefore we need to go back to the Strategic Health Authority and say, within the context of finances that have been allocated to this health economy, Stoke, Staffordshire, Worcestershire, wherever, this is all that can be achieved and we must not go out with an over-ambitious programme.

Q607 Charlotte Atkins: Are we now on the right road or are there still things to be fixed?

Mr Ridley: We are on the right road, but my fear is that the deficits (the accumulated deficits, the deficits being carried forward) could be the straw that breaks the camel’s back. Under the RAB arrangements we have got to recover this year. There is no timescale; we have got to achieve £18 million savings in-year in Stoke, we have got to achieve £16 million in-year in Worcestershire. That is desperately hard. That has the potential to impact on services; that has the potential to impact on staff.

Q608 Mr Campbell: With all the trouble and financial trouble you have had, you have managed to get a three-star. That is only one off being a foundation. How did you manage that?

Dr Keeton: We did, and we worked very hard for it, and we have worked hard this year in a very difficult financial position with the new system. One of the problems if you are in deficit is to get panicked, I think, into just looking at the money, and what we have tried to do at the same time as looking at the money and looking at it very hard and trying to do things in a different way is be absolutely clear about the fact that we have got to try, with whatever limited resources we have, to meet the standards that
are laid down for us. So, as an organisation we have worked very hard to keep our eye on the standards at the same time as trying to do service change.

Q609 Mr Campbell: So the financial pressure is not the big issue, the aim is to get the three stars. It was there, but it was not the big issue.  

Dr Keeton: It was not the biggest issue but it is a big issue. To me finance is always a big issue, but, at the same time, I think what we deliver to service users and to patients has to be just as big an issue. I always in the organisation have tried to maintain an equal focus, so, yes we are doing change but, hang on a minute, are we meeting those standards? When I came into the organisation we were zero-rated, and that is because the organisation had got panicked, I think, into not understanding that there were the two streams to do it, and we have worked hard to try and maintain that.

Q610 Mr Campbell: Can you tell us the number of administrators that are employed over £100,000?  

Dr Keeton: In my organisation, none.

Q611 Mr Campbell: Yours as well, of course?  

Mr Rostill: In my organisation it will be two, three if you include the medical director.  

Dr Keeton: I did not include the medical director. I did not consider him an administrator.  

Mr Campbell: It is an interesting question. Other trusts have got those over £100,000. I am trying to get an average of where these big salaried people are and how many.

Q612 Sandra Gidley: A question to all of you about what action you have had to take to deal with the deficits. We had the figures earlier about the what action you have had to take to deal with the deficits. We had the figures earlier about the...

Q614 Sandra Gidley: And support clinical services?  

Mr Rostill: Yes.

Q615 Sandra Gidley: You mentioned outsourcing. What are you outsourcing and to where?  

Mr Rostill: Things like what is known as the back office stuff. Our accounting and supply areas are done by the shared services, which I think you do as well.  

Dr Keeton: Yes, the whole of the health economy uses Bristol Shared Services.

Q616 Sandra Gidley: So it is combining low-key provided services?  

Dr Keeton: No, Bristol Shared Services nationally provide outsourcing of our basic finance functions, our creditors, debtors, et cetera, et cetera, but we do also have some local arrangements of shared services—catering, estates, recruitment—not that we are doing any of that at the moment, but those sorts of things often, as a health economy, to try and get economies of scale, but, as John was saying, we have also outsourced to national providers such as Bristol Shared Services.

Q617 Sandra Gidley: In my neck of the woods they are outsourcing medical record writing to India. You have not gone down that route yet?  

Dr Keeton: No.  

Mr Rostill: We have not yet gone outside this country for the digital type system. There are clear benefits in reducing the work that some of the secretaries have to do so they can concentrate on other things, and we have trialled a couple of systems and we are out to tender for it at the moment.

Q618 Sandra Gidley: Did Mike Ridley want to add anything?  

Mr Ridley: The PCT is concentrating on savings, bringing the PCTs together. We have got to make 15% savings, so, clearly, we are in the process of revising our structures to make sure that there are very significant management savings across Worcestershire from the three original PCTs into one.

Q619 Sandra Gidley: That will make the Daily Mail happy, but will reductions in management savings mean that clinical staff have to take on more of a management role?  

Mr Ridley: Not really, no. One of the issues relating to the reorganisation is that there has to be allocated from those savings funding to particular areas of direct patient care. That is one of the real benefits that will come out of this reorganisation. Having one board, one chairman, one set of non-executive directors will produce savings which will be reallocated directly into patient care.

Q620 Sandra Gidley: Have any of you had to cut your drugs budgets?  

Mr Ridley: As far as prescribing in primary care is concerned, we have only allocated a 5% inflation uplift, which is probably below what we would have had to put into the drugs budget, on the basis that
we are demanding more savings from GPs, better prescribing in a whole range of different areas and so to that extent it is a cut.

Dr Keeton: We have done some work on prescribing practice across the organisation and our spend on drugs this year is lower than it was last year. We did not impose a cut, but we have looked very radically at how we prescribe the use of generics, et cetera, and, as I say, we are coming in below budget at the moment, which will contribute towards our deficit.

Mr Rostill: We will not be below budget on drugs at the moment. There was a report done by the auditors on medicine management and we came out very well in that, and, like Ros and the PCTs, we will be always looking at reducing the number of different manufacturing drugs that we use to get to the more generic. I have to say, I think there is still a lot more work that can be done. I do not think we have finished on that score yet.

Q621 Dr Naysmith: Dr Keeton, first of all, I was interested in your response to the three-star question. One of the things that is looked at now in assessing trusts is financial ability and financial control, and yet you still got a three-star rating, so someone must have taken the view that if there were any deficits then it was not your fault, is that right?

Dr Keeton: I did not have a deficit in the year we were a three-star trust. This year we have got a “good” for quality of services but a “weak” for use of resources because of our deficit. Any organisation with a deficit nationally was scored “weak” and we would have only scored “fair” and that is an area we need to improve on next year. Whether or not we have a deficit, I would want to see us scoring better than “fair” on our financial management procedures.

Q622 Dr Naysmith: Okay, I just wanted to clear that up. Still, there clearly is a financial problem in your health community. I am not talking about mental health particularly. Did you get any help from the Department of Health or from the Strategic Health Authority in dealing with these problems?

Dr Keeton: My organisation had no support whatsoever.

Q623 Dr Naysmith: None?

Dr Keeton: No.

Q624 Dr Naysmith: Mr Rostill?

Mr Rostill: Historically the Worcestershire Acute has received support from Strategic Health Authorities or their predecessors and this year we will get a loan made up of three components that comes to just over £15 million.

Q625 Dr Naysmith: You did not get any of these assistance teams that were sent into places where there were difficulties?

Mr Rostill: We are a turnaround trust, but we have not had a turnaround team come in. We have been given some money from the SHA to assist us in turnaround and we do two-weekly reports to the SHA turnaround director, who is very supportive of what we are trying to do to balance the books at the end of the year.

Q626 Dr Naysmith: You do not feel deprived that you have not had any physical assistance?

Mr Rostill: No, I do not feel deprived or that we are missing out on the turnaround team coming in, no.

Q627 Dr Naysmith: How have you improved your financial management then? What have you done to get a grip on this situation? I know we have talked about various things.

Mr Rostill: I think, in fact, that is the word which we have used. We have now got “a grip”. We have got people in the organisation, including me, who can say “no”. We have improved all of our systems and processes and we have done a complete review of delegated responsibility, so, for instance, we have got a very good vacancy management control system which has to go to the executive team, nobody else can authorise appointments and so on. We are currently not as good as we should be on the non-paying side, but that is something we are developing.

Dr Keeton: Could I add to that. I think everything John said is absolutely right but one of the other key issues is getting real ownership by clinicians and people in the front row about what the financial situation is because some of them spend the money, not us, and they need to have real understanding and ownership of the issues. I think alongside all the things John has been doing, I am sure he will concur with me that the other issue is getting real ownership throughout the organisation to the level of clinicians so that they understand the implications of the decisions they are making.

Q628 Dr Naysmith: Adopting stricter accounting procedures and making sure they are really strict, firm and in place is happening, is it? Mr Rostill?

Mr Rostill: The answer to that question is yes, but I agree with Ros entirely. We are engaging our clinicians much more than I think they have ever been engaged in Worcestershire. We have what we call a “turnaround board” and we have clinical directors and the managers coming to that board explaining what they propose to do and so on. Also, we have reduced the number of clinical directors from 17 to 10 to focus much more on a smaller group of clinical decision-makers who are prepared to engage with management.

Q629 Dr Naysmith: Finally from me, there were recommendations from the Audit Commission about better financial management. I do not have time to go through them all, but in the light of something that was said earlier, could I have your comment on what they said which was that RAB should not be applied to NHS trusts as it is “incompatible” with trusts’ financial regimes. Instead, trusts should use a regime that emphasises cash and liquidity and allows borrowing for investment and working capital. I think, Mr Ridley,
you commented earlier on RAB and maybe we could get all of your views on what the Audit Commission’s recommendation means to you.

Mr Ridley: I think I have been generally supportive of that recommendation. We need to be clear about the timescale, but the direction of travel that we have been following for the last five to 10 years in Health Service accounting has been more and more sophisticated in terms of paying the full cost of what you are buying. We are very clear about the financial framework in which deficits will be recovered and I think that the direction of travel which the Audit Commission has identified—

Q630 Dr Naysmith: You think they are right to say they should not be used for trusts?

Mr Ridley: I think it is inevitable it will not be used for trusts. I think that trusts will become more much self-contained as foundation trusts, almost as mini-businesses, and apart from anything else it is more understandable. I would suggest.

Dr Keeton: I would agree. I am not a fan of RAB and we are already incurring a penalty this year under RAB. I would concur with what the Audit Commission has said.

Mr Rostill: So would I, particularly in terms of having to pay it back in within the next year. There needs to be a longer timescale.

Mr Ridley: In answer to Dr Stoate earlier on, we all agreed it would make things more transparent and accessible.

Mr Rostill: That is not inconsistent with what I have said. You can still have it, but you would not want to do it in one year. You cannot solve NHS finances with serious deficits in one year, the SHA has agreed that with us. There needs to be much more longer-term planning and recognition of what would appear to be ambitious targets and the actual cost that they are going to incur.

Dr Keeton: Otherwise you only ever do quick-fixes, you never make fundamental change. One of the points I made earlier was we need to make fundamental change and that takes time to implement; otherwise you continuously get caught in a quick-fix routine.

Q631 Dr Stoate: I was fascinated by your comment that you are now getting a grip on the situation. These deficits did not come up and bite you on the bum. Why did you not get a grip earlier to head these things off at the pass? Because if you can sort them out by getting a grip now, why did you not sort them out by getting a grip then?

Mr Rostill: I think it is an evolving process. We are getting better all the time at controlling the finances.

Mr Ridley: Could I say we are getting a grip, we have not got a grip, we used to be getting a grip and we will never fully get a grip while we have things changing with a month’s or two months’ notice. We have not got a grip this year because two or three things happened outside our control—contributions to NHS bank, purchase of parity agreement—a range of things that came in at the last minute when we were supposed to be having a three-year planning cycle. It throws the plans out and we have got to make short-term decisions, so we are getting a grip but I can confidently guarantee the NHS will never fully get a grip as long as there is short-term intervention in terms of our finances.

Dr Stoate: Fair enough.

Q634 Chairman: You have said about the Audit Commission’s RAB and you agree with them on it. Could I ask you, do you agree with the statement that RAB has concentrated minds inside the National Health Service? It might be it has just come along for one year and very quickly. Has it concentrated the minds of people who are responsible for income and outgoings in the National Health Service?

Mr Rostill: Yes, I agree.

Mr Ridley: No question at all. It has over-concentrated our minds on the financial position to the exclusion almost of all else. It used to be a set of equal targets, equal priorities, now there is one slightly more equal than the rest and that is we have got to balance the financial books and it has got to be in-year. I fully accept that, we are accountable, using taxpayers’ money and it has got to be done, so RAB has concentrated my mind, my chairman’s mind and my board’s mind almost to the exclusion of all else.

Q635 Chairman: Mr Rostill, do you agree with that?

Mr Rostill: Yes.

Q636 Anne Milton: The man from the Department would disagree with you, Mr Ridley. I asked him that question and he said that financial targets did not take precedence over patient care.

Mr Ridley: I have heard him say that.

Q637 Anne Milton: I am not meant to be here answering questions for you, but to my colleague, the NHS is not a private business. The trouble for
these people in front of us is they do not have control over the business they are running. They are done to and that is, I think, one of the problems you will get into but, to move on, mental health. My concern would be that mental health provision is often a soft target because a lot of the outcomes depend on quality of care and difficult things to measure, so I would be interested to know, Dr Keeton, how you feel your area has been affected by deficits.

Dr Keeton: We have been affected by the deficit and clearly this year when there has been a top-slice, and John’s organisation worked on PBR, the PCT had no option but to levy a 5% cut on mental health services, as it did on its own provider services, and that is because that is the only option it had. It might not have been something I liked but that is 5% on a service that, in terms of Worcestershire, as most of us would claim, is under-funded. I am concerned about it, yes. What we have had to try and do is make the best out of the resource we have got, but we are under-resourced.

Q638 Anne Milton: It is interesting during all this evidence-giving nobody has yet mentioned quality of care.

Dr Keeton: I think I have tried to.

Q639 Anne Milton: This is not a criticism of you, but the focus, with some good reason, has been on targets and the financial targets in particular. It is the quality of care that concerns me with people with mental health problems.

Dr Keeton: Yes, and I think that takes me a bit back to the answer I gave earlier which was my view has been that we cannot do everything, but what we do need to do to a good quality and that is the way the programme is taken in Worcestershire. Where we have made change it has been about trying to do that in a way which moves us towards the things that are important for service users and their families, but at the same time doing that to a good quality. The sorts of things I have been doing in terms of tackling our deficit are focusing very much on alternatives to hospital admission, intensive day-recovery services, home-treatment services, crisis resolution not only for adults but for older adults as well, so that we can shut in-patient beds. We have shut 39 adult beds this year, which is just over 32% of my bed stock. That has been able to release a lot of money, some of which has been able to contribute to our deficit, but it has also been about making sure those alternatives to hospital admission deliver what people want and that is a trick.

Q640 Anne Milton: Yes, and in mental health services there is a huge impact on families and carers.

Dr Keeton: Yes, absolutely.

Q641 Anne Milton: Although you might be balancing your books, it would be interesting to see what the cost is out in the community for families, carers and sometimes neighbours, to be honest.

Dr Keeton: Yes, certainly when we set up home treatment and our intensive day-recovery service, we have been doing surveys of all users of the service and their carers independently about whether they feel the service has delivered what they wanted and whether it has been of the right quality, etcetera. The results of the surveys from both carers and service users are extremely positive with extremely high levels of satisfaction. I think you are right, you have got to measure not just what happens to the individual but to their family and friends.

Q642 Anne Milton: Time is very short, because we are over by 20 minutes now. I can feel the Chairman’s eyes burning on the side of my face. Quickly, there are two things I wanted to ask about. One is the impact on social care provision of deficits and the other thing, which we have not mentioned, is specialist nurses. There are a lot of stories and anecdotal evidence around about specialist nurses across the board now being asked to maybe work half their week on general wards, ie out of their areas of specialism. Those two things briefly: social care and specialist nurses.

Dr Keeton: We are a partnership organisation, so I am responsible for delivering social care as well as healthcare services. The sources of income, however, are quite separate for those two streams and at the moment, although we have had incredible pressure on the health element, we have not seen that pressure on social care. However, next year I will start to see, because I know already, there is going to be pressure on the social care elements as well. What we need to try and do is keep them separate but at the same time understand it is integrated provision to the service user, it is the one-stop-shop issue. It is about trying to work those together to not adversely doubly effect what happens down here, so it is working closely with the county council saying, “If you want to do this, you have got to see that in the context of what is going on here in health” and we need to get that relationship so there is an overall understanding of the picture.

Q643 Anne Milton: My concern about social care, looking after people at home, cutting beds, is the danger is that the health budget deficit gets shifted on to the county council.

Mr Rostill: That may well be. I think, unfortunately, the financial mechanisms between social care and health do not facilitate a smooth pathway, so often we have more people in hospital, what we would call “delayed discharges”, than we should and I think we do need to find a mechanism to improve on that. We are much better than we were within the county but it is still too much. If you block at one end, you stop people coming in at the other end.

Q644 Anne Milton: What about specialist nurses, have you cut any?

Mr Rostill: We have not as yet cut any specialist nurses. I noted the comment you made that some specialist nurses have been asked to work on general wards. The Director of Nursing has asked specialist
nurses to do a shift here or there on one of the wards that is part of their speciality and, indeed, the Director of Nursing from time to time will do a shift.

Q645 Anne Milton: So this is happening?
Mr Rostill: Yes.
Anne Milton: I am sure it does the Director of Nursing good to do a shift from time to time. On that note, I will end.

Q646 Chairman: Could I thank all three of you very much indeed for coming along and giving evidence. We are hoping that this report will be published before the Christmas recess and hopefully we will have a response from the Government before the end of the financial year. I do not know whether that means anything to you, but it may do.
Mr Rostill: Thank you very much.

Witnesses: Dr Jonathan Fielden, Chair, Central Consultants and Specialists Committee, British Medical Association, Mr Paul Turner, Executive Officer, Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, and Professor Anne Marie Rafferty, Head of the Florence Nightingale School of Nursing and Midwifery, King’s College, London also representing the Council of Deans, gave evidence.

Q647 Chairman: Good morning. Could I, first of all, apologise for the delay that we have had in this session. I think all three of you probably know the reasons why. I wonder if I could ask you, for the sake of the record, to introduce yourselves and the positions that you hold.

Dr Fielden: I am Dr Jonathan Fielden. I am Chairman of the Consultants Committee of the BMA and a consultant anaesthetist working largely in intensive care in Reading.

Mr Turner: I am Paul Turner. I am the Executive Officer of the Council of Deans for Nursing and Health professions. I was previously Dean of Health and Human Sciences at the University of Hertfordshire.

Professor Rafferty: I am Anne Marie Rafferty. I am the Head of School at the Florence Nightingale School of Nursing and Midwifery at King’s College, London.

Q648 Chairman: Thank you very much indeed and welcome to this, our fourth session of evidence-taking. We now want to start looking at the consequences of deficits and I wonder if I could ask all of you a question. We know that there have been about 900 redundancies so far in the National Health Service, but how many fewer jobs do you think there are now than, say, there were one year ago?

Dr Fielden: I think there are two aspects to this. The 900 figure from the Department of Health is the figure for compulsory redundancies, but if you freeze a post, if you remove a person from doing that work, unless you assume those posts were unnecessary in the first place, which is a fairly significant criticism of the organisation that had them, there is a double impact both on patient care and on the other people within the organisation who are continuing to deliver the work. It is very difficult for us to be precise and it is slightly surprising the Department of Health has not got a more direct idea of the number both of posts going and individuals who are being made compulsorily redundant, but there is a significant impact and it is a major reason for the reduction of morale. Sitting on the clinical side, and I know from my nursing colleagues, these posts are being reduced and impacting on patient care significantly.

Q649 Chairman: How is it impacting on patient care?

Dr Fielden: I think that if we assume the posts are largely required on the clinical side, if you remove that post or do not fill it then you increase the pressure on the individuals left to deliver that care. It means you have fewer nursing staff per bed on the wards, and I am sure Anne Marie has got more evidence along those sides. From the doctors’ point of view, we know that there is almost a complete freeze, certainly a significant freeze, in many specialities across the country and that means those remaining have higher workloads. We know consultants work 8% to 10% over and above their contracted hours just to continue delivering care to patients. It increases the pressure, the stress and reduces the morale, all of those, there is evidence, reduce and impact on patient care. It is not just removing the post, it is the impact on those who are there. There is also a fear now across many trusts that posts will be lost. We heard earlier that to get change, financial balance, you need ownership and understanding. One of the ways of losing ownership and understanding is to threaten someone’s job before they start.

Q650 Chairman: Mr Turner?
Mr Turner: I want to make a clear distinction between the numbers of compulsory redundancies, which the Government quoted earlier this week as 903, and the estimates of reductions in posts. The estimate of reduction of posts I have seen is provided by the Royal College of Nursing which currently runs at 19,485, recognising, of course, that the figure will have been increasing during the year as more organisations addressed the issue and may then be reducing as individual negotiations happen around the reductions in post within any individual organisation.
Q651 Chairman: Professor Rafferty?

Professor Rafferty: I would like to echo Jonathan and Paul’s remarks. Certainly from the research we have been involved in, which is part of an international research study that has looked at the impact of nurse to patient ratios on patient outcomes, 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.

Q652 Chairman: Could I ask you, when was that report published?

Professor Rafferty: It is about to be published in February, but we have it on Science Direct which is an internet-accessible resource.

Q653 Chairman: We all have had the emails about it, but I understand the evidence was taken in the late 1990s, is that correct?

Professor Rafferty: That is correct.

Chairman: It will be published at some stage.

Q654 Dr Stoate: On that issue about nurse-patient ratios, how many more nurses are there now in the NHS than there were, say, 10 years ago?

Professor Rafferty: I think it is very difficult to say. There are a number of varying estimates, but the degree of precision—

Q655 Dr Stoate: Approximately how many more nurses now than there were?

Professor Rafferty: We are given to believe there is something in the range of 18,000 to 19,000.

Q656 Dr Stoate: Nineteen thousand more nurses than there were in 1997?

Professor Rafferty: Apparently, but—

Dr Stoate: That is funny, because there is something like 30,000-odd more doctors.

Anne Milton: Let the lady answer your question.

Q657 Dr Stoate: I am trying to clarify this, I think I am entitled to clarify. Nineteen thousand more nurses than there were in 1997?

Professor Rafferty: These are claims, I think, that have been made by the Department of Health, but there has been a series, as you will acknowledge, of very many different kinds of workforce reconfiguration initiatives of one sort or another that one of your previous witnesses mentioned in his evidence following on from the NHS plan itself. There has been a plethora of initiatives. What these amount to in terms of the ratio changes at the bedside may, in fact, be significantly less than that overall resource might suggest and, of course, there are significant questions to be asked about how that headcount is arrived at and, ultimately, it is not just the headcount that is important, it is how staff are deployed and the quality of the working environments that are provided for, in this case nursing staff, that enable them to flex their skills and work to the top end of their abilities.

Q658 Dr Stoate: I understand that, I am talking about ratios. My understanding is there is something like 60,000 more nurses than there were in 1997, so what I am trying to say is, surely, bed-to-nurse ratios must have significantly improved in the last few years? Logic would determine that if there are fewer beds in the NHS now than there were and there are more nurses in the NHS than there were, then, surely, bed-to-nurse ratios must have improved?

Professor Rafferty: I think that would be logical but, in fact, the empirical reality or at least, as one is given to believe, is somewhat different because you have had a series of countervailing changes which may, to some extent, have offset any apparent benefit that might have been derived. For example, as you will probably be aware, there has been an increasing intensification of the whole caring process, length of stay has radically reduced, and the acuity levels of patients, of course, are on the rise. This essentially means that you are asking people to work very much harder than they were and the whole throughput of patient through the pathway of care is at an accelerated kind of process. In a sense, we are having a kind of silent-movie moment where everyone is scurrying around to deliver healthcare at an increasingly rapid rate and that puts immense and intense pressures on the system. Even though there appears to be more nurses in the system, you have to look at the ward level, the primary care trust or the patient’s home and how the overall benefit that you are deriving is experienced by the carers, as we were hearing, and their families. What is the patient experience that we have derived from this? I think we have got a very complex set of processes that are impacting on the pathway and the delivery of care which make it more tricky to look at the impact of the numbers alone.

Q659 Dr Naysmith: Could I say, Professor Rafferty, because I have been very confused by what you have been saying, we were not talking about the role of nurses and what nurses do, we were talking about the numbers, and you were casting scepticism on the numbers. Surely, what we are talking about is an increase or a decrease of the people who are qualified to be called nurses. Is that not the case? Are there more or less?

Mr Turner: I can note the actual numbers, which are from a report from Professor Jim Buchan to the RCN of September. The numbers he quoted in that report are, for England in 1997, 246,011 full-time equivalents, increasing in 2005 to 307,744.

Q660 Dr Naysmith: That is 60,000 more so that is an increase in numbers. You could argue if there were fewer beds and various other things that there were more nurses being able to ply their skills in the trade, maybe working a bit harder, some of them, but it is clearly an increase.

Professor Rafferty: It does appear to be a quantum kind of increase.
Q661 Dr Naysmith: I am not casting doubts on what they are doing but the fact is that there is an increase in numbers of qualified nurses employed by the National Health Service.

Professor Rafferty: I am not disputing the fact there is an increase. It is what nurses are doing that is different.

Dr Naysmith: You are bringing that in. We were just asking you about the numbers.

Q662 Chairman: I think I would like to move on. There is one thing we did not distribute. Professor Naysmith, which is, while the report is not yet published, a quote which has been mentioned in the media in the last seven days. That is one I have seen on my emails, which is just about nurses to patients. There is nothing about this issue of quality of care or what Anne was talking about earlier and you have mentioned as well. Is anybody doing any studies around that at all because it seems to me we are just keep getting into this situation of a numerical argument, which probably does not advance the case on either side, about what is right or wrong in this respect. Is anybody doing these studies about quality of care at the bedside, in the community or in the acute sector?

Professor Rafferty: There is certainly a need to do those kinds of studies and we would obviously love to repeat the study that we did in 1999 in the contemporary situation and do a replication of that very same study. There is evidence from the Healthcare Commission that looks at quality of care issues and there is, of course, the NHS staff survey that will give you some further global data on indicators. There is evidence from the Healthcare Commission on staff morale and how it has been impacted on more recently. There is also a workforce strand of research from the service delivery organisation arm of the NHS R&D programme which has looked at this area and which in itself will be commissioning work around this as a policy research programme from the Department of Health’s own platform of activities. As far as the opportunities to look at this are concerned, there are a number that could be taken forward.

Anne Milton: There was a report about care at home that came out a few weeks ago, was there not, about the clinical governance issues and the poor quality of care in people’s homes? It was a rather damning report, I think.

Q663 Chairman: There have been one or two individual inquiries that—

Dr Fielden: It is particularly important that it is looked at. One of the other aspects which has only just been touched on lightly is the substitution of roles and there has been a massive change in what nursing staff and the movement of roles between doctors and nursing staff in particular. I think there is a desperate need to assess what impact that has had on the quality of care because that is what we are interested in. It is a futile argument just to talk about the numbers.

Q664 Chairman: It would be a lot better to get away from this numerical argument that we seem to be in the thick of at the moment. Could I move on to another aspect of the numerical argument now? This is in relation to the proportion of doctors, nurses and other staff who have qualified this summer and who in your estimation are still not in substantive posts. What do you think the long term consequences of this are?

Mr Turner: Our concern from the Council of Deans is that we have up to now had a position in which people who have qualified in nursing, midwifery and the allied health professions have almost automatically been able to get a post. For the first time across the board this year (and last year it also applied to physiotherapy) this has been substantially different and very difficult. The best estimates we have at the moment are that as far as nursing is concerned about 56% of those who qualified this year are employed, although there are wide variations between institutions even within particular SHA areas. In midwifery our latest information is that 58% are currently employed. Both those figures are normally 100%. In physiotherapy it looks as if the figure at the moment is that around 15–20% of those graduating this summer are employed. I had a discussion with the head of allied health professions in one of the universities in the Home Counties yesterday and he told me that, of 81 graduates in physiotherapy from that university this year, only 25 have obtained jobs which involved physiotherapy, and of those only five have obtained full-time posts. He is also aware that 10 of the graduates that have not obtained posts are now actively seeking jobs outside the UK. In terms of midwifery, if I can return to that, there was a television report on Channel 4 News on 11 October that referred to the cohort of student midwives at Salford University where, out of 35 graduates, only 12 got midwifery jobs despite the fact that the local maternity units are short-staffed. One student who graduated with a first-class degree is now returning to her previous employment as a teaching assistant. I confirmed with the Dean of the Faculty of Health at the University of Salford yesterday that that situation was still the case. It is certainly a huge impact on the morale of individuals who have spent a number of years qualifying for their chosen profession. This gives feedback to students that there are problems and therefore they persevere to get their qualifications, and a number of colleagues fear that this may have an impact of attrition within programmes, and ultimately become a fairly quick feedback loop to applicants applying for those courses as to whether they should do so. This, of course, follows a period in which the universities have worked closely with their NHS partners and with organisations like NHS Careers to expand dramatically, by 60% over the last five years, the entries to courses in all of these professions.

Q665 Chairman: Professor Rafferty?

Professor Rafferty: I would just like to endorse what Paul has said. You will be familiar with the phrase “boom/bust”. I think the adverse impact on further...
recruitment will only be felt in the future and, whilst we are familiar with cycles of workforce fluctuations within the NHS and within higher education institutions, 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 HEIs but also the NHS and, of course, the future generations of students, and our reliance on the delivery plans that have been set out in the NHS Plan, particularly in the community, I think is severely under threat.

**Dr Fielden:** From the doctors’ point of view the main concerns are coming up early next year with trying to match up the numbers going into the run-through grade through Modernising Medical Careers. There has been a significant and substantial debate about numbers but, although we are a few months away from the significant impact of the interview process, the figures still as yet do not add up and the figure of up to 9,000 not being able to get into training positions is at the moment certainly of grave concern. As far as the exact figures are concerned, we can supply some further evidence to you. One other area we need to touch on, importantly, and hopefully we will get to during the session, is the impact of the number of changes related to the MPET monies which had significant impact, particularly on medical academics and trainees there, and there are radical cuts in areas such as clinical academic trainees. I think that is something we also need to touch on because that is going to have a major medium and long term impact.

**Chairman:** We are going to move on to that in a few minutes, Dr Fielden. I have asked at my local nurses and my hospital trust and they have had 37 who were doing the practical side at the hospital and 33 of them are now in work but they were not all guaranteed a job on 1 April, which is not the norm. Are there any studies around the country to find out, because if only 58% of trainee nurses are getting work there must be some areas, if we get 34 out of 37, where there are hardly any trainee nurses getting any work whatsoever. Has that been done to any extent?

**Mr Turner:** I believe that NHS Employers are doing some work at the moment and we indeed have recently agreed to do some work between the Council of Deans and NHS Employers in two particular SHA areas late this year or early in the new year to see what lessons can be learned because our concern is not only about this graduating cohort but particularly about the nursing cohorts that will emerge in February/March next year. There is, as I say, a wide variation in the data we have received from across the country and from different institutions and I think it does depend on the extent to which local NHS trusts in particular are happy to work very closely with the university to see if there are ways of finding positions for the qualified nurses that are emerging from the programmes. That clearly does differ significantly across the country and you are right: the figures vary very significantly.

**Dr Taylor:** You have told us that physiotherapists are particularly badly hit with, I think you said, only 15% getting jobs.

**Mr Turner:** 15–20%, that is right.

**Dr Taylor:** What other groups as well as physios are badly hit? I am thinking particularly of occupational therapists, speech therapists, MLSOs. Have you any figures to show that they are hit as severely?

**Mr Turner:** The evidence that we have, which is a little limited because it is merely gathering evidence from our institutions, is that physiotherapy is the most heavily hit. In occupational therapy, though from a relatively small example, it is looking like about half have got employment, although in discussions with the College of Occupational Therapy yesterday they were a bit more optimistic than that, and radiography is looking around 75%, and perhaps 75–80%, have got employment. In that area it looks as if therapeutic radiographers are almost 100% employed but it is rather less in terms of diagnostic radiographers. I am afraid we have not attempted to collect figures for the other professions that you mentioned.

**Dr Taylor:** Have you any explanation for why physios have been so badly hit particularly?

**Mr Turner:** I think that is a matter that the Chartered Society of Physiotherapy may be better able to answer, but my understanding is that the argument goes something like this, that there are a number of vacancies at senior levels in physiotherapy and those vacancies have remained, but there have been very few vacancies both last year and this year at the level of junior posts, even in advance of the current vacancy freeze that has been imposed. That is for a number of complex reasons, including that people have been reluctant to move from junior to senior posts until those senior posts have been evaluated as such under Agenda for Change, and I think there are other factors that the Chartered Society of Physiotherapy have explained to me and they may have explained in their evidence to this Committee.

**Dr Taylor:** Could it be partly that trusts regard them as in some way less important than nurses?

**Mr Turner:** I am not able to say that.

**Mr Amess:** Professor Rafferty, Florence Nightingale is telling me that you are arguing your case extremely well on behalf of nurses and midwives, so I certainly think that the points you are making to the Committee have not been lost. In this research that you have undertaken about the relationship between the number of nurses and patient risks I would have thought is self-evident and surely no-one in their right mind could challenge it, but it is being suggested that perhaps the risks could be reduced through more efficient working practices. Is that a silly suggestion?

**Professor Rafferty:** What we argue in the paper is that the staffing levels of the best staffed trusts should essentially operate as a reference point for the
worst staffed trusts to come up to strength on, and that that could, according to our calculations within our sample, which was of 30 trusts, save something in the region of 246 lives. If you were to extrapolate that and extend it to the rest of the NHS, at least in principle you could save thousands of lives according to that particular algorithm. That would be one of our main points. Clearly, there are different ways of organising care in which efficiency gains could conceivably be made, but on the basis of the numbers that we were looking at that is one of our key conclusions and I commend you, if you are having a séance with Florence Nightingale, to mention it to her.

Q672 Mr Amess: Another hidden talent the Committee were not aware of. The Government is claiming that lost posts would not matter as much as forced redundancies. What is your view of that?

Professor Rafferty: I agree with Jonathan that all losses are losses, and I think to some extent the impact of not filling posts and of losing further posts, as we again heard from John Rostill in the previous session, where his figures were impressive in terms of the planned impact on front-line staff, is according to what we have managed to discover, which ties up very effectively with research evidence from North America and Canada, and demonstrates that there will be an impact on patient welfare from this continuing erosion. I think we have to be very careful about the overall numbers that we were quoted, and indeed that Paul Turner came to my rescue on, because although there have been significant gains what I was really talking about was the increase in the number of nurses who had entered the system in the last two to three years through the increase in training. The overall numbers of improvements is much more impressive but it is also made up of a significant recruitment drive from overseas nurses, so there are several contributory factors to that overall benefit.

Q673 Mr Amess: Finally, and this is to the three of you, is there anything that you have not already mentioned that you believe as a result of deficits affects patient services, or do you think you have got it all off your chests?

Mr Turner: There is one area clearly I hope we may be moving into later, which is the impact of deficits on education and training budgets.

Q674 Mr Amess: That is on our script.

Dr Fielden: The important point that needs to be re-emphasised, which was brought up in the last session, is that despite comments that any action the NHS takes to reduce deficits should not lower quality of care provided to patients is not the case. Finance is the front-line, number one issue for every single trust in England, it is not quality of care any more, and that is a significant deficit and a major impact on patient care. We would wish as clinicians, and I am sure my nursing colleagues would be there, to have quality of care first, maybe first equal with finance, but it has got to be up there. It is no longer.

Mr Amess: Thank you for sharing that view so firmly with the Committee. I hope that our report in some respects will reflect the point that you have just made.

Q675 Chairman: Does quality of care mean more clinical staff in all instances?

Mr Turner: No.

Dr Fielden: You want the right staff in the right place at the right time doing the right jobs and appropriately trained.

Q676 Chairman: So there is a trade-off between how many people are employed inside the organisation and the quality of care of patients? It is not all about numbers?

Dr Fielden: No.

Professor Rafferty: There is also research from Michael West and others that has been widely quoted, and I think was included in the NHS Plan, on the impact of teamwork on patient mortality, and indeed on the morale and welfare of team members and patient satisfaction. They have most recently keyed in their patient outcome with their staff satisfaction data and found a correlation between the two, so it is not just the individual professions and how they are deployed. It is also what the sum of the parts is in relation to overall team working.

Q677 Chairman: So it is really not numerical in terms of the number of people working inside the institutions as opposed to the care that people get within them?

Professor Rafferty: Numbers to some degree I would argue are the pre-condition for quality to be delivered. Enough people in the system and deployed at the bedside delivering direct patient care is the prerequisite for quality and has an impact on staff morale, and we know that job satisfaction is an important predictor of intention to leave and therefore the retention capacity of an organisation to keep its staff, of course, is an important factor in the overall recruitment cycle.

Q678 Chairman: We heard that earlier in terms of the need to hang on to staff who are important to the bottom line, as it were, in terms of looking after patients, which is not quite the same as saying we need to have X number of people stood round a bed, is it, no matter what their grades are?

Professor Rafferty: You need a quality quotient of staff as the bedrock of quality.

Dr Fielden: There is a number which, if you fall below it, and where I work in intensive care there is fairly good evidence about the ratios from the Intensive Care Society and others, your quality of care does significantly impact on patient care, but your quality of care does not increase lineally with the number of staff. If you drop below a certain level, and I think what we are all saying is that many trusts are perilously close to that, if not below it, then it impacts directly on patient care.
Q679 Chairman: And, of course, if you were below it in the sense of you as a profession, you as an individual would fall out potentially with the regulator. If there were any real issues that were going into critical situations, potentially we would see a large increase in referrals to different regulatory bodies, would we?

Professor Rafferty: I suppose it would also be interesting to look at trusts who have had long-standing vacancies in their staff numbers, who are, if you like, under-recruiters.

Dr Fielden: Although we have a duty as doctors to the GMC to continually point out where there are problems in patient care, there comes a point beyond which it is very difficult to do that in a system that is focused on getting a financial bottom line by end of year.

Q680 Dr Taylor: Now we come to what you have all been waiting for, education and training, and if Jonathan will understand I am going to miss him out on this because his bit comes a bit later, so it is for the other two.

Dr Fielden: As long as I get a chance to come back.

Q681 Dr Taylor: We have had a lot of information on this from various places and not all of it agrees. We know that the gross budget for the whole NHS was reduced by £524 million which was borrowed from surpluses with SHAs. The figure that the Department have given us is that £133 million of this came from training budgets. They call that an underspend on training budgets. Is that really the sort of figure you would agree with and what is the difference between an underspend and not being allowed to spend something? Do you see what I am getting at?

Mr Turner: I see what you are getting at and perhaps I could answer that as briefly as I can by putting it into context. Up to the last two years the MPET (the overall education and training funding) has again been a targeted saving out of MPET funding during last year. There is a difference in a sense between an underspend that happens because you have not been able to spend a certain amount of development funding in that year and an instruction to make a saving, which is what happened.

Q682 Dr Taylor: Small? What sort of figure?

Mr Turner: Yes, I gave you a number of examples in the written evidence that we submitted to the Committee.

Q683 Dr Taylor: Fund underspend?

Mr Turner: Yes, underspend.

Q684 Dr Taylor: In the previous three years?

Mr Turner: Yes, but that has then been all of the relatively small sums to be brokered through each SHA at the end of the year. The difference in 2005–06 is that we gathered substantial evidence that we presented to your other inquiry on workforce planning that there have been deliberate decisions within Strategic Health Authorities, particularly those Strategic Health Authorities that were anticipating a substantial deficit within the overall health economy, to ask Workforce Development Confederations, indeed to instruct Workforce Development Confederations, to make savings out of MPET funding during last year. There is a difference in a sense between an underspend that happens because you have not been able to spend a certain amount of development funding in that year and an instruction to make a saving, which is what happened.

Q685 Dr Taylor: And I think you have given us concrete examples of those.

Mr Turner: Yes, I gave you a number of examples in the written evidence that we submitted to the Committee.

Q686 Dr Taylor: Appendix A, cases 1–5.

Mr Turner: Correct. Also within our written evidence we highlighted a freedom of information inquiry which was made by the Shadow Spokesman for Health’s office to each Strategic Health Authority as to what had been their underspend within education and training and their individual replies totalled 150 million. The point that we made in our evidence is not that overall total but the way in which it was handled in a number of individual Strategic Health Authorities where clearly there had again been a targeted saving out of MPET funding to contribute to, as you say, the surplus being generated by the SHA itself in order to offset the deficits in the overall SHA health economy.

Q687 Dr Taylor: We certainly have had letters from SHAs who have been pointing this out. How badly is this impacting on the professions and the development of nurses particularly?

Mr Turner: We had indications during last year that there were going to be substantial reductions to the new commissions for nursing, midwifery and allied health professional students starting in 2006–07 and this has been confirmed in the feedback that we have had from the 60-odd universities that are involved in this across England. I think you also need to look forward, as we have done partly in our evidence, though I have further information and you may want to ask about that at an appropriate time, as to how this is carried forward into 2006–07, because in 2005–06 the MPET funding was notionally ring-fenced; I use the word “notionally” in the light of my reply to your earlier question. In 2006–07, ie, in the current year, the Department of Health decided not to ring-fence the MPET funding, but to put the education and training funding alongside other central budgets into what they call a bundle of central budgets which totalled £6.1 billion. From that central bundle they have asked Strategic Health Authorities, we understand, to make a saving of £650 million. Part of that was reported in the NHS Finance quarter one report that was issued in June, which referred to a £350 million saving being made
from the central budgets, and that was held as a contingency reserve to be held by the NHS bank. We remain a bit unclear about the transition from that £350 million to the £650 million but we have very recent evidence coming in, which I can quote at the appropriate time, of Strategic Health Authorities making additional savings within the MPET budget at this very moment. I have seen some letters that were issued last week that refer, for example from one SHA, to an additional £13 million being asked for from the MPET budget and a quote, which is on the website and I am happy to quote it, from the Yorkshire and Humber SHA board meeting of last week which says that the most significant issue facing the NHS in Yorkshire and Humber is delivery on the required savings as a result of the central budget bundle and is talking about savings of 15% from MPET in this year. You need to remember, of course, that these are discussions going on now seven months into this financial year.

**Q688 Dr Taylor:** From memory I think Lord Warner told us at a previous session very clearly that there would be these same cuts next year.

**Mr Turner:** I am disappointed to hear that. I am aware that discussions on the MPET budget for next year are currently under way in the Department of Health and my understanding is that the Department is hoping to make an early announcement about that budget. I had not heard that. I had heard, and indeed Lord Warner yesterday at the Chief Nursing Officers’ conference, in answer to a question from one of my colleagues, the Head of the School of Nursing and Midwifery at the University of Hertfordshire, confirmed that he was not prepared to ring-fence the education and training budget for next year although the original statement being made was that the lack of ring-fencing would be for 2006–07 only.

**Q689 Dr Taylor:** Would Professor Rafferty have any numbers, for example, of healthcare assistants who want to train as nurses and who are being prevented from doing that?

**Professor Rafferty:** I do not have specific numbers. What I do know is that this principle, certainly in our Strategic Health Authority as it exists at the moment, which as you know is a bit of a moveable feast and is just beginning to galvanise itself into action, has essentially created a situation whereby the salary support that these secondees, as they are known, would have received in order to undertake training and education to become nurses, so to convert, if you like, their qualifications as healthcare assistants into nursing qualifications, is not being provided and this is having an impact on the providers but also on the trusts concerned. It is stymieing the aspirations of that particular group to move through the system in a manner consistent with government policy.

**Dr Taylor:** In the *Health Service Journal* every week there are umpteen glossy brochures for training courses and it staggers me that the cost of a day’s course is always £463.

**Chairman:** Plus VAT.

**Q690 Dr Taylor:** Plus VAT. Is there any evidence that take-up of these courses is declining because these budgets from which this money presumably comes are going down, and could this put any pressure on the organisers to charge a bit less?

**Professor Rafferty:** I could not, of course, comment on the latter part of the question but certainly the take-up of courses has radically reduced, certainly in our experience. I am sure Paul will give you a much more global review but, as far as post-registration education and training is concerned within our own school, that budget reduction is of the order of 17%, which is a large chunk of our activity.

**Q691 Dr Taylor:** One of the best ones was a course in reputation management.

**Professor Rafferty:** I think we could all do with that.

**Mr Turner:** I am not sure that the courses you are referring to are the ones that are within a continuing professional development or post-registration programme that is negotiated with a university. An example I have, for instance, is from the University of Nottingham in discussion with the Head of Nursing there yesterday, is that there the local trusts have cut the payments of student fees and removed any entitlement to study leave for staff following post-registration programmes and this has meant in one particular example that staff on their part-time Masters in Advanced Clinical Practice have had to suspend their study on that course. That is a multi-professional course specifically prepared in partnership with the local NHS to prepare staff for extended clinical roles in anticipation of the full implementation of the European Working Time Directive in 2009.

**Q692 Dr Naysmith:** Some of the questions I was going to ask have been answered already, which brings me to asking a slightly different one which has a philosophical content to it. We have been sitting here this morning talking about 50% of nurses graduating not having jobs to go to and the same sort of thing applying to health professionals. Now you are complaining that we are cutting the training budget so we are going to produce more and more young people who are undergoing courses but who are not going to get jobs next year. Is that a sensible attitude to take?

**Mr Turner:** The decisions that are being made now about education and training budgets as far as pre-registration, pre-qualification programmes are concerned will have an impact in 2009–10 and 2010–11, and the evidence from a number of sources is that the current reductions that are being made in terms of the number of posts being available are not sustainable, because even the Department of Health workforce review team itself in its final recommendations that were published last week said that one of the most significant risks in the current financial climate is that trusts and SHAs will make short-term cuts in workforce and planning training commissions to affect current financial balance to the detriment of medium and long term planning, and the Department of Health’s own workforce review team, again in those recommendations for
Dr Fielden: Within the National Health Service, but there is huge investment by the public in training these individuals so to then throw them on the scrapheap is madness.

Professor Rafferty: There was evidence submitted by Sir Liam Donaldson, I think, that suggested that the expectation would be for medical students in particular to be able to be employed at the end of their education and it has often been a similar expectation for nurses and indeed for midwives. I do not think anyone expects that to happen in their home trust or their back yard, but I do think that the point needs to be made about the short-termism, about which we have heard a lot, and the need for longer range planning. As far as the demographics are concerned (and you will be familiar with this) of the nursing and midwifery workforce, and particularly that in the community which is at least in principle supposed to be bearing the delivery of the future services and being very crucially involved in moving patients more into the home care setting, is in danger of becoming an endangered species. Certainly there is no suggestion, notwithstanding all of the technological developments that we hear about, new drugs, et cetera, that the demand for the labour-intensive processes of care delivery are going to diminish in the future. We have also heard that we are going to be the beneficiaries of improved investment up until 2008 within the NHS, which we obviously look forward to. One of the prospects that we hope will be in view for us as educators and as people with a vested interest in the success of the NHS itself is that that will filter through to staff in the future.

Dr Naysmith: You are very good, Professor Rafferty, at answering five other questions on top of the one that I have asked. Thank you very much.

Q695 Chairman: Can I ask you a supplementary to that because you are the Council of Deans that goes across the UK, I am led to believe that people who are coming out of nursing in a part of the United Kingdom, Scotland, will actually get a job for 12 months.

Mr Turner: Yes. The Scottish Executive Health Department has given a guarantee for the last few years that nurses and midwives in Scotland will be guaranteed a job in the NHS for 12 months, not necessarily in the area, of course, in which they trained.

Q696 Anne Milton: I am slightly lost on these questions. To some extent, Dr Fielden, you have probably answered this but would you just clarify the impact of the reduction in training budgets on some newly qualified staff, particularly specialist registrars and whether they will get the continuing professional development that not only they need but is also possibly mandatory for them?

Dr Fielden: I think the threat, certainly in several SHAs, and I mentioned Leicester and Central and Southern, is that no, they will not. Their study budgets have been cut in year. Many of them have already spent that money on necessary courses, courses that they have to go on to continue through
their training. This will directly impact on their training. Whether it will then lead to their training being delayed we will see when they come up to their RITAs, their assessments at end of year, but there is the potential for that. Over and above that the inability to continue to progress, the inability to continue to improve care for patients, is a significant detriment to the morale of those individuals. They want to improve their skills so that they can improve care to patients, and again it is a short term cut mid-year rather than looking at the long term implications to get staff so that they can treat patients better.

Q697 Anne Milton: So not only do you think their career progression will be delayed but will it be aborted altogether? Will they be able to get the senior posts?

Dr Fielden: The logical conclusion of continuing to impact on study leave budgets and training is that that will become increasingly at risk. From a medical academic point of view the posts will not be there in certain trusts and that therefore means no, there will not be posts for them to go to.

Chairman: May I thank all three of you very much indeed for coming along and assisting us this morning. You may have heard me say earlier that we hope this inquiry will be reporting to the House before the Christmas recess and hopefully the Government will be reporting back to us before the beginning of the next financial year.
Tuesday 21 November 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess
Charlotte Atkins
Sandra Gidley
Anne Milton

Dr Doug Naysmith
Mike Penning
Dr Howard Stoate
Dr Richard Taylor

Witnesses: Rt Hon Patricia Hewitt, a Member of the House, Secretary of State for Health, Mr David Nicholson, NHS Chief Executive, and Mr Richard Douglas, Finance Director, Department of Health, gave evidence.

Q698 Chairman: May I welcome you all to our fifth evidence session and ask you, for the record, to introduce yourselves and the position you hold. Could I start with you, David.

Mr Nicholson: David Nicholson, NHS Chief Executive.

Ms Hewitt: Patricia Hewitt, Secretary of State for Health.

Mr Douglas: Richard Douglas, Finance Director, Department of Health.

Q699 Chairman: Welcome. Perhaps I may start by asking why so many bodies are still forecasting deficits. Is this a sign that the Department does not have the problem under control? The six-month financial position, we understand, is that 176 bodies are now forecasting deficits, which is a similar number to last year. With all the furore we have had in the media over the last few months, we question whether or not this has been of any use.

Ms Hewitt: It most certainly has been useful. As I will explain in a moment, Chairman, the underlying financial position is improving and will have improved significantly by the end of the year. We have seen an increase in the number of organisations who are projecting small deficits at this halfway point in the financial year. Clearly we will be working with them and the Strategic Health Authorities will be working with them to ensure that they are, at the end of the year, in balance or as close to it as possible. If you look at the bigger picture here, in 2004–05 there was a net deficit of £221 million across the NHS as a whole. In 2005–06 that had grown to a net deficit of £547 million. If nothing had been done and you just took a straight-line projection, that would have grown to about £750 million by the current year. Even on quarter 2 forecasts, we are forecasting a deficit of just under £94 million by the end of the year; in fact, I am quite confident we will be in balance. What we have seen is an improvement this year of around £0.75 billion compared with where the NHS would have been had we not taken corrective action.

Q700 Chairman: Basically, you are saying that the underlying position is better than the six-month forecast.

Ms Hewitt: That is correct, the underlying position is better. I am confident that most NHS organisations will be in run rate balance by the end of the year, if they are not already. It is also worth stressing that most of the organisations which need to make significant savings are planning for the majority of those savings, around 60% or so, to come in the second half of the year. That is why the position at quarter 2 is not as good as we confidently expect it to be by the end of the financial year.

Q701 Chairman: Will the full set of six-month accounts, as supplied last year, be made available?

Ms Hewitt: Do you mean from each individual organisation, Chairman?

Q702 Chairman: Yes.

Mr Douglas: We have made available each organisation’s bottom line number, so the same information as we provided last year—the forecast position for this year—has been made available for each organisation across the country. It is the same as last year.

Q703 Chairman: Okay. You argue that a minority of organisations are in deficit but we have been told that the deficits are passed around health economies, with the agreement of the SHAs in particular. If the deficit for a whole area is being held with one trust, we really have no idea of the financial positions of each organisation. It seems to us that the whole thing was a charade. The witnesses have sat in front of us and said, “This year the PCT has the deficit; last year the SHA decided the acute sector could have the deficit.” How do you measure things like this? It seems immeasurable in the evidence that we have had put in front of us.

Ms Hewitt: I do not think it is at all immeasurable. I think you have to start with the position of each individual organisation but you then need to look more broadly and the position not just of one organisation but of the position of the broader health economy. May I take the example of my own city, Leicester. The Leicester University Hospital Trust at Leicester is in surplus. The Primary Care Trusts in Leicester City but also in the county are in deficit. The health economy as a whole in Leicester City is in deficit and the cure to that problem will be found predominantly within...
the hospital, because although the hospital is providing some excellent care and is in surplus, it also has some quite significant inefficiencies: a very long length of stay, for instance, for elderly patients with broken hips. By dealing with those inefficiencies, they will release the savings that are needed to pay for, for instance, better services in the community and better mental health, which at the moment are suffering because of a deficit in the Primary Care Trust. You do need to analyse not just the position of individual organisations but also where the underlying problems are. However, you cannot ignore the stated position of individual organisations and the need for those organisations to take responsibility for their own actions and their own expenditure as well as the working in partnership with other parts of the local health community to deal with the wider problems. David, would you like to add to that point.

Mr Nicholson: I think the position is getting much more transparent. I think we are seeing that this year. It is true that in the past it was a matter for local judgment about where final year 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. Now, with the accounting process we have, it is much more transparent. Certainly this year it is pretty clear where the deficits lie in the system. It is transparent. You can see it.

Q704 Mr Amess: Chairman, that is not exactly in agreement with what the Secretary of State has just said.

Mr Nicholson: I think it was exactly what she said.

Ms Hewitt: I think it was exactly what I said.

Q705 Mr Amess: I did not quite see it like that.

Ms Hewitt: Let me stress my understanding of the position. Part of the reforms that we have been making over the last few years have been designed to introduce proper transparency and financial rigour and discipline across the NHS as a whole. By removing brokerage, we have removed one of the major sources of a lack of financial transparency: a problem that has given rise to organisations believing they were in financial balance when they were nothing of the kind but the position had been obscured by the brokerage going on. I was simply making the broader point and giving you the example of Leicester; that, although the hospital is in surplus, it is in the hospital that most of the answers to the deficit of the health economy as a whole will be found.

Q706 Mr Amess: I absolutely accept what you have said, but the Chairman's question was about the evidence that we have been presented with of all these overnight being shifted around.

Ms Hewitt: I think that reflects what used to happen, not what is now happening.

Mr Amess: They did tell us something slightly different.

Q707 Chairman: I put a question to a witness we had in front of us from the acute sector in Worcestershire. I reiterated what had been said to us by the chief economist for the Department, that the recorded deficits do not reflect reality; sometimes they sit on the PCT side and sometimes on the acute trust side, and the witness said, “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.” If this brokerage (for want of a better word) is taking place in the SHA, it does not reflect the true picture at all. How can we assume how the acute and the PCTs are really operating if this type of thing happens in the health economies?

Ms Hewitt: Mr Chairman, the point you have just raised from that chief executive makes it quite clear he was talking about what had happened in the past over a period of years. In one year the deficit had sat on one side; in the following year it had been shifted to the other side. That is not satisfactory. 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 becomes clear and something then has to be done about it. David, I think you are in the same place on this.

Mr Nicholson: Yes, absolutely.

Q708 Dr Stoate: You just told us that the legal responsibility for the budget lies with the PCTs, but some of the evidence we have received is that some PCTs do not even have financial directors. How are they supposed to manage the enormous budgets with these complicated accounting arrangements if they do not even have a financial director who is able to make those complex decisions?
Ms Hewitt: One of the difficulties that we had and which led to us inviting Primary Care Trusts to look at whether they had the right organisational structure last year was precisely that some of the 303 Primary Care Trusts that we had had not been able to recruit directors of finance, in some cases they had struggled to recruit a chief executive or some other key parts of their management team. We had some who were sharing management teams and wanted to merge but had not been allowed to do so. All of those factors were amongst those which led us to the highly controversial but in my view absolutely necessary reorganisation of many of those Primary Care Trusts.

Q709 Dr Stoate: Are you confident that they now have the financial expertise to manage these very large, complex budgets and make financial decisions for their area?

Ms Hewitt: We are now putting that in place. 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, but alongside that we have been starting on the fitness for purpose reviews for each of those Primary Care Trusts, which has given both us and their boards and the Strategic Health Authorities a very useful diagnosis of where the strengths and weaknesses are. Alongside that, we are putting in place stronger training for the finance teams and the boards, including the non-executive directors, to ensure that they do have the expertise they need, because the chief executive of the PCT is the accounting officer for what you rightly say are very large budgets.

Q710 Chairman: Can we be assured that we now have in place or soon will have in place a more meaningful and consistent measure for accounting inside the NHS?

Ms Hewitt: Yes. Richard might want to elaborate on that answer.

Mr Douglas: The Secretary of State said earlier on that over the last three years we have progressively removed the things that might distort the financial position. We do not allow capital to revenue transfers. That was the first thing we got rid of. The second thing we got rid of was called “unplanned support”: late movements of money around the system. The third thing we got rid of this year was what had previously been called “planned support”: money that was agreed at the start of the year that was added to people’s income. You will now get a very clean position for every organisation of how they have performed against the resources to which they were entitled that year. The only thing I would add is that none of that was possible without introducing payment by results first, because payment by results allowed one to determine what the income is for an organisation.

If we were to go back prior to payment by results, the income would be negotiated every year and something that we might now call planned “support” could have been bundled into the income line and so on, so you had to make other changes first to the system before we could eliminate all the other potential means of not showing the true position.

Q711 Anne Milton: I think we have heard it in evidence before this Committee, but certainly I have heard it from people working in the service, that one of the problems for PCTs and trusts is that the situation changes suddenly, so that income which they expected has suddenly been cut. The goalposts are not set at the beginning of the financial year and then stay the same; they change halfway through. That makes it extremely difficult for organisations to manage their financial position.

Ms Hewitt: I think that is a legitimate criticism. You will no doubt have heard from some organisations of the change we made in phasing out the purchaser-parity adjustment. We had always said it would be eliminated by 2008. We decided that, rather than going from full purchaser-parity adjustment to nothing very, very quickly, with a cliff edge, we would do that over a period of years. We did not signal that in advance, and so the change we made this year to the purchaser-parity adjustment came as a very abrupt surprise to a number of organisations, and that was not helpful, but we have signalled what will happen for 2007-08, next year, when there will be a further reduction in that purchaser-parity adjustment. It is technical stuff, but it does make a real difference on the ground.

Q712 Anne Milton: I think the trouble is that, with the best will in the world, the best financial management cannot manage the situation if the goalposts change each month. At the beginning of the year, they need to know how it is going to be for the rest of the year. If there continue to be changes halfway through the financial year, finance directors, however good they are, are going to struggle, because suddenly you are facing a deficit when you thought you would be in surplus because the rules have changed.

Ms Hewitt: As I say, I think there is a legitimate criticism about the Department of Health not always having given a clear indication of what was going to change for a future year in advance, and not always having made available in sufficient time the information that was needed to plan for the following financial year. That is why David Nicholson and I are so determined to have the operating framework for the next financial year, 07-08, available to the service before the end of this year—which will be earlier, I think, than the NHS has ever had.

Mr Nicholson: About then.

Q713 Anne Milton: Are you able to guarantee that there will be no further sudden changes?
Ms Hewitt: That is our intention.

Q714 Anne Milton: Can you guarantee your intention?

Mr Nicholson: The issue for me is that there will always be changes in the way the NHS operates, in the way patients are treated, in the pressures on the system. There will always be changes and the financial directors and the boards need to be much better at managing those changes. They need to think, for example, about what a down-side case might look like: “What happens if something does not happen in the way that you have planned it?” in a way that perhaps we have not done before. Foundation trusts and the diagnostics showed us how we can do that and sensitize our financial planning much better. There will always be changes, but we want to make sure that changes in rules, centrally determined, do not come out out of mid-year. That is why we are so focused on delivering by the end of the year.

Q715 Anne Milton: Can you guarantee that will not happen, Mr Nicholson?

Mr Nicholson: I cannot guarantee it. Our expectation is that that will be the case.

Q716 Anne Milton: The Department will not change the rules.

Mr Nicholson: Absolutely. We do not want to change the rules. We want to get all the rules out by the middle of December.

Q717 Mike Penning: Secretary of State, could we move on to the causes of the deficits. Evidence given to this Committee has shown a clear relationship between deficits and resource allocation for 2004–05; the funding formula, basically. There is a relationship between the size of deficits and that. Do you agree?

Ms Hewitt: No, I do not.

Q718 Mike Penning: The evidence was given by your own chief economist. Are you disagreeing with him?

Ms Hewitt: Might I put one qualification to the no.

Q719 Mike Penning: I thought you might.

Ms Hewitt: I think there is a very small—very small—correlation between the funding allocations and the deficits. Our own analysis, including that of our own chief economic adviser and confirmed by the Audit Commission and the National Audit Office, is that there is no one single cause of deficits. Part of the problem has arisen because of a financial framework that was not transparent—the problem of brokering that we have just discussed. In some places it has arisen because there was a small deficit some years ago that was not dealt with at the time that has since grown into a big deficit—and I heard exactly that story at the Royal Cornwall Hospital Trust last week; in some cases you have the hospital doing more work than the local NHS can afford; in some cases you have an inefficient use of resources or an inefficient organisation of services and buildings. In a small minority of cases, as the Audit Commission report and public interests reports made clear, there has been weak financial leadership from the organisation.

Q720 Anne Milton: So the evidence from your own chief economist to this Committee was wrong.

Ms Hewitt: No. My recollection of his evidence was that he said there was a small correlation. I think that is right but I think the important thing is to look at the larger causes, and, even more important than the causes, to look at the cures and concentrate on the action that needs to be taken.

Q721 Mike Penning: You are perfectly happy that in the 2005–06 year, where figures are becoming available, there is an even smaller or larger correlation between the funding formula and deficits.

Ms Hewitt: I have not seen that analysis yet. Almost everywhere I go around the country and in almost every group of parliamentary colleagues I meet, people complain to me about the funding formula. I hear people say, “We are in a rural area, we are not getting enough.” “We are in a fast-growing urban area, we are not getting enough.” “The market forces factor is unfair.” “Payment by results is being introduced too quickly.” “Payment by results is being introduced too slowly.” Whatever it is, somebody has a complaint to say that their funding allocation is unfair and is the cause of whatever problems they have. I have already asked the Advisory Committee to review the formula. We will look at their report. We have asked for that in good time so that it can inform the funding allocations for the next round, from April 2008, but I have to say, Chairman, and I really want to stress this point, all this argument about funding formula is in my view a complete distraction from the need to make decisions to sort out the problem now, because, whatever is right or wrong with the funding formula, we are not going to reopen the allocations for the current year and next year.

Q722 Mike Penning: Surely, Secretary of State, you would say that, because the funding formula was set by your Department. At the end of the day, there are trusts in this country—and you may say they are in a minority—which are in severe financial problems, and a timely increase or a fairer increase in the funding formula would take them out of deficit. You are fully aware of my own trust, the West Herts Hospital Trust, that would need less than £100 on top of the £960 it received for the financial year we are referring to, to take it completely out of crisis. You referred to your own area, Leicester, where you get some £1,300. There are serious problems around the country with the way in which the funding formula is allocated. Your own chief economist said so and we have had numerous other people come before this Committee to say so, and yet you say it is such a tiny proportion of the deficits. What is tiny?
Ms Hewitt: I will leave it to the chief economist and perhaps Richard Douglas as well to talk about the statistical correlation, such as it is—

Q723 Mike Penning: What is tiny, Secretary of State? You said tiny.
Ms Hewitt: Let me finish my point. If I recall correct, the chief executive said there was no correlation between the funding formula and the deficits in the year when the deficits started to arise. The really rapid change in the pace of growth, in ensuring that underfunded areas—underfunded according to the formula—were brought up as close as possible to their funding target, is taking place this year and next year and therefore has nothing to do with deficits that arose last year or the year before or indeed the year before that. When I read, as I did in evidence from one particular academic to this Committee, that the formula has a particular bias against affluent rural areas, I have to say that I had a look at some affluent rural areas, and consistently one finds, in North Yorkshire, for instance, more GPs (in other words, fewer patients for each GP) than the English average and lower rates of cancer, of diabetes, of heart disease—

Q724 Mike Penning: Secretary of State, that is not the question I asked. You are going off on a completely new tangent. The question I asked is what is tiny. What percentage of the deficits is tiny? It is your language, Secretary of State, not mine: tiny.
Ms Hewitt: I am quoting from memory our chief economist who said that there was a very small correlation between the funding formula in one year and the deficits in that year, but he also stressed that the deficits had started to arise in the previous year, when there was no correlation at all with the funding formula.
Mr Douglas: The work the Audit Commission did in looking at the relationship between the funding formula and deficits suggested that between either 7% or 9%—and I will have to check which of those it was—of the variation in the PCT deficits you could potentially explain by variations in the funding formula. That was only looking at PCTs. It did not also bring trust deficits into that. It was a small proportion of PCT deficits that could be explained.

Q725 Mike Penning: Secretary of State, this does not make sense. Evidence given to this Committee clearly shows that some trusts get nearly double what another trust gets in the funding formula. How can you have a National Health Service that runs on funding formulas which are so diverse? It does not make sense. How do you explain how a trust can survive with half the funding that another trust can have?
Ms Hewitt: The reason I think is very simple: in order to have a National Health Service which enables a cancer patient in one part of the country to get as far as possible the same quality of care as a cancer patient in another part of the country, you have to give more money to those parts of the country which have more cancer patients. It is more complicated than that because you also have to take into account a range of disease factors. You have to take into account that for various reasons some population groups are much less likely to use the Health Service and therefore get a far worse service than in areas where the population has more GPs and is more likely to use the Health Service. For instance, looking at the variety of communities represented by members of this Select Committee, in your own constituency, Chairman, people are 17% more likely to get cancer; 26% more likely to have coronary heart disease; 7% more likely to have diabetes, and your funding is 7% above the English average. If I look at Guildford, Ms Milton’s constituency, people are 15% less likely to have cancer; 28% less likely to have coronary heart disease; 19% less likely to have a stroke; 24% less likely to have diabetes; and it has 9% funding below the English average. It seems to be absolutely right and fair that places with worse health and greater health needs get greater funding and places with better health and less health needs get less funding. That is fair, in my view, and, rather more importantly, in the view of the Independent Advisory Committee. As I have stressed, I have asked the Advisory Committee to look again at the funding formula; to look, for instance, at this question of whether rural areas are underfunded. That is something for which they have found no evidence in the past—except on ambulances, where there is a specific adjustment for the additional cost of providing the Ambulance Service in rural areas. It is already taken account of in the formula—and rightly so, in my view. I have asked them to look specifically at the rural issue because it has been raised so often, not only by this Select Committee but by individual Members of Parliament.

Q726 Mr Amess: Secretary of State, following on from my colleague’s question, why is it, if you look at the list of those areas which are in real difficulty because of the formula, those areas are often represented by opposition Members of Parliament? Is it a coincidence? It is a bit unfortunate really.
Ms Hewitt: We have noticed—and I have made this point to the Select Committee before—that although there are overspending organisations in every region and there is overspending in some very poor parts of the country, including my own city of Leicester, which is a very disadvantaged area, if you look at the average picture it is true that the overspending is concentrated in healthier, wealthier parts of the country, and it is certainly true that wealthier parts of the country are more likely to return Conservative MPs, although there are clearly exceptions to that rule, and poorer parts of the country are more likely to return Labour MPs although there too there are exceptions to that rule. But there is no connection in terms of how we run the NHS or how we allocate funding between our decisions and the changing political representation of different constituencies. It is simply not a factor we take into account.
Q727 Mike Penning: Secretary of State, I asked you a very specific question and you gave me a long drawn out set of figures but you never answered the question. That was a waste of time. If a PCT or trust is getting about half as much as another trust in the country, you are quietly confident and happy that that is fair and we are not operating a postcode lottery and that people in my constituency are getting the best possible treatment, the same as someone else in another area which gets nearly double the funding.

Ms Hewitt: Yes, I am satisfied—

Q728 Mike Penning: Why are my hospitals closing?

Ms Hewitt: I am satisfied that the funding allocations are fair and I am also satisfied that the decisions that are being made in Hertfordshire are being made on the basis of reviews. I think there have been 10 reviews of hospital services in Hertfordshire, going back over 15 to 20 years, going back over a period in which the political composition of the Hertfordshire constituencies has changed quite significantly in various directions, and your constituents would get an even better service from the local NHS if the resources that the NHS was getting in Hertfordshire, which are bigger than they have ever been before and will be substantially bigger again next year, were used more efficiently. That is precisely why the boards of the two Hertfordshire Hospital Trusts are looking at the configuration of hospital services in Hertfordshire so that they can give your constituents and others in Hertfordshire even better care than they are getting at the moment. You mentioned earlier the fact that in Hertfordshire the funding is about £100 less than, I think you said, the English average.

Q729 Mike Penning: I said £1,000 per head per year on average.

Ms Hewitt: Yes, that is right, which is, I think you said—

Q730 Mike Penning: I said if there was £100 next year there would not be any deficit.

Ms Hewitt: That is right, £1,000 per head on average. In my constituency it is around £1,300 on average per head. I believe that that reflects the very real differences in health needs, in illnesses and in prevalence of disease, between our two constituencies. Your constituents have the good fortune to be significantly healthier than my constituents and—

Q731 Mike Penning: I think my constituents will not believe the arrogance of that answer.

Ms Hewitt: It is not arrogance, it is a statement of fact reflected in the formula that an independent body recommended.

Chairman: Could we have a question and answer session here as opposed to a debate.

Q732 Mike Penning: You are doing an internal inquiry into deficits at the moment, as I understand it. Are you going to publish that inquiry?

Ms Hewitt: The finance director asked our chief economist to look in detail at the cause of deficits and distribution across the country, and, yes, we are going to publish that report.

Q733 Mike Penning: Do you have any idea when?

Ms Hewitt: Before the end of the year.

Q734 Mike Penning: Financial year or calendar year?

Ms Hewitt: We expect before the end of the calendar year.

Q735 Anne Milton: As you mentioned Guildford, there is another set of statistics which will demonstrate that people in Guildford wait longer for outpatient departments, for surgery, et cetera, but I do not think that as a Committee we want to get into discussions about statistics. One of the academics is sitting in the audience today and dismissing what the academics say about how the funding formula is put together is unwise because they have a point to make and I do not think they have a particular drum they wish to bang. The only issue I would like to bring up is the issue of health needs. Everybody gets into a huge muddle about this: probably the strongest epidemiologically determinant of morbidity is age: older people need and use more healthcare. If you want to do something about deprivation and forgive me saying so, Secretary of State, but you are getting muddled up with the care people need and deprivation and health indicators. Why are people more ill at a younger age in more deprived areas? If you want to do something about that, you could give the public health establishment an early Christmas and say you are going to ring-fence public health money to do something about deprivation, you are going to put money into education and urban regeneration and then you will see people not getting heart disease at such a young age. If you want to meet the healthcare needs people have, you would give it to old people because old people have more illness, they have more healthcare needs.

Ms Hewitt: Of course older people have more healthcare needs—

Q736 Anne Milton: Would you agree it is the biggest determinant of morbidity?

Ms Hewitt: Could I answer the question. Of course older people have greater healthcare needs. Indeed, if I remember correctly, for an over 85-year old, the average cost of providing healthcare is about five times that of providing healthcare for the average 44-year old or average 15-year old. Of course that is a very important factor in the formula. It has always been part of the formula and certainly my view, for what it is worth, is that it should remain part of the formula. But it 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 to which I was referring. My predecessors took advice on
this many years ago from the Independent Advisory Committee who looked at a whole range of indicators, not only age, but also a variety of socio-economic indicators, which are also directly correlated with health need. That was all built into the formula along with this very specific issue that some populations, for a whole variety of reasons, do not make good use of the Health Service and the Health Service needs, if you like, to reach out to them in order to meet their health needs. On the final point, you suggest that the way to deal with deprivation is simply to increase or ring-fence the public health budget.

**Q737 Anne Milton:** I did, but I also mentioned some other things.  

**Ms Hewitt:** You did, but you did say that the public health budget should be ring-fenced in order to deal with deprivation. I think we should give Primary Care Trusts the responsibility for the whole budget with as little ring-fencing as possible. Of course they need to be putting more emphasis on prevention and early intervention, because that is the way to get the best health outcomes for people, but that still needs to take into account that in the places where you have the worst health problems and the lowest life expectancy you will need significantly more money than in the areas where you have longer life expectancy and better health.

**Q738 Anne Milton:** Would you accept the fact that age is the strongest indicator of morbidity?  

**Ms Hewitt:** I think on that I would want to hear the views of the Advisory Committee.  

**Chairman:** Could we move on a little.

**Q739 Dr Taylor:** Secretary of State, there is another aspect of the funding formula. As we have heard from the Worcestershire PCTs, they are going to be £13.6 million below their capitation target. Is that something that can be investigated as well? Are there trusts throughout the country that not only are low on the funding formula by the way it works but also below what they should be getting from the capitation target?  

**Ms Hewitt:** This is a very important point, Dr Taylor. When the formula was reviewed by the Advisory Committee back in 2002, we found that some Primary Care Trusts on the old boundaries were 15% or 20% above their target funding formula; others were 15% or 20% below. Obviously, if we had tried to get everybody to exactly what the funding formula said they should have, we would have ended up making actual cuts in the cash budgets that some Primary Care Trusts had. We were not prepared to do that because we also think the historic spend needs to be taken into account. That is why alongside the funding formula we have the pace of change. We have speeded up the pace of change for the current year and next year, in order to give at least 8% growth in cash each year, this year and next year, to every primary care trust but to give a much faster rate of growth to those which are furthest behind their funding target. By April 2008, no area in the old boundaries will be more than 3.5% below their funding target, their allocation target. We could not get everybody even closer to exact target without reducing the amount of growth going to areas that are above target. In other words, I did what I think you are implying would be desirable: Get everybody up to at least their target funding, or we would have even louder complaints and cries of unfairness from your colleagues on the other side of the table.

**Q740 Dr Taylor:** You have reassured us that you are gradually reducing the gap.  

**Ms Hewitt:** We are significantly closing the gap. Although I do not have it with me, the White Paper published in January you will see a table which shows what the gap was and how much we will have narrowed that gap, very significantly, in April 2008. We were only able to do that, of course, because the overall funding was increasing at such an enormous rate.

**Q741 Chairman:** In terms of the evidence on the funding formula, we have taken no evidence on this Committee about whether the formula is designated in any way towards party political representation anywhere.  

**Ms Hewitt:** Of course it is not.  

**Chairman:** The chief economist did tell us that the last time the formula was changed, in the year 2003-04, the resource model was changed and there was no impact at all that could be measured. However, in 2004-05 there was a moderate correlation between the funding formula and deficits. We have taken nothing beyond that, expect people’s opinions, I have to say. Could we now move on to other causes of deficits and Sandra.

**Q742 Sandra Gidley:** The Secretary of State does not appear to think the formula has anything to do with it, so I am going to move on to staff. You are probably aware that we are also running an inquiry into workforce planning at the same time and the two inquiries often seem to be inextricably linked. In the NHS plan of 2000 large numbers of staff targets were set. Some figures from the NHS showed that the NHS had recruited an additional 268,000 staff over the last six years. Did we employ too many people? Were the costings of the plan adequately forecast?  

**Ms Hewitt:** I am very glad that Ms Gidley has raised this particular point. As you rightly say, in the NHS plan the Department and the NHS and other colleagues worked out what increase in staffing was needed in order to bring waiting times down and make all the other improvements that we wanted to see in the NHS. We set targets for the increase in staff. The NHS has achieved those targets ahead of time and in some cases has quite significantly overshot those targets. Might I give you a few figures on this, Chairman. The NHS plan target for hospital doctors was to get to 74,590 by 2007.1 In fact, by 2004 the NHS was already

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1 See Ev 136
employing over 78,000 hospital doctors and by 2005 over 82,000. Already, several years in advance, the NHS is employing more hospital doctors than it intended to by 2007. Very much the same is true for nurses.

**Q743 Sandra Gidley:** Should somebody not have been keeping an overarching view of that?

**Ms Hewitt:** Yes. Individual hospitals and PCTs, but particularly hospitals, made their decisions about how many staff they think they needed and could afford. We measure the total NHS workforce retrospectively, because it is a very large survey that has to be done to get accurate data. For instance, the workforce survey figures that we published in January of this year related to a survey that was done in September of last year covering the previous financial year. So the information we collected retrospectively and it comes back to what we were saying earlier about organisations not always having a good understanding of their own financial position because the financial framework of the past did not give them that clarity and transparency. The reality is that the NHS has spent more of the growth money on additional staffing than was planned and has taken on significantly more hospital doctors and significantly more nurses and somewhat more GPs than the NHS plan intended. 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, in order to get back into a position where they are employing the right number of staff they can afford and using them in the most effective way possible.

**Q744 Sandra Gidley:** You appear to be saying that it is understandable that extra staff were taken on in order to hit targets, but, now that they have achieved their purpose, they are dispensable.

**Ms Hewitt:** No, I am not saying that. I am saying that the NHS plan estimated the number of staff who would be needed in order to meet the targets. In fact, the NHS took on more staff faster and that is clearly a reason why some organisations are in real financial problems. They employed more staff than they could afford. I can give you the example of the Royal Cornwall Trust because I happened to be there last week. The organisation had a small deficit about four years ago; they should have dealt with it then; they did not; and it is now a very large deficit. As the deficit got bigger and became more obvious—even last year—they took on an extra 250 staff last year. The truth is they could not afford them and they are now in the very difficult position of having to consult on redundancy, which is a dreadful experience for the staff. This is a hospital which has day case rates well below the English average and can quite clearly give better care and faster care to patients with fewer staff than they decided to employ.

**Q745 Sandra Gidley:** I think we would all agree that there are ways of improving staff usage, but, if you look back at the political imperatives over the last few years, the hanging offence was not to hit your waiting time target. It did not matter so much if you went slightly over budget. It seems that staff are the casualty of a changing political imperative, because now the imperative seems to be to break even rather than to hit other targets and chief executives and financial directors will always try to work to save their necks.

**Ms Hewitt:** Getting the waiting times down was absolutely imperative—not for political reasons but because that was what patients wanted and that was what we had promised—and I think rightly so—and that is what the plan undertook to deliver. But the financial targets have always been important. Indeed, hospital trusts are under a statutory duty to break even and Primary Care Trusts have accounting officer responsibilities for how they manage their budget. You are absolutely right in saying, however, that in organisations that have overspent, it is the staff who then bear the brunt of the very difficult decisions that have to be made. Although a hospital trust in that position would do everything possible to avoid, particularly compulsory redundancies, because staff costs are the great majority of NHS expenditure, there is a limit to how much a hospital trusts can do, for instance, to get its prescribing bill down—although it can also do that—or to reduce their agency staffing bill—although they can also do that. Sooner or later some of those trusts, because the scale of their overspending, will come to the point where they have to reduce their permanent staffing level, and some of them have found that they cannot do that without a small number of redundancies—not anything like the sort of headline figures we have been seeing over the last several months.

**Q746 Sandra Gidley:** Talking of headline figures, there was an announcement last week by the gentleman sitting on your right saying that there would be further compulsory redundancies in the NHS before the end of the year. Would you put any figure on that?

**Ms Hewitt:** No. We will publish figures each quarter. We are now monitoring those. Of course we recently published the figures for the first half of the year: 903 compulsory redundancies, most of them non-clinical—compared to these headline figures of 20,000 that we have been seeing. We will publish the next figures when we get them in the quarter 3 report. I would also like to make the point that there is another source of redundancies and job losses: that is the administrative savings of £250 million that we promised in our manifesto and which we are achieving by making Strategic Health Authorities and Primary Care Trusts more efficient. Having fewer SHAs and fewer Primary Care Trusts in many parts of the country means, of course, that we will need fewer chief executives, finance directors, fewer managers and administrative staff. Even, for instance, in London, where Primary Care Trusts are not reorganised, they are changing the way they get their back office functions and their administrative staff in order to contribute their
share of the £250 million savings which we promised and which will go directly into frontline clinical care. That will inevitably involve some redundancies. We do not yet know how many, but, again, as we get those figures from the Strategic Health Authorities, we will publish them.

Q747 Sandra Gidley: I do not think any NHS reorganisation so far has resulted in a reduction in management costs. You talked about financial management. How many finance directors have been removed?

Ms Hewitt: I do not know. On the issue of financial management, I was referring to the Audit Commission report based on the public interest report they have done in a small number of organisations which have given rise to particular financial concern. In almost every case, there is new leadership in those organisations.

Q748 Sandra Gidley: Will the current finance directors lose their jobs if they do not break even?

Ms Hewitt: No. We are not going around sacking people. There will be redundancies in Primary Care Trusts—

Q749 Anne Milton: Which is not sacking at all! Ms Hewitt:—through reorganising and making themselves more efficient. I have been very clear and drawn the Committee’s attention to that point. On the issue of finance directors, I think we are very fortunate in the NHS to have excellent financial and other managers in most organisations. I think it is worth remembering that, if the NHS were a country, it would be the 33rd largest economy on the world. This is a very large and complex organisation. There is always room for improvement, but I think it is much too easy for people quite unfairly to criticise the great majority of the leadership of the NHS, managerial as well as clinical, when they are doing an excellent job.

Q750 Sandra Gidley: As you have mentioned leadership—my final question—is your job on the line if you do not break even over the next year?

Ms Hewitt: I have said that we will return the NHS as a whole to financial balance by the end of March next year and I take personal responsibility for that.

Q751 Dr Stoate: You have mentioned that hospitals can make efficiency savings by coming back to the use of agency staff and perhaps reducing their prescribing budgets, but I would like to turn to the issue of fixed costs, which they have little control over. How big a factor are PFI payments and access charges in hospitals and independent sector treatment centres?

Ms Hewitt: I do not think they are a big factor at all. There are a small number of organisations who are in deficit who also have PFIs. There are many organisations with PFIs who are not in deficit. I do not think there is a correlation there but I do think we need to look very closely at new proposed PFIs to ensure that they are going to be affordable for the local health community for the long term because they are long-term commitments. That is why we are reviewing the capital investment programme at the moment.

Q752 Dr Stoate: Certainly Worcestershire Acute Trust blames PFI for part of their problem. Queen Elizabeth Hospital in Woolwich, which is one of the hospitals with a very large overspend, certainly the evidence we have received from there and from Amicus cite about half of their overspend they attribute to PFI.

Ms Hewitt: In the Worcestershire situation I do not know the details. The Queen Elizabeth, Woolwich, situation, I know more about simply because I have had meetings with the local Member of Parliament and the chief executive. That was a very early PFI. It was judged at the time not only to be value for money but to be affordable. The reality is that with or without PFI, if you build a beautiful new hospital and your staff and patients benefit—as they certainly are from those better facilities—you are going to be paying more for those facilities than if you continue on struggling with a clapped out Victorian building, as so many hospitals were previously having to do. It will cost you more and that needs to be taken into account. That was an early PFI. The interest rates and the financing regime were less flexible than they are now, which is something the local trust complains about. On the other hand, construction costs were a great deal lower than they are now, which they tend not to talk about. My own view about that, since they cannot change the building, is that they need to look for other sources of savings in order to ensure that they live within their budget, which is still a great deal larger than it was at the time they entered into the PFI.

Q753 Dr Stoate: Professor Appleby, who has looked at some of these issues for us, has pointed out that although they number only 11% of all trusts, hospitals with major PFI schemes nevertheless account for 25% of the total trusts in deficit. He also points out that half of these hospitals were in deficit compared to only 23% of hospitals without PFI schemes. There does seem to be some correlation between these fixed costs which hospitals simply cannot shift and their ability to go into deficit.

Ms Hewitt: I have to say I am very dubious about that. I am not a statistician but I think you are talking about such small numbers of trusts that the percentages may not be meaningful.

Mr Douglas: I should also say that in the set of questions to the chief economic adviser one of the other issues we have asked to look at is the incidence of PFI and new capital investment generally, because the issue is not just a PFI one but one of having put a lot of money into the fixed costs of your building.

Q754 Dr Stoate: Do you have any further evidence you can provide to the Committee? We still have this rather nagging doubt that PFI does seem to add an immovable burden to a trust which may not be the case in other hospitals.
Ms Hewitt: I would like to reiterate the point that this really has nothing to do with PFI. PFI is a way of funding a very substantial capital investment; LIFT is another way of doing it; and doing it directly from the public sector is a third way of doing it. However you do it, you are going to have to pay capital charges on the capital investment and you pay those capital charges in the public sector as well as the private sector. You are also going to have to pay the costs of porterage, cleaning, associated facilities and so on. Whether you do them through a PFI contract or an outsourcing contract not linked to PFI or through direct employment, better facilities cost more money and that is something that the trust board, the Department of Health, and the Treasury all need to take into account and have taken into account when they make the judgment about whether a particular scheme should go ahead.

Q755 Dr Stoate: There are two main issues. One is the element of profit which obviously PFI companies will make and that adds to the burden of costs. Secondly, the very long contracts mean that it is much less likely that trusts in future can be flexible about their plans for the long term, because most contracts run for 25 or 30 year, over which they have very little chance of making any alterations.

Ms Hewitt: They are indeed very long contracts, which is another reason why it is so important that we review all the proposals coming forward now to make sure that people are not over-estimating their ability to finance these long-term projects. Let us say that the Queen Elizabeth in Woolwich had been built purely using public funding, the chances are it would have cost more than was estimated and would have taken longer to build. It would not have been delivered on time and on budget because that is the history, I am afraid, of large public sector capital projects, and the hospital no doubt would have been complaining about that. Secondly, if you have got yourself a very large new hospital, you are not going to mothball it 10 years down the line just because it has been publicly funded. The Treasury regime of capital charges, quite properly, would not allow you to do so. This is not an argument about PFI. It is an argument about making sure that when medicine is changing so fast you do not lock yourself into a pattern of provision that may turn out to be out of date because medical technology enables you to deliver so much care in the community, in a GP's own surgery or indeed in a patient’s own home, but meanwhile you have got yourself a very large hospital and you are locked into providing the care there.

Q756 Dr Stoate: If we look at different models of care in the future, if in 10 years time we are no longer doing cardiac surgery the way we are doing now, if we are locked into a PFI contract, what is going to happen to the contract if the work, because of changes in medical practice, no longer exists?

Ms Hewitt: That is one reason why we are reviewing new PFI contracts. This is not really about the PFI. It is about building not just hospitals but primary health care centres and community hospitals that give you more flexible provision and wards that you can change from providing, let us say, cardiac surgery perhaps to providing own community diagnostics. You may need to use buildings in a very different way in the future. The more we can build that kind of flexibility in from the outset the better the NHS will fare in the future.

Q757 Dr Taylor: Can I pick up three specific items on PFI contracts to check that they are being changed in the later ones? The first one is the whole question of bed occupancy because it came as quite a surprise to me to discover that, with the Worcestershire PFI, if the bed occupancy went above 90%, one had to pay a supplement. Bed occupancy, because beds are fewer, is usually above 90%. Is that written into the current or the new PFI contracts? Is there what I call a penalty clause for over-occupancy?

Ms Hewitt: I do not know but perhaps we could come back to you.

Q758 Dr Taylor: It is terribly important.

Mr Douglas: I can make sure I have checked it before Thursday’s hearing.

Q759 Dr Taylor: In the Health Committee report we did on the role of the private sector, we had a number of witnesses who argued about the method of working out risk transfer. The conclusion to that Committee really was that risk transfer was much more of an art than a science. Is there any way you have made that more of a science than an art with the new contracts?

Ms Hewitt: It is extremely difficult but I think the expertise that has been built up, not just in the department but in the Treasury and in Partnerships UK, means that across government we are now much more sophisticated in negotiating real risk transfer to the private sector than we were in the early days of public/private partnerships.

Q760 Dr Taylor: Certainly people in Worcestershire now feel that the people who negotiated the contract initially did it very quickly and amateurishly.

Ms Hewitt: I cannot comment on the amateurish bit but I think it is true that we have learned lessons with every PFI contract, whether in health or some other part of the public sector. That may be difficult for the early PFIs. On the other hand, their staff and patients have had the benefit of a new hospital much earlier than those who are still waiting, as in Leicester.

Q761 Dr Taylor: Do you think it is a penalty for trusts that have PFIs that they cannot benefit from the cut in capital charges? I think I am right in saying that capital charges have been cut from about 6% to about 3%. Is that correct?

Mr Douglas: That is right but there is an adjustment for the funding at the same time. It is neutral to the NHS as a whole.

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Q762 Dr Taylor: They are not benefiting?
Mr Douglas: Any change in the capital charge system in terms of the rates of charge is neutral on the funding we have overall. It is classed as a change the Treasury made to the internal movement of money in government.

Q763 Dr Taylor: It has just been pointed out that we will not be talking about this on Thursday.
Ms Hewitt: Shall we let you have a note?
Chairman: We will. I do not know whether we will now that you have done it this morning.

Q764 Anne Milton: Moving on to the consequences of the deficits, you did refer to the fact that there have been a number of reports out there, one of them suggesting that 20,000 posts have been lost. For the record, there are compulsory redundancies, voluntary redundancies and posts that are lost—i.e., the person leaves and the post is not filled. Would you agree that it is in the region of 20,000 posts that have been lost?
Ms Hewitt: No. We do not have information on that. What we have is information on compulsory redundancies which we have published and will go on publishing quarter by quarter. We will do the annual workforce survey and publish that in the normal way. The next one will be due out in the New Year. That will give us a picture to compare with where things were a year earlier. Then we have examples of organisations—for instance, the South Tees Trust—that said over a year ago now that they needed to reduce their wage costs by the equivalent of 300 jobs. That became a headline and fed into the 20,000.

Q765 Anne Milton: Do not let us go into that.
Ms Hewitt: I do just want to make the point because it is an important one. They ended up with three or four redundancies. They managed the rest of the change, in part through not filling vacancies, through natural turnover, but also by significant redundancies in agency staff, who are not counted as part of the head count when we measure the 1.3 million plus total workforce of the NHS. There are real problems with that 20,000 figure which wraps up a whole series of different organisations, making different forecasts over different periods, some one year, some two years, some three years, pretending that it is something that is all happening practically overnight. It is not.

Q766 Anne Milton: You think the RCN are pretending?
Ms Hewitt: I think what the RCN and the press have done is to take a whole series of different announcements and add them all up. What they are adding up is announcements which may say, “We need to reduce our staffing over one year or in some cases over three years by the equivalent of X jobs”", even though they end up not only with redundancies that may be a tiny fraction of the headline number but even a reduction in the total number of posts that is less than the original headline number.

Q767 Anne Milton: If you do not know how many posts have been lost, you do not know if those figures are true unless and until you have done your audit of this NHS establishment.
Ms Hewitt: That is correct at a high level.

Q768 Anne Milton: It could be double that.
Ms Hewitt: For instance, if I look at the North Staffordshire Trust which Charlotte Atkins knows very well, it is one of the trusts with the worst financial problems. They started off by consulting on over 1,000 redundancies.

Q769 Anne Milton: I am talking about jobs lost.
Ms Hewitt: 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.

Q770 Anne Milton: Out of interest, that 1,000 went down to what? What did they end up with?
Ms Hewitt: They have not finalised. Charlotte Atkins may be more up to date than I am on this.

Q771 Charlotte Atkins: Well under half.
Ms Hewitt: It may even be less than that.

Q772 Anne Milton: We will not know until you have done your audit. That 20,000 could be double or half.
Ms Hewitt: Every organisation we have looked at, including those with the biggest headline figures, has ended up with less than the headline figure, not more.

Q773 Anne Milton: What about the impact on patient care and what is the department doing to monitor this?
Ms Hewitt: Even in organisations where there are very serious deficits, the waiting time targets are still being met. Patients are not being asked to wait more than six months and in many cases they are continuing on track to 18 weeks to get it below the six months. Cancer treatment has radically improved in the last 12 months right across the NHS, including in the deficit organisations. The A&E four hour waiting target is being maintained as it has been for a couple of years now in virtually every organisation across the NHS. 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.
Q774 Anne Milton: Do you feel you are measuring the right things to determine what is happening to patient care?

Ms Hewitt: I think it is right that where we have promised that, for instance, waiting times will come down or that cancer care will be speeded up, we should measure that and see whether or not the NHS is delivering on promises we have made and funded the NHS to achieve. In future we need to place greater reliance than perhaps we have done in the past on what patients themselves say about their own quality of care, although if I look at most of the patient surveys and most aspects of patient care, patients are continuing in the great majority to be satisfied or very satisfied with their patient care and in some cases that is continuing to improve as well.

Q775 Anne Milton: There is some interesting research around. We heard evidence from Professor Rafferty from Queen’s College who has done a study which demonstrates that patient to nurse ratios had a significant impact on people’s mortality. One of the concerns both in the medical and nursing professions is that, if you start to lose posts because your waiting times are still the same, there will be less care. It is all that soft stuff which is difficult to measure. People do not live as long.

Ms Hewitt: I saw a reference that research. I have not yet had a chance to read it. I think it is very interesting. I will have a look at it. I have no doubt at all that the quality of patients’ experience of care and the care and attention they receive from nurses and other ward based staff is immensely important to their recovery along with the clinical care, the quality of the operation and so on that they get. I would come back to the point I was making earlier about staffing. The NHS plans set out a very clear set of targets to increase enormously the level of staffing with more nurses and staff than ever before in the NHS. We have more than achieved those targets. I cannot help feeling that, if what the NHS had done was manage to achieve those targets year by year as they were originally set in the NHS planning, we would not have had people complaining bitterly that we had failed to go above them. What has happened is that the NHS has gone above them. Because 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. That is very difficult for the staff who are displaced but it is true.

Q776 Anne Milton: There are concerns out there about how trusts are going to respond to the budget deficits, that lost posts matter. I can give you a stack of anecdotal evidence: a nurse who came up to lobby me who said that she had just done an eight hour shift and she was asked to do the next eight hour shift because there were not enough nurses around. We have reports of a PCT in Buckingham shedding 15 district nursing posts in a time when the Government would like more people to be looked after in the community. Consultants in my own trust have had a letter asking them to voluntarily reduce their programmed activities or sessions to deal with the budget deficit. The concern out there is that the financial balance is above all else the most important thing; that nursing and medical posts will be lost. You are right to suggest that changes in how we deliver medicine must alter the way we behave and the staff we employ but the concern now is that you are cutting it to the bone and below the bone. Do not laugh, Secretary of State. That is outstandingly disingenuous to the people listening to this.

Ms Hewitt: I have said several times during this morning and on many other occasions that I know very well how incredibly hard it is for staff across the NHS.

Q777 Anne Milton: And patients.

Ms Hewitt: And how difficult it is where, for instance, staff are being asked to work longer hours, to deal with some of the things that you were describing there. The reason why I gasped at the idea that the NHS is being cut to the bone is because that is frankly absurd. The NHS has more money and more staff than it has ever had before and, if I can make a party political point, vastly more, nearly treble the amount that it had in 1996.

Q778 Mike Penning: We do not do party political broadcasts.

Ms Hewitt: The NHS budget has already doubled. By 2008 in cash terms it will have trebled. This is not an NHS that is being cut to the bone. This is an NHS that by 2008 will, for the first time, be funded at the European Union average. I mean the old European Union of 15, obviously not including those new Member States. This is an NHS that not only has more staff than it has ever had before—35,000 more nurses than it had nine years ago—but has significantly more doctors, GPs and nurses than was agreed and set out in the NHS plan. That is not being cut to the bone. If the Committee looks, as I really hope you will, at the quality and value indicators that we published a couple of weeks ago, you will see there hospital by hospital how much better the care for patients would be if every hospital were reducing average length of bed stay, unnecessary emergency admissions or increasing day case surgery, not to the level of the best because that is not feasible; not even to the level of the top 10%, but just to the level of the top 25%. Over £2 billion would be saved from that to put into new drugs for patients, better mental health services, more public health, all the other things we all want to see; but that does mean fewer staff and fewer beds in parts of the acute hospital sector. With respect, Members of the Committee need to decide whether they want an NHS that uses all the increased money that taxpayers have given it to the best possible effect or whether they are simply not willing to support difficult decisions that have to be made to achieve that goal.

Q779 Anne Milton: I said it for a reason. Maybe you should come and visit me in Guildford and I will demonstrate.
Ms Hewitt: I will certainly try and do so. I spend a great deal of time visiting the NHS and I make a point of going, as I did to the Royal Cornwall recently and to North Staffordshire and Nottingham, for instance, to places where the financial problems are biggest, precisely so that I can hear directly from the staff. I also stress that the more you have consultants and managers in the hospitals working together and the more you have the hospitals and the Primary Care Trusts working together the more you will make decisions that not only get the NHS into financial balance but can give you better care long term.

Q780 Dr Naysmith: You will get some support from some Members of this Committee who deprecate the way the 20,000 figure has been used by some organisations, including the opposition party and some trade unions, to give the impression that next week there are about to be 20,000 people who are in post now who are going to be unemployed. That is clearly part of a political campaign. You do not need my support after what you have just said. However, nevertheless, there are posts being lost in the National Health Service. No one is denying that. It is having an effect particularly on newly qualified staff. I suspect. There are some indications that that is the case. What are you doing to monitor and evaluate the impact on newly qualified staff, mostly young people?

Ms Hewitt: You are absolutely right about the impact on newly qualified staff. 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. I have talked to a number of those newly qualified staff, including newly qualified mental health nurses in my own city in Leicester. It is a desperately difficult situation for people who have invested a great deal of their own time and effort into acquiring those qualifications, in the belief not surprisingly that they would have a job at the end of it. I have asked the chief nursing officer to lead the work in the department. She is working with the directors of nursing and the directors of workforce within each of the Strategic Health Authorities to look at the position on a regional basis. What we have found in some parts of the country is where, for instance, a hospital trust cannot employ all its own newly qualified staff, if it works with other parts of the NHS in the wider region, it has been able to find at least some employment for most of those newly qualified staff. It is only by very intense cooperation, really working with each individual and the NHS pulling together across a region that we hope to be able to find employment for most, if not all, of those newly qualified staff. 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 except where there are very specific skills needs that those newly qualified staff can meet.

Q781 Dr Naysmith: We have spent some time trying to get across the idea that nursing is a really good career that we ought to encourage as many people into as possible. What effect does this have on the numbers applying for training?

Ms Hewitt: I do not have the figures in front of me but 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.

Q782 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. That is why we need to work through this region by region and profession by profession.

Q783 Dr Naysmith: The physiotherapy situation is puzzling because there are shortages of physiotherapists in many parts of the country. I know of orthopaedic units with long waiting lists for physiotherapy and yet there are physiotherapists qualifying who are not being employed.

Ms Hewitt: That is absolutely right and it is as true for physiotherapy as for nursing and midwifery. There are vacancies for those professionals somewhere in the NHS but not necessarily in a place to which particularly a newly qualified graduate can travel. It may not be possible for the family to move to another part of the country where there is a job, particularly for more mature students. The other problem with physiotherapy is the vacancies are for more senior staff. Obviously newly qualified graduates cannot meet those. One of the issues that we have asked trusts to look at is whether they can have accelerated promotion for some of the physiotherapists in the upper middle band into the more senior jobs and that in turn would free up some vacancies lower down. It has to be looked at hospital by hospital because it very much depends on the overall picture, the skill links that they believe are best and also what is being done by the Primary Care Trust to increase the physiotherapy services in the community, which is often what is needed. We are acutely aware of this problem. We have given best practice guidelines already to the NHS and that is what we are now working to achieve.

Q784 Dr Naysmith: It should be an opportunity to do something about the physiotherapy shortage.

Ms Hewitt: We would like to use it in that way. I agree.
Q785 Chairman: Secretary of State, I wonder if you can help me and the Committee with the issue about jobs. You pointed out this morning to us about the overshoot from the National Health Service plan of 2000. Some of those overshoots were quite massive, with over 300% on nurse recruitment. Who did the recruitment? Who overshot those marks? Did they need permission to have this bigger increase than the 2000 plan suggested they should have?

Ms Hewitt: We do not try and run the NHS like some kind of Soviet Union industrial sector. We do not do recruitment centrally. I think it would be dreadful if we tried to. The recruitment is done by individual hospital trusts, individual mental health trusts, individual Primary Care Trusts. What they will look at is what they think they need and also what they think they can afford. It comes right back to the discussion we started on about NHS trusts not always having had a good understanding of their own actual financial position.

Q786 Chairman: I think it was Alan Milburn’s plan. Did not somebody build into NHS expenditure the cost of employing 20,000 more nurses? Five years down the road they find they have 80,000 more nurses. What happens then?

Ms Hewitt: What happens then is that sooner or later deficits start to emerge because you are absolutely right. The NHS plan said: here are the improvements we want to achieve for NHS patients. Here is the increase in staff numbers that we need to achieve that and here is the funding to go with it, plus obviously like all the other things needed like more drugs. That was the plan and that was the funding. In an organisation in the 33rd largest economy in the world you are never going to have precise accuracy on every single dimension, whether it is pay, staff numbers or anything else, but there has been very significant overshooting on staff numbers. In most cases we are already at the level where we said we would be in 2007. That has caused financial problems to emerge and therefore in the medical delivery plans that are agreed with Strategic Health Authorities and in the recovery plans that are agreed staff numbers are part of the calculation. I remember saying to this Committee maybe a year ago I had been having a look at the recovery plan for Hertfordshire and that was very interesting because part of Hertfordshire’s recovery plan a year ago was to bring their staffing levels, which had risen too fast, back down to where they had been a year or two earlier—not cut them to the bone but just—

Q787 Mike Penning: 750 jobs.

Ms Hewitt:—bring them back to where they should have been. What had happened was that staff numbers had continued to increase. There is sometimes a gap between the plan and the reality.

Mr Nicholson: It is true that we have overshoot but we are talking about 1.3 million people in the NHS. In any one year about 10% of those turn over so 130,000 people move jobs. There is a complexity and a scale in all this which is quite significant to manage. Organisations are very ambitious. They want to drive services forward. They are very keen to drive services forward and we have seen some of that in the numbers that we have.

Q788 Chairman: I accept that but what organisation would employ more people without knowing that they have the financial security to pay for those positions? I know of none.

Ms Hewitt: Most individual organisations believed when they took the staff on that they could afford them, which is why it comes back to individual organisations not necessarily understanding their true financial position. 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.

Q789 Charlotte Atkins: That was not centrally controlled. It was individual departments taking on staff.

Ms Hewitt: Indeed.

Q790 Chairman: It seems that financial planning and workforce planning do not necessarily run together in the National Health Service. They certainly have not done in the past. When we talk about losing posts, presumably these are posts that the people who have been employing people beyond national targets for the last six years think should be filled. They are not posts that the central NHS say they should have.

Ms Hewitt: That is correct.

Q791 Chairman: You do not do that type of planning.

Ms Hewitt: That is correct. We do not do that planning from the centre. That is done locally.

Q792 Chairman: These posts that we are talking about could be somebody’s aspirations to have more people working in their department than there are. I want to provoke this debate because we need to have it out.

Ms Hewitt: In some cases there are posts that are nominally part of the establishment but have been vacant for a very long time. There are others where the vacancy has only arisen very recently because of the turnover David Nicholson referred to and then because of the financial deficit that vacancy has been frozen. Then, clearly what the hospital trust needs to do is to say that that particular vacancy has been frozen because that is the one that happened to arise and financially we may need it to be filled, in which case we may want to move a staff member from somewhere else in order to fill that. For instance, if you increase day case rates and therefore you need fewer people in acute wards, what most hospitals are doing is simply redeploying staff whose jobs have been lost as a result of an increase in day case into other jobs that happen to be vacant in the hospital because somebody has left, but where those jobs are still needed for patient care. This is a difficult process. It is difficult for the staff who do not always
get it right first time and I think Anne Milton’s examples reflected some of those difficulties, but it is the right thing to do.

**Q793 Sandra Gidley:** Are you telling us that in the NHS plan—I appreciate you were not the Secretary of State then—there were target figures for the number of nurses and doctors; yet nobody thought to somehow cascade those figures down so that people in a region or Strategic Health Authority had some idea what scale they should be looking at? Why did that not happen?

**Ms Hewitt:** I think that was done.

**Mr Douglas:** The targets for the growth in staffing would have been cascaded down to SHAs. There was a breakdown of the expected growth at SHA level and the expected improvement in performance targets but they were not key controls that as a department we would monitor. What we would monitor is the delivery of service in performance targets and financially.

**Q794 Sandra Gidley:** Nobody is keeping an eye on this?

**Mr Douglas:** At a local level we should have been tracking what was happening with our workforce. We track it annually at a national level but, provided people could afford that staffing, there would not be any intervention from the department or the SHA. The intervention would only come if people could not afford something. We do not run every single hospital from the Department of Health.

**Q795 Sandra Gidley:** I find that hard to believe because my local hospital has been in deficit for some time and was taking on staff like crazy to try and achieve some of the targets that were mentioned earlier. It is now in a situation of desperately trying to shed staff. Who would be looking at an acute trust at that stage?

**Mr Douglas:** It would be the Strategic Health Authority.

**Q796 Sandra Gidley:** David Nicholson was running the Strategic Health Authority.

**Mr Nicholson:** Not that one.

**Q797 Sandra Gidley:** He says, backtracking quickly.

**Mr Nicholson:** I am not backtracking on any of this. We were originally given targets for the NHS plan to deliver in terms of doctors and nurses because we were moving through a process to significantly expand the capacity of the NHS through a whole set of things that we had not done before—in particular, delivering shorter waiting times for patients. As long as the organisations could afford them, there were not any upper limits on what we could do. If we could go faster and could afford it, that was all absolutely fine. Most organisations have gone faster and have met their financial targets and can afford it. There are some organisations though for a variety of reasons, some of which we talked about today, which are around use of non-recurring funds, shifting capital to revenue and brokerage around the system, which could not afford it and were given short term support to enable them to do it. The way the financial regime was developed has exposed that very clearly. That is where we got into difficulties in the NHS.

**Ms Hewitt:** What it has meant for your hospital, for instance, is that the financial problem which is now very clear to everybody has forced the hospital and the local NHS to focus on the inefficient use of some of those resources, as revealed in the quality of those indicators. That is where the attention needs to be paid, but obviously it would have been much better if the position had not arisen in the first place and the staff were not then being subjected to the huge uncertainties and difficulties about consultations, job losses and redundancies.

**Q798 Mr Amess:** I know we cannot do it but it would have been very interesting to have had the then Secretary of State for Health to come and give this evidence, because I do recall what he was saying at the time.

**Ms Hewitt:** Hindsight is a wonderful thing. There was a point where the Committee was berating my predecessors for under-spending. The criticism, going back about three years I think, was that the NHS was not spending the extra money fast enough so there were pressures in the other direction.

**Q799 Charlotte Atkins:** Mr Nicholson, you were not responsible for Sandra Gidley’s hospital but you did have experience of my local Strategic Health Authority and therefore why was it not picked up that the University Hospital of Northamptonshire was recruiting staff so rapidly that it could not afford it? What would have been the process by which this strategic health authority should have picked that up?

**Mr Nicholson:** In those circumstances, there would have been a plan agreed at the beginning of the year but the mechanism for monitoring that plan would have been financial and hitting targets. The financial number in the bottom right hand corner was the one that people focused on, which was the cause of many of our ills in terms of that particular hospital. Although in the year it managed to balance its position, it was doing so with, first of all, an upward trajectory of recruiting staff so rapidly that it could not sustain it; and secondly by using non-recurring money to support what it already had. If we had been looking more accurately at the financial position and the manpower, we would have been in a much better position earlier to have spotted that, as indeed the board should have been doing, to be fair.

**Q800 Charlotte Atkins:** Of course the board should have done that. That is what the SHA is there for. What lessons have you learned and what is now in place to make sure that does not happen again?

**Ms Hewitt:** First of all, the transparent financial framework so that you can no longer lose sight of your true, underlying position. Secondly, much stronger financial management, both in Primary Care Trusts and in hospital trusts. Thirdly, real attention being paid right across health
communities, not just individual organisations, to ensure that care is organised in the best possible way that gives patients the best results but gives you the best value for money as well. Those two things, as we increasingly see, go hand in hand. Also, much stronger leadership at the Strategic Health Authority level with a strong chief executive, a strong director of finance and a director of turnaround as well. The final point is real emphasis, particularly in the hospitals, on getting clinicians and managers working in a proper partnership to get the best results. Successful hospitals have it; very often the ones in trouble do not.

Q801 Dr Naysmith: The Committee has been told that a contingency fund has been created by Strategic Health Authorities from centrally managed budgets. How is it and in what ways is it that SHAs set aside funds from contingencies from these budgets? How is it being done?

Mr Douglas: There were a number of budgets that historically we had put direct to PCTs and departments. We bundled all those central budgets together that we put out to PCTs.

Q802 Dr Naysmith: Some of these bits of budgets would be for a service?

Mr Douglas: There would be a whole mix. There are training budgets in there, individual service budgets. There is a whole mix of some very big ones and some very small penny packets in there. We discussed with SHAs about how they could manage those budgets better than the Department of Health could because they knew the local circumstances far better than we do. In discussions with them, we came to an agreement that if they were given control of that sum of budgets they would be able to deliver the services that we require from those budgets at a cost that was roughly between £350 million and £500 million less than we had assessed it at. The SHAs have then agreed locally how to manage that as a group.

Mr Nicholson: That is exactly what happened. In the first quarter we projected the £350 million-worth of savings. Out of that the Strategic Health Authority were clear that they could deliver the higher figure now being considered.

Q803 Dr Naysmith: Is there any evidence that this has resulted in reductions or cuts in services?

Ms Hewitt: It is certainly involving a reduction in the training and education budget this year. That is difficult and certainly unpopular. I do not think I have ever come across an organisation in serious financial difficulties that did not have to make, at least in the short term, some reductions in their training budget. That is certainly part of how they are creating that contingency.

Q804 Dr Naysmith: There have been some very severe reductions in training budgets. What was the purpose of this contingency fund which I understand is about 367 million or more?

Mr Douglas: We recognised that we created 350 million at quarter one. Discussions with the Strategic Health Authorities now suggest that there is another 100 million that will be able to be freed up. That will take us up to 450 million. The purpose of it was effectively to provide some cushion for the impact of the brought forward deficits from last year. If you remember, when we added it up last year, there was a £547 million problem. We then had to deduct that resource from the NHS. The NHS allocations were reduced by the amount of last year’s overspend. By creating a contingency it gives you a way of managing the impact of last year’s deficits.

Q805 Charlotte Atkins: What has been the impact of those very significant cuts in education and training of the NHS workforce? We would all argue that the NHS workforce is absolutely crucial to the success of the NHS and therefore to significantly cut training and education budgets must be very short sighted.

Ms Hewitt: It 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. What is happening this year is that, for instance, health care assistants who should have been given and would have been given the opportunity to go on a nursing course are simply not able to do so. It is particularly frustrating that a lot of the impacts of the reductions in this year’s training budget are falling on those who in the past have had the least training and whom we have always wanted to give more opportunities to and have indeed been doing so. It is not possible, for instance, with a doctor who is in training simply to cut off that training half way through the training programme. It is possible in the short term to say that somebody who is expected to start a new training course next January will not be able to do so. This is part of the very difficult decisions that we have to make. The truth of the matter is if you look at the NHS budget the bulk of it comes from staffing. You have a situation where the NHS is employing far more staff than projected. Some organisations have taken on more staff than they can afford. We have the unions asking for quite substantial pay rises. We have a training budget which in a sense is also overshot because clearly this year more people are graduating than the NHS can afford to employ. We were talking about newly qualified staff and it is in that context that for this year the training budget has to take some reductions.

Q806 Charlotte Atkins: Effectively what we are doing again is starving the lower paid staff like the health care assistants of much needed training and thereby demoralising those staff we would like to incentivise to stay in the NHS because we know they are the people who are more likely to stay in jobs for a longer period of time, saving the NHS money.

Ms Hewitt: Those points are true. I very much hope that staff, including health care assistants, who had expected to go on a course perhaps starting in January or next April and now cannot do so, will be able to do so next year or the year after next. We have to make some decisions this year to get the
NHS back into financial balance and back on track. The alternative would have been leaving the training and education budget untouched and take out more jobs or have a pay freeze. There are difficult decisions to be made wherever you make them and my view is that it was right to have some difficult decisions in the area of education and training, some difficult decisions around the area of workforce numbers and to try and spread the burden of adjustment rather than concentrate it all on the issue of staffing numbers.

**Q807 Charlotte Atkins:** You implied in your comment earlier that doctors were not as adversely affected as perhaps health care assistants, but we were told by the BMA that there had been a 25% reduction in university funding for medical academics. Presumably there is a knock-on effect.

**Ms Hewitt:** There are certainly reductions in doctors’ training as well. I was simply making the point that what you cannot do is cut off the training of a doctor who is half-way through his or her medical training programme. There are doctors who had hoped to go on perhaps a short term specialist course and that is now not happening this year. This does involve difficult decisions and I make no bones about it.

**Q808 Charlotte Atkins:** Alongside that we are seeing in some hospitals and in a hospital I know very well is a dilution of the skills mix. For instance, advanced skills nurses are being made redundant and effectively being replaced by lesser qualified nurses. Therefore, that begins to build in a disincentive for nurses and other staff to upgrade their skills and aspire to higher skill levels.

**Ms Hewitt:** What I have come across in several places is not so much highly specialist nurses being made redundant, but highly specialist nurses being asked to spend much more time on wards in general duties. Making a highly specialist nurse redundant would not only be quite short sighted; it would also be quite expensive.

**Q809 Charlotte Atkins:** Advanced skills nurses have been made redundant in North Staffordshire. It is not very many; maybe two or three, but all the same it is short sighted from that point of view.

**Ms Hewitt:** I do think individual hospitals need to make their own judgment about the right skill mix and the right configuration of services. There may be situations where—I do not know specifically about the one in North Staffordshire—they simply do not need as many clinicians providing a particular service as they did a few years ago. Certainly that was the situation that arose in Oxford in relation to dermatology consultants.

**Q810 Charlotte Atkins:** What you say is that this clearly is a short term decision and it would be very damaging if it was longer term. Will you consider ring fencing the training budgets again because if we do not get that it is going to be the fund which every chief executive in the country will start taking from whenever problems get difficult.

**Ms Hewitt:** I am very reluctant to go down the ring fencing route. We have been there before. We used to have a great deal of ring fencing of different pots of money for the NHS. It means that people running organisations locally no longer have the flexibility to find the best way to achieve the outcomes that they and we want to achieve. If you think of one of those long balloons, you squeeze it in one place and it pops out in another place. In a sense, if you ring fence the training budget and you say you cannot make any cuts there and you cannot deal with the financial problems by making reductions there, you are going to have to make other decisions and other reductions in some other part of your budget. Then somebody else is going to say, “That is an outrage. You should ring fence the budget for physiotherapists so you cannot reduce physiotherapy staff” or, “You should ring fence public health”. You end up ring fencing everything, removing necessary flexibility, reducing the responsibility of the local people who really know what is going on and not solving the problem. I do not think we can do that.

**Q811 Dr Naysmith:** Charlotte is making a very good point about training budgets because they are something you can cut without having an immediate effect on your own organisation. In my area in north Bristol, the fact that there are cutbacks going on in training for nurses and other medically associated professions is having a devastating effect on the universities in the west of England and the courses they are running. That is not having an immediate effect on the National Health Service yet but it is having an effect on education.

**Ms Hewitt:** I am very aware of that problem and I do think we have to look at how this is better organised longer term because what I have been trying to stress is you can make short term reductions in your training budget and organisations in financial difficulty always do that. It is very difficult to avoid it. If you do it year after year, you completely undermine the basis of the skilled staff that you need. Also, we need to understand better not only the overshoot on staffing numbers but also what may have been an overshoot on the commissioning of training places and just get those back into balance so that the NHS is financially sustainable for the longer term. It comes back to the point about quality and value and productivity. If you are doing more day case surgery you do not need so many staff in your acute wards, you do not need to train up so many people to perform those roles in future. We need to make sure that the commissioning of training and the kind of skills we are building are really orientated to the way medicine is going, which means, for instance, we need to be much more focused on services in the community and not simply services in an acute hospital. That is what modernising nursing careers is specifically looking at now.

**Q812 Charlotte Atkins:** If you will not ring fence training, how about saying that the training that goes on in universities could come under the Higher Education Funding Council rather than the NHS
because they are often very displaced. Therefore, you will not have that huge temptation to dip into that pot whenever the going gets difficult.

**Ms Hewitt:** That is a very valid point. Of course we will look very carefully at whatever recommendations the Committee chooses to make on this and every other point. Of course we will look longer term at the best way of organising the training budget and making sure that the country as a whole is getting the skills it needs. We have to make sure that the NHS this year and next year, when it has these enormous increases in funding and will get to the European average, organises itself in a way that makes the most effective use of those resources.

**Q813 Charlotte Atkins:** Let us make sure that stealing money from the training budget does not become habit forming.

**Ms Hewitt:** I would endorse that.

**Q814 Dr Taylor:** I am very relieved that you mentioned health care assistants because it is good to know that the lack of training for them is acknowledged. You have spoken about short term reductions. I am trying to tie you down a little further than Charlotte. We have had the reductions in training 2005–06; we have them in 2006–07. Are we going to have them in 2007 and 2008 because two years strikes me as the maximum, short term.

**Mr Nicholson:** Having said all of that, we are still spending more than £3 billion on training across the NHS and we have more doctors and nurses in training than ever before. Generally speaking, I would go for a position where the NHS is in a better place to make decisions about the numbers and how they do it than the Department of Health. I would support the delegation of that responsibility.

**Q815 Dr Taylor:** To SHAs?

**Mr Nicholson:** Yes, but SHAs do not just do it in isolation. They do it in relation to talking to universities and all the rest of it to make it happen, which is quite important for them to do. It is not all problematic as far as training is concerned. There are significant amounts of money still being spent to train doctors and nurses in this country.

**Q816 Dr Stoate:** You said earlier on that difficult decisions have to be made to ensure financial balance at the end of the year. Can you explain to the Committee what your department is doing differently this year to ensure organisations reach that financial balance?

**Ms Hewitt:** We are supporting organisations through the whole turn around process. We have put in place a much clearer financial framework. We have agreed through the Strategic Health Authorities a whole series of recovery plans so that organisations know what it is they need to do and what they need to deliver. There is month by month monitoring on that. We have the turnaround directors, finance directors and other parts of the management leadership meeting together within Strategic Health Authority areas but also across turn around organisations so that they share the lessons they are learning and spread best practice. We have published the quality and value indicators which provide this hospital trust by hospital trust bench marking for the first time ever so that people can see much more clearly the real scope of productivity improvements that they have.

**Q817 Dr Stoate:** Is the costing of policies right this year? Previously I think you would probably agree that the GP contracts and the consultant contracts cost considerably more than was predicted. Are there any cost problems this year that may cause similar difficulties?

**Ms Hewitt:** As the Committee has heard, there was a cost overrun of £90 million on the consultant contracts—these are 2005–06 figures—compared with what had been predicted. There was an overrun this year of about £200 million on *Agenda for Change* and something rather less on the GP contracts. These were very small proportions of a total very large pay bill. Although attention is often drawn to that, at the same time there was a cost undershoot if you like on the projections that had been made on the pharmaceutical bills. What we are seeing this year—we reported on this in the quarter two report—is we think the redundancy costs will be somewhat higher than originally estimated. That is a consequence of the Age Discrimination Directive and the changes made to the structure of redundancy payments. On the other hand, there will be unanticipated, unplanned for savings in the pharmaceuticals budget because what we found was we were overpaying on some pharmaceuticals and we have changed that. PCTs will benefit by about £150 million.

**Q818 Dr Stoate:** You are happy to say to the Committee that you are confident that the costing policy this year is right.

**Ms Hewitt:** I think we are strengthening it every year. There are always unexpected things but we allow for them and we try and anticipate those risks. They tend to go in both directions. Redundancies are costing more. Pharmaceuticals are costing less than planned for.

**Q819 Dr Stoate:** There is evidence in some cases that bad financial management has led to deficits. What specifically are you doing to address the issue of bad financial management in some organisations?

**Ms Hewitt:** If you look at the Audit Commission report on the organisations where they produced a public interest report along with the accounts, you will find very significant changes have happened in almost every place—I do not have the figures with me—in the leadership and management of those organisations.

**Q820 Dr Stoate:** You are prepared to make significant changes in the leadership management where that is needed?

**Ms Hewitt:** Of course, non-executive as well as executive.
Q821 Dr Stoate: I will pick two organisations at random. Hillingdon PCT has a very large deficit of £66 million. Sussex Hospitals Trust seems to have a deficit of around £19 million. I am not trying to pick on those particularly but just use them as examples. What are you doing to help those organisations and others like them to get back into balance?

Mr Nicholson: Obviously the Strategic Health Authorities in both those areas are working very closely with the organisations. Both have extra resources to allow them to support them. One of them at least has had a new chief executive recently to help and bring the plans forward. We are working very closely with them to make sure that they can get themselves back into some kind of balance over a reasonable time. For those organisations it is extremely difficult but what we do not want is a set of plans that no one believes can be delivered. We have been there before. The issue is not only the plan but also the time it will take to make sure we deliver it and that they have the resources to make it happen.

Q822 Dr Stoate: Does not the use of turnaround teams also leave you open to the charge that you have no real confidence in the existing management?

Mr Nicholson: I do not think so. 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. I think there is some evidence that, in those places where it has been working longest, it works very well. The other thing about turn around is that those places which engage clinicians in these changes are much more likely to get lasting change than those who do not.

Ms Hewitt: It was very striking that when we sent KPMG about a year ago to do an initial assessment of organisations that had serious deficits they came back and said that, in many cases, the financial management and so on is good but the problems have built up over so many years and are now so deep that however good the existing team they need extra management resources and financial expertise to sort the problem out. That is not a criticism of management at all.

Q823 Dr Stoate: Some of the PCTs I mentioned earlier who did not need financial directors seem to have woken up once they found the bank statement on the mat and panicked. Should that not have been headed off at the pass years before it reached the critical stage?

Q824 Chairman: Could I move on briefly. You asked the Audit Commission to look at the Resource Allocation Budgeting regime. They have now reported to you. What action are you going to take about it in view of their major recommendation to have the use of this regime inside NHS Trusts?

Ms Hewitt: As you say, Chairman, having learnt a great deal about the financial framework, I thought it would be very helpful if Sir Michael Lyons from the Audit Commission came in and looked independently at the financial framework and the application of resource accounting and budgeting to the NHS. Obviously resource accounting and budgeting applies right across Government and that is not going to change. It was quite right to apply accruals based accounting to the public sector rather than simply a cash management system as we had in the past, but whereas the application of RAB to hospital trusts might have been appropriate in the old days what we and the Audit Commission found was it was not consistently applied as between one region and another or one Trust and another. It is not consistent with payment by results and the new financial regime we are putting in place and it cannot be applied to foundation trusts. For all of those reasons we all agreed that it needed to be looked at. The Audit Commission has done a very helpful piece of work. In most respects most of their recommendations we are already doing, and of course the Department worked very closely with them on that review. On the specific issue of how we deal with the application of RAB to NHS Trusts, we are looking very carefully at their initial proposals, and that is as I think we said all they are. We are working closely with the Audit Commission and the Treasury as well as with colleagues in the NHS to come up with a solution to the problem. I am confident that we will have a solution. It will be better, it will be fairer, it will be more transparent but there is no such thing as a free lunch and therefore we have to work out how we resource a better and fairer system without falling into the trap that I think the NHS has fallen into in the past of simply writing off some of these deficits and then finding the next year they are over-spending again. We cannot go back to those days.

Chairman: Thank you for that.

Q825 Charlotte Atkins: I can appreciate that finance is obviously very important but it seems to me that looking at what has been happening around the country the trust boards are now being packed with accountants and financial experts to the detriment of for instance non-executive directors who represent the community. Is that because you consider that these trust boards should be taking over responsibility of financial directors and that somehow non-executive directors who represent the community have not got any value?

Ms Hewitt: I certainly do not believe that. When I agreed with the independent Appointments Commission the specification for the job and the people we want for the new Primary Care Trusts, but this also applies to hospital trusts, I stressed that what we need is a balance of expertise. We certainly do need people who have got experience of running large organisations and managing large budgets whether that is in the public sector, private sector or the not-for-profit sector, we stress that as well. We also need people, and they may be the same or they may be different people, who have real experience of different local communities, particularly disadvantaged communities where health inequalities and health problems are most entrenched. That was something on which we gave
a very clear mandate to the Appointments Commission, particularly for the Primary Care Trusts. I would stress that of course in line with the manifesto promise we made in 2001 the Appointments Commission is independent. Although trust boards and PCT boards—I am talking NHS trust boards not foundation trust boards—are ultimately accountable to me I do not appoint them.

Q826 Charlotte Atkins: I appreciate that but I think you have got the balance absolutely wrong because when Primary Care Trusts and new trust boards were set up it seems to me that people who have been giving a very good service, who have got excellent community links have been shelved and have not even got interviews for those positions. I think the balance has gone in completely the wrong direction if we are really committed to patients and public involvement.

Ms Hewitt: On the PCT side, with fewer organisations it was always going to be the case that some serving members of the predecessor organisations, including some very good and long-serving members were not going to be reappointed. That has been really quite a blow for those individuals who have made such a good contribution. If you have got examples or indeed any Committee member has got examples of cases where you think there was a completely wrong judgment made, including not to interview somebody, it would be very helpful if you could let us have that because obviously we discuss that with the Appointments Commission. Since we are now at the stage where we will shortly be appointing a new chairman of the Appointments Commission, without in any way wanting to criticise the existing Chairman, I think it is an opportunity for the Appointments Commission to take stock of what has been an enormous recruitment and appointment exercise, get some feedback from it and then ensure that where there are lessons to be learnt those are learnt for the future.

Charlotte Atkins: Thank you. I will do that.

Q827 Dr Naysmith: Can I just explore that a little bit more because my experience is very similar to Charlotte’s, some very good people have not been reappointed to the board. What is the process going to be for the replacement? Are you going to have a specification drawn up?

Ms Hewitt: Yes.

Q828 Dr Naysmith: Is that going to be made public?

Ms Hewitt: Yes. We have already drawn up the specification. The advertisement has been published. We could perhaps send copies to the Committee and that would be helpful. This has all been done under the auspices of the Public Appointments Commission and so on. Interviews will be taking place in December.

Q829 Dr Naysmith: December?

Ms Hewitt: Yes. Have I got that timetable right?

Mr Nicholson: Yes.

Q830 Dr Taylor: I do not think any of us have got any argument that it is right that the NHS should be striving to get into balance. I think what worries us is the speed with which this is expected to happen. It is this that is leading to these cuts in the training budgets and the staff reductions. I am a little bit confused. Earlier on today you said by the end of March next year you expect us to be in balance, that is taking into account the contingency fund. It is taking into account the top-slicing of PCTs. You still think it is possible, taking those into account, that there can be a balance by the end of March?

Ms Hewitt: Yes. Taking those factors into account, as you rightly say, I am confident the NHS as a whole will be in balance by the end of March next year but not every individual organisation will be in balance. North Staffordshire will not be in balance by the end of this financial year, its problems are too big.

Q831 Dr Taylor: You are allowing those that have got the biggest deficits a little bit more flexibility?

Ms Hewitt: We have to and we have said this from the outset, Dr Taylor, because it would be completely impossible for an organisation that has built up a very big problem over several years to get itself back into balance in one year without doing serious damage to patient care, and we are not prepared to allow that to happen. Those organisations are being given longer but the NHS as a whole has to return to financial balance. There is not money that I can take from the education budget or the policing budget or anywhere else to compensate for a deficit. That is why for any NHS Trust or PCT that is in deficit this year there has to be a surplus somewhere else in the system either in another Primary Care Trust through the top-slicing mechanism or through the contingency fund that has been created out of the central budgets. Therefore when people say to me as they constantly do “Give us more time, give us more time”, we look at it by case, but people have to recognise the longer an organisation in deficit takes to get into balance, the longer somebody else—the Chairman’s PCT in Rotherham for instance—has to hold back on its spending and not make the improvements they have promised for their local conscience because they have got to balance the deficit—I think in the Rotherham case in Sheffield—in some other part of the service.

Q832 Dr Taylor: Can I take you back to something you said in the health debate last Thursday. I forget the actual word but you did say that there would be a time of peace or a time of calm in the NHS. Can we take that as an assurance that we are not going to have another major reorganisation in the next few months?

Ms Hewitt: Absolutely. I made that comment and I cannot remember the exact—
Q833 Dr Taylor: It was in response to a question from one of your own backbenchers.

Ms Hewitt: Yes it was, and it was a question specifically relating to reorganisations of Primary Care Trusts and Strategic Health Authorities. I believe we have now got a very good structure and increasingly strong leadership both with the Strategic Health and Regional Health Authorities and the Primary Care Trusts, and I certainly do not envisage another reorganisation.

Q834 Dr Taylor: It was intended to send a message to the workforce that they are not going to be altered drastically in the near future?

Ms Hewitt: I have already made the point that in terms of Primary Care Trusts and Strategic Health Authorities there are still job losses and redundancies to take place. We will announce those as they happen. Certainly in terms of stability in the new PCTs and SHAs yes that is what will happen. In the broader NHS, medicine is not standing still, as you know better than I do, therefore the NHS will go on changing because medicine and patient needs are continuing to change.

Q835 Dr Taylor: Just going back to this year, 2006-07, we have been given figures for increases and I just want to make sure that these have been taken into account in claims to get into balance. A further 2.5% efficiency saving, costs for this year’s Agenda for Change £394 million, consultants contract £48 million, non-consultant career gain £10 million. Are all those being taken into account in your belief that you can get into balance?

Ms Hewitt: Yes.

Q836 Dr Taylor: They are?

Ms Hewitt: Yes.

Q837 Chairman: Can I go on to top-slicing, Secretary of State. You did say earlier about the incidence of health inequalities in my constituency.

My PCT which has been in balance has just been top-sliced for a second time this year. My PCT which has been in balance has just been top-sliced for a second time this year. 0.5% not £6 million has been taken off this year. Whilst not all of it is growth money by finance, a substantial amount of the money could be spent on the capital health of my constituency than many others as well. How long is this going to go on? We are an area with high health inequalities and it just seems unfair from the point of view of the health profile of areas like Rotherham.

Ms Hewitt: Of course it feels unfair, Chairman, to an area like yours and all the others which have been top-sliced in order to compensate for the over-spending in a minority of organisations. It would indeed be grossly unfair if what it meant was a permanent cut to the resources available to the people of Rotherham and other places that are being top-sliced. That is not what we are doing. In the past, with the support and brokerage that we talked about earlier on, that was a permanent loss in resources to the organisations that had money taken away from them in order to make up for the over-spending in the minority that had over-spent. 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 top-slice will get those resources back. They will get them back as far as possible within the three year allocations period and I have made it very clear that the areas with the biggest health problems should, as far as possible, get the top-slicing money back first. It is a transparent way of managing the problem that Dr Taylor referred to but it is simply not possible to get over-spending organisation back into balance in one year. You are making precisely the argument I make to the over-spending organisations that they do have to make some difficult decisions within a reasonable but not too long timeframe because otherwise it is not fair to areas that have got very big health problems that they also need to invest.

Q838 Chairman: I accept that and I agree with you on that, in view on the fact, as I said earlier, it is not all the growth money that is in areas like Rotherham and therefore it is reassuring that it is not. You say it will be paid back within the three year allocation period, do you mean this current three year allocation period or the following one?

Ms Hewitt: In a sense we will roll forward into the new allocation period once we know what the CSR settlement is. I very much doubt if every organisation will have got its top-slice back within the current two years, though the better we can do this year and the better the deficit organisations do in making the necessary decisions the easier it will be to repay those top-slices within a reasonable period, but some of the repayments will go into the first year of the new allocation period.

Mr Nicholson: Yes, they will be driven by our ability to sort those organisations out that are in deficit.

Q839 Chairman: One of the drivers in that year, the first year of the new spending round cut, is the Treasury, they are the big drivers in all this. What guarantee do PCTs like my own get that they will get the money back if it is not all paid back by the end of this current spending round by not something that is obvious and transparent but it is not, “You get the money back so your budget is being reduced to take into account the expenditure that the Treasury has”. We are all thinking we are going to drop off the end of a cliff in terms of public expenditure at the end of this current financial three year round, now my view is that we are probably not because there are things like elections coming along at some stage in the future. Nonetheless you need to reassure areas like Rotherham and Leicester, I suspect, that this will happen, the money will come back.
Ms Hewitt: Chairman, what I want to stress then is first of all there is very substantial growth going into the NHS in this year and despite the top-slicing organisations are still continuing to grow. Next year we have another year, the final year, of very substantial growth so that by 2008 we will be up there with the European average. We will then continue to have growth in the following financial year and so on, although everybody knows it will be slower growth than we have had for the last five to seven years when we have had this unprecedented period of catch-up. We will still want to keep up with the European average. We will still go on growing the NHS in significant real terms. From the point of view of moving from a period of very fast growth to one which is still significantly slower, actually having some of those resources returned in the first year of the new spending period will be very helpful to organisations, areas like your own, in managing that transition.

Q840 Chairman: Can I just ask: will it be transparent?
Ms Hewitt: We are making this as transparent as we possibly can.

Q841 Mr Amess: Secretary of State, I have been listening very, very carefully to everything you have said this morning about these deficits and, in the light of all that, is it not a bit of an odd time to have announced this money for hospitals to advertise their services? It does not seem to fit in with everything we have been discussing this morning?
Ms Hewitt: Well, Mr Amess, we have not announced any money at all for advertising. What we are doing is working on a draft code of practice, I think a draft has been leaked to somebody. We are working on a draft code of practice which we will publish shortly and which we will consult on to make sure that NHS organisations do not waste money on excessive advertising and damage their own reputation and that of the broader NHS in doing so. I do not think any of us want to see hospitals out there buying television advertising, for instance, but there is an important role for giving patients more information about the quality of services that they can expect to get, and of course hospitals want to do that. That is the code of practice that provides a framework within which they can do it.
Mr Amess: I am happy to be corrected.

Q842 Mike Penning: After everything I have been listening to this morning clearly there are areas of great pain and concern within patients and staff, wonderful staff we have. Do you think it was in hindsight—hindsight is a wonderful thing—that "the best year ever" was the right comment to make in this financial year?
Ms Hewitt: That was a direct quote from the Chief Executive’s annual report which had been published including that phrase without particular comment.

Q843 Mike Penning: Which you signed, it is in your name.
Ms Hewitt: I repeated it because if you look at the number of patients being treated, if you look at the reduction in waiting times, if you look at the quality of care on a number of key indicators, actually there were more patients being treated faster and better than in any previous year and there were more people’s lives being saved as a result. If you look at this year, if you look for instance at the quarter 2 report, you will see there that the waiting times have either stayed stable or continued to reduce and on cancer, despite the financial difficulties and the pain that you rightly referred to, there has been a very, very marked improvement in cancer care with most patients, instead of only about two-thirds, getting right through from an urgent referral from the GP right through diagnosis and testing to the beginning of their treatment within 62 days. We know that the faster you diagnose and start treatment the more likely somebody is to survive. These are real improvements and I do think NHS staff deserve more credit than they get.

Q844 Mike Penning: At the same time there are massive concerns which is why this Committee is doing this inquiry.
Ms Hewitt: Yes.

Q845 Mike Penning: Do you not accept that for the people who are suffering because of the problems with the NHS the comment that “this is the best year ever” for them was inappropriate?
Ms Hewitt: That is not what I said. What I said was for patients more patients had been treated in that year faster and better than ever before and that remains the case. I do hope, Mr Penning, that you will give the credit to NHS staff that they absolutely—

Q846 Mike Penning: I have already done that on this Committee on more than one occasion.
Ms Hewitt: Good, which they really deserve for the improvements in cancer care—

Q847 Mike Penning: Even you and I are shoulder to shoulder on that.
Ms Hewitt:—that have taken place at a time of real financial pain which I acknowledge just as much as you do. I think it is a great pity that the financial difficulties absorb acres and acres of press space and television time, the improvements in cancer care get almost no coverage at all and NHS staff almost no credit at all. I do think if we could get it from the media some balance in that would be appropriate.

Q848 Mike Penning: I do not want to keep this debate going on but when we were debating this in the Chamber just a few weeks ago an ex-Secretary of State on the Opposition benches said, “It is absolutely true because every year has been a better year for the National Health Service since it was formed in 1948”, I think that is absolutely true.
**Ms Hewitt:** I am not sure that it felt like that in 1996.

**Chairman:** Order. I do not want to extend the debate. I was just quoting what an ex-Secretary of State said when you were in opposition, Secretary of State.

**Q849 Dr Taylor:** I think we are on to the last question. Plumbing the depths of the confusing NHS accounting which I cannot begin to understand, we are told that the detailed accounts for 2005-06 show that the SHAs Revenue Resource Limit—which I do not understand—was raised by £433.8 million. Where did that money come from?

**Ms Hewitt:** This is definitely one for Richard.

**Q850 Dr Taylor:** I never understand what he explains in any case. Where did it come from and what was it for? Short answer.

**Mr Douglas:** The short answer would be I would have to give you a note. There will have been a number of additions to the Revenue Resource Limit. The Revenue Resource Limit is basically the money the SHAs themselves are in control of.

**Q851 Dr Taylor:** Is it the same as the cash they have got?

**Mr Douglas:** It is not quite unfortunately. It is expenditure. It is how much they can spend basically. For the purposes of not getting this too confusing we will take it as broadly equivalent to cash.

**Q852 Dr Taylor:** They are allowed to spend more than they have got?

**Mr Douglas:** No, the addition will be additional cash they will outspend. Some of that will have been in that case transfers from other organisations, others will have been central budgets that will have been paid out from the Department during the year. When a central budget goes from a department to an SHA or to a PCT what we do is add money to their resource limits. It is the additional resources they would get in the normal course of business. I can, if it will be helpful, provide you with a breakdown of that precise figure.

**Q853 Dr Taylor:** It is not specifically targeted at Trusts or organisations which look as if they are going to be in deficit?

**Mr Douglas:** No, that would not be targeted. I would have to check on that particular one to know precisely what it was that that addition was for. It could have been money around the NHS planning—

**Q854 Dr Taylor:** Send us a note.

**Ms Hewitt:** If it is any comfort, Dr Taylor, every time I listen to the explanation of something like this I comfort myself by thinking it is a technical adjustment.

**Q855 Dr Taylor:** And you gaze over!

**Ms Hewitt:** I glaze over.

**Q856 Chairman:** Could I thank all of you very much indeed for coming along. We are hoping that this report will be published and sent on to the Government by the Christmas recess. Whether or not that will take place we will have to wait and see, I suspect that this debate and some of the debate we have had this morning will carry on beyond the end of December. Thank you very much indeed for the evidence and your attendance today.

**Ms Hewitt:** Thank you very much, Chairman. We look forward to the report as always.
Written evidence

Supplementary evidence submitted by the Department of Health (Def 01B)

INQUIRY INTO NHS DEFICITS

1. Definitions of Deficit

Definitions of the types of deficit are shown below. These have been divided between NHS trusts and Primary Care Trusts/Strategic Health Authorities to reflect their differing status.

The level of deficit for each type (based on the provisional outturn figures for 2005–06) is shown at the end of each definition. A more technical definition for each type is shown at Annex A, along with illustrative examples at Annex B.

NHS Trusts

(i) In-year deficit/surplus: the final “bottom line”—retained surplus or deficit—when recorded income is compared with recorded expenditure in any one year. It is the NHS or public sector equivalent of the net profit/loss reflected in the accounts of a commercial company.

(ii) Net deficit/surplus: the sum of all NHS trust in-year deficits and surpluses. (£560 million deficit.)

(iii) Gross deficit: the sum of all NHS trust in-year deficits. (£674 million deficit.)

(iv) Cumulative deficit/surplus: this is sometimes referred to as the accumulated deficit or NHS trust historic debt. In the balance sheet, it is recorded as the Income and Expenditure reserve. It is the sum of all in-year deficits and surpluses over the life of the organisation, and totalled £447 million net deficit at the end of 2005–06. However, it is the statutory breakeven note (see below) which records the actual performance measure over time.

(v) Statutory breakeven duty: Each NHS trust has a statutory duty to breakeven over a three year or exceptionally a five-year period, subject to a materiality test. As a result, the cumulative deficit of an individual trust, where it exceeds 0.5% of the current year turnover, must be eliminated by subsequent surpluses over three years, or exceptionally five years to meet this duty. The breakeven duty was defined and recorded in the accounts from 1997–98, and is a key measure of financial performance for NHS trusts over time. (91 trusts have material cumulative deficits for the purposes of the breakeven duty totalling £1,305 million which need to be recovered by generating surpluses.)

Primary Care Trusts and Strategic Health Authorities

(i) In-year under/(over) spend: for an individual organisation, the under or overspend against that organisation’s agreed resource limit for the year. (£48 million underspend.) This is comparable to the “bottom line” in the trust sector.

(ii) Gross overspend: the sum of all PCT/SHA in-year overspends. (£603 million overspend.)

(iii) Net overspend the sum of all PCT/SHA in-year overspends and underspends. (£48 million underspend.)

Unlike NHS Trusts, PCTs and SHAs have an annual statutory duty to live within the resource limit set by the Secretary of State and do not record the cumulative over/under spend in their accounts. Any in-year under/(over) spends are followed by equivalent increases or reductions to the following year’s resource limit.

The Committee may be interested to know that the report recently published by the Audit Commission on the NHS financial regime, which was commissioned by the Secretary of State, makes recommendations for changes that would affect the way in which the recovery of prior year deficits is handled, particularly in relation to recovery from NHS trusts by deduction of income. The Department is considering these recommendations and will report in the autumn.

2. Where the Difference Between the Gross and Net Deficit has Gone

The gross deficit is the sum of all in-year deficits in NHS Trusts plus the overspends of all SHAs and PCTs. It excludes surpluses and underspends. The gross deficit based on 2005–06 provisional outturn figures is £1,277 million.

The reported net deficit is the sum of all NHS trust surpluses and deficits and PCT and SHA over and underspends.
The table below reconciles the gross and the net deficit positions:

<table>
<thead>
<tr>
<th></th>
<th>Gross deficit</th>
<th>Less surpluses</th>
<th>Net surplus/ (deficit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>PCT Sector</td>
<td>(603)</td>
<td>127</td>
<td>(476)</td>
</tr>
<tr>
<td>NHS Trust Sector</td>
<td>(674)</td>
<td>114</td>
<td>(560)</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>(1,277)</strong></td>
<td><strong>241</strong></td>
<td><strong>(1,036)</strong></td>
</tr>
<tr>
<td>SHA Sector</td>
<td>0</td>
<td>524</td>
<td>524</td>
</tr>
<tr>
<td><strong>England Total</strong></td>
<td><strong>(1,277)</strong></td>
<td><strong>765</strong></td>
<td><strong>(512)</strong></td>
</tr>
</tbody>
</table>

3. **Source of Surpluses**

The gross surplus of £765 million is made up of surpluses in SHAs, PCTs and NHS Trusts, with the majority (£524 million) in the SHA sector.

A surplus occurs where an organisation has higher income than expenditure. The surpluses in the SHA sector are derived from three sources.

The first is underspending on programme budgets where the allocations for NHS trusts and PCTs are managed by the SHA—the largest of which is the workforce budget covering education and training, where the provisional 2005–06 underspend is around £133 million.

The second source is from underspends on the 2005–06 £145 million budget to cover SHA running costs.

The third source is underspends being held by the SHA, as some organisations pass their surplus income to the SHA rather than record it in their own accounts—the SHA will typically return the resources to those organisations in the following year. In the past, such surpluses would have been passed to organisations in deficit to cover their overspending. Since we have placed greater restrictions on providing support to overspending organisations, the surplus now sits with the SHAs and is no longer passed to individual trusts and PCTs with deficits.

4. **Evidence of Relationship Between Funding Formula and Deficits**

We note the evidence given to the Committee on the relationship between the funding formula, the allocation of funds to Trusts, and the size of their deficits or surpluses, submitted by Professor Sheena Asthana and Dr Alex Gibson.

We have looked into the factors that have contributed to the financial position of NHS organisations, and have concluded that there is no single cause of financial problems. The provisional analysis shows that there is very little correlation between the size of deficits and any of the factors relating to funding—including allocations per head, and increases in allocation.

Similarly, the analysis suggests there is no trade off between managing within the budget and improving the quality of patient care. There appears to be no significant relationship between deficits and the Healthcare Commission ratings, and there is no evidence that organisations need to overspend to deliver improved services.

The Department’s Chief Economic Adviser has been asked to carry out further detailed analysis on the causes of financial problems. The analysis submitted by Professor Sheena Asthana and Dr Alex Gibson will be reviewed as part of that work, which will include a more thorough investigation of the financial data and consultation with local organisations. The outcome from this analysis will be available in the autumn.

5. **Resource Allocation Formula Including the Old Long Stay Adjustment**

I agreed to provide a note to the Committee about the funding formula and the adjustment relating to the closure of long stay institutions.

Revenue allocations are made to PCTs on the basis of the relative needs of their populations. The weighted capitation formula is used to determine PCTs’ target shares of available resources, to enable them to commission similar levels of health services for populations in similar need.

The components of the formula are used to weight each PCT’s “crude” population according to their relative need (age, and additional need) for healthcare and the unavoidable geographical differences in the cost of providing healthcare (the market forces factor).

The aim of the formula is to ensure there is sufficient funding to provide equal access for equal need in all parts of the country, and to reduce health inequalities.
Allocating funds to PCTs on an equitable basis is an important objective. To ensure this objective is met, the Advisory Committee on Resource Allocation (ACRA) continuously oversees the development of the weighted capitation formula. ACRA is an independent body, made up of NHS managers, academics and GPs.

Prior to each allocations round, ACRA agrees a work programme to support the revenue allocations to PCTs. Once the work programme is complete, ACRA makes recommendations to Ministers on possible changes to the formula. Any recommendations that ACRA make in relation to proposed changes to the formula, are based on the best evidence and research available.

The key workstreams on ACRA’s current work programme, in support of the revenue allocations post 2007–08 are:

— to determine the most robust population base for revenue allocations to PCTs;
— a review of the need element of the formula; and
— a review of the adjustment for unavoidable differences in cost—the market forces factor (MFF).

This work involves two main pieces of research, with a particular focus on unavoidable differences in staff costs. The first is a review of existing approach to MFF (based on private sector wages). This review has been commissioned from a team led by the University of Aberdeen. The second is research into an adjustment for unavoidable differences in cost based on actual NHS costs. This research is being delivered by a consortium that includes a private sector consultancy, University of York, and City University London.

**Rurality**

In calculating the health needs of rural areas, the weighted-capitation takes into account the effects of access, transport and poverty. ACRA has looked at rurality on a number of occasions, and ACRA’s current work on unavoidable cost differences includes further consideration of the issues facing rural areas.

ACRA’s terms of reference are:

— to advise the Secretary of State for Health on the distribution of resources across primary and secondary care, in support of the goal of equitable access to healthcare for all; and
— to develop and apply methods which are as objective and needs-based as available data and techniques permit.

A short guide to resource allocation and the weighted capitation formula is attached at Annex C.

**Old long stay adjustment**

The Old Long Stay (OLS) adjustment is outside the funding formula. It compensates PCTs for the costs of patients with learning disabilities admitted to hospital prior to 1 January 1970 and patients with a mental illness admitted to hospital prior to 1 January 1971. It is a way of recognising that, because of the uneven location of long stay hospitals, there is an uneven spread of people with learning disabilities and mental illness across the country with NHS spend being uneven as a result.

When the OLS central budget was consolidated into health authority (HA) budgets in 1999–2000, each HA received their fair share. The process, which was then applied to HAs, is now applied to PCTs. Because the distribution of expenditure is uneven, an adjustment is made to PCT allocations each year so that PCTs receive funding equivalent to their declared expenditure on OLS patients. PCTs, which spend more than the national average on OLS, receive an addition to meet their costs and PCTs, which spend less than the national average on OLS, receive a deduction. Nationally the additions and deductions sum to zero.

Changes to the OLS adjustment are made on the basis of a census of OLS patients, which is conducted approximately every three years—most recently in 2004. The declared spend on OLS patients by PCTs in the 2004 census was £564 million (£607 million when uplifted to 2006–07 prices), of which £496 million was on patients with learning disabilities.

Rotherham PCT, which does not have any long stay hospitals, receives a negative OLS adjustment of £3.4 million in 2006–07. The three Doncaster PCTs receive positive OLS adjustments totalling £1.2 million. East Elmbridge and Mid Surrey PCT receives the largest OLS adjustment of £20.4 million.

**Recognising multiple sites in the market forces factor element of the weighted capitation formula**

The market forces factor (MFF) is used in the resource allocation formula to PCTs and in Payment by Results (PbR) to adjust the national tariff to give the local price for each trust. The aim in both contexts is to take account of unavoidable differences in the cost of providing services across the country.

The MFF combines three separate indices: a staff index, a land index and a buildings index.

The land index, unlike the staff and building indices, is specific to each trust and PCT. While it would be possible to use average land values for geographic areas such as counties or PCTs, the nature of land prices is very specific to locations and there can be considerable variation within any given area. We therefore use
a land valuation specific to each organisation. The land index is the land value per hectare provided by the Valuation Office and reflects the outcome of the recent revaluation of the NHS estate. We make a technical adjustment for two London trusts that have a significant non-London site in recognition of the very different way that land is used in central London compared to less urban areas. Their land index is constructed in proportion to activity on each site rather than land area on each site.

The staff and building indices relate to geographical areas. To assign these indices to trusts, we therefore need to know the PCT, or PCTs, within which trusts are located. Where trusts have more than one significant site (we take significant to be a site providing more than 10% of activity), we estimate the proportion of each trust’s activity that is assumed to be located within each PCT. The best indication of activity by site held on a consistent basis is the numbers of beds, because the site identifier in activity data is not sufficiently reliable. The plan is to keep the data sources under review. The staff and building indices are combined in proportion to these activity weights.

I hope this answers your questions sufficiently, but I am very happy to provide more information if needed.

Richard Douglas  
Director General Finance and Investment  
Department of Health  
8 September 2006

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**Annex A**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Impact on Types of Organisation and Accounts location</th>
</tr>
</thead>
</table>
| NHS In-Year Deficit/surplus | Term used to describe the collective results of the NHS in any year. This is the aggregation of the net surpluses and deficits for NHS Trusts and the under/overspends of PCTs and SHAs for the year. This may include the impact of income or resource limit increases or deductions as a result of previous year’s performance. | Applies to NHS Trusts and PCTs/SHAs.  
Appears in annual accounts as follows:  
NHS Trusts—Income and Expenditure statement.  
PCT & SHA—Operating Cost Statement (Under/overspend against resource limit)  
NHS Trusts—Statutory breakeven duty applies to all NHS Trusts, and can be located in Note 23 to the annual accounts of NHS Trusts.  
PCTs and SHAs—do not have the statutory breakeven duty of NHS Trusts. Where a PCT makes a deficit in one year, its income is reduced the following year without the need to make a surplus. |
<p>| Cumulative surplus/Deficit | The cumulative deficit of a trust forms part of the Income and Expenditure reserve recorded in the balance sheet of NHS Trust accounts.                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Statutory Breakeven duty | NHS Trusts have a statutory duty to match income and expenditure over a three (or exceptionally up to five) year period. A surplus must follow a deficit in later years to comply with the breakeven duty over the period. A separate note to the accounts of NHS Trusts records the cumulative surplus/deficit at the end of each year from 2007–08 to measure compliance with this duty. Where organisations merge, the original organisations are dissolved and a new NHS Trust is established. When the new organisation comes into operation, it has zero cumulative deficit and the statutory breakeven period re-starts. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Impact on Types of Organisation and Accounts location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Deficit</td>
<td>The sum of all organisations with a deficit or overspend, ignoring any underspending or surpluses in other organisations.</td>
<td>Includes all NHS Trusts and PCTs/SHAs showing a deficit/overspend.</td>
</tr>
<tr>
<td>Net Deficit/Surplus</td>
<td>This represents the position when the figures for all organisations (surplus/deficit/under/overspends) are added together.</td>
<td>Includes all NHS Trusts and PCTs/SHAs.</td>
</tr>
</tbody>
</table>

**Annex B**

**ILLUSTRATIVE EXAMPLES OF DEFICITS**

**In-year gross and net deficit**

<table>
<thead>
<tr>
<th></th>
<th>SHA A</th>
<th>SHA B</th>
<th>NHS total</th>
<th>col</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Trust 1</td>
<td>25</td>
<td>0</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>NHS Trust 2</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>PCT 1</td>
<td>20</td>
<td>5</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>PCT 2</td>
<td>15</td>
<td>10</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>SHA</td>
<td>15</td>
<td>5</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Gross Deficit</td>
<td>60</td>
<td>10</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>Gross Surplus</td>
<td>15</td>
<td>15</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Net surplus/(deficit)</td>
<td>45</td>
<td>5</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

**NHS Trust breakeven duty**

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>100</td>
<td>90</td>
<td>90</td>
<td>100</td>
<td>110</td>
<td>110</td>
<td>600</td>
</tr>
<tr>
<td>Expenditure</td>
<td>110</td>
<td>100</td>
<td>90</td>
<td>90</td>
<td>100</td>
<td>110</td>
<td>600</td>
</tr>
<tr>
<td>In Year/Cumulative</td>
<td>(1)</td>
<td>(10)</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>(10)</td>
<td>(20)</td>
<td>(20)</td>
<td>(10)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Annex C**

**2006–07 AND 2007–08 PCT REVENUE ALLOCATIONS: A SHORT GUIDE**

**INTRODUCTION**

1. This is a short guide to the setting of revenue allocations to primary care trusts (PCTs) for 2006–07 and 2007–08. A fuller explanation of the weighted capitation formula is in “Resource Allocation Weighted Capitation Formula: Fifth Edition”.

2. Recurrent revenue allocations to PCTs of £64 billion in 2006–07 and £70 billion in 2007–08 were announced on 9 February 2005, an average increase of 19.5% over the two years.

3. Three-year allocations were introduced from 2003–04, which gave PCTs the scope to plan services over the medium term. With the recent allocations, PCTs once again have three years of funding certainty.

4. Funding is allocated to PCTs on the basis of the relative needs of their populations. The weighted capitation formula is used to determine PCTs target shares of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare need.
5. The weighted capitation formula is used to set targets, which then inform allocations. It is the pace of change policy that determines actual allocations, as it dictates how quickly PCTs are brought nearer to target through the distribution of additional funds. The pace of change policy is considered by Ministers at each allocations round.

6. The aim of the pace of change policy is to ensure stability of funding for PCTs, and allow them to make progress nationally and in local priority areas.

**Elements of Resource Allocation**

7. The following four elements are used to set PCTs’ actual allocations:
   
   (a) weighted capitation targets—set according to the national weighted capitation formula which calculates PCTs’ target shares of available resources based on the age distribution of the population, additional need and unavoidable geographical variations in the cost of providing services;
   
   (b) recurrent baselines—represent the actual current allocation, which PCTs receive. For each allocation year the recurrent baseline is the previous year’s actual allocation, plus any adjustments made within the financial year;
   
   (c) distance from target (DFT)—this is the difference between (a) and (b) above. If (a) is greater than (b), a PCT is said to be under target. If (a) is smaller than (b), a PCT is said to be over target; and
   
   (d) pace of change policy—this determines the level of increase, which all PCTs get to deliver on national and local priorities, and the level of extra resources to under target PCTs to move them closer to their weighted capitation targets. The pace of change policy is decided by Ministers for each allocations round.

**The Weighted Capitation Formula**

8. Healthcare is for people and the primary determinant of need must be the size of the population for which PCTs are responsible. Population is therefore the basic divisor used to distribute available resources to PCTs. The population is then weighted (or adjusted) for:

   (a) age related need—recognising that levels of demand for health services vary according to the age structure of the population;
   
   (b) additional need—reflecting relative need for healthcare over and above that accounted for by age; and
   
   (c) unavoidable costs—taking account of unavoidable geographical variations in the cost of providing services.

**Population**

9. PCTs are responsible for funding the healthcare provision of all patients registered with GPs in practices forming the PCT. This means patients registered with a GP in one PCT area who are resident in a neighbouring or other PCT area remain the responsibility of the PCT with which their GP of registration is associated. PCTs are also responsible for residents within their geographical boundaries who are not registered with a GP. The population for which the PCT is responsible is referred to as the relevant population.

10. The calculation of PCT relevant populations involves scaling GP registered populations to the resident populations from the Office for National Statistics (ONS) Census. Two data sources are used:

   (a) a national count of patients registered with GPs (the Attribution Data Set (ADS)) for mapping cross border flows; and
   
   (b) population estimates or projections produced by the ONS for the overall count. 2003 based Local Authority population projections for 2006 and 2007 were used for 2006–07 and 2007–08 allocations respectively. The 2003 base takes account of various revisions made by ONS to their 2001 mid year population estimates.

**Components of the Weighted Capitation Formula**

11. The weighted capitation formula has four components to reflect the funding within PCT revenue allocations. The four components and their relative weights are:

   (a) HCHS (77%);
   
   (b) prescribing (13%);
   
   (c) primary medical services (9%); and
(d) HIV/AIDS (1%).

12. A similar approach is followed in each component: each PCT’s population is weighted for age related need, additional need and unavoidable cost.

**FORMULA CHANGES FOR 2006–07 AND 2007–08 ALLOCATIONS**

13. Five changes were made to the formula for 2006–07 to 2007–08 allocations:
   (a) ONS population projections provided the population base;
   (b) a primary medical services component replaced the GMSCL and GMSNCL components;
   (c) the HCHS market forces factor (MFF) was reviewed to support the implementation of Payment by Results. The main resulting change was an increase in the number of zones in the staff MFF from 119 to 303 to match the geography of PCTs;
   (d) the rough sleepers adjustment was dropped; and
   (e) a Growth Area adjustment was introduced.

**HCHS COMPONENT**

*Age related need*

14. The age adjustment is derived using a variety of activity and cost data sources across 23 different programmes to calculate national average resource use in seven age bands. Table 1 below shows the estimated national average of 2000 to 2003 expenditure per head in each age band used to inform allocations for 2006–07 and 2007–08.

<table>
<thead>
<tr>
<th>Age band</th>
<th>0–4</th>
<th>5–15</th>
<th>16–44</th>
<th>45–64</th>
<th>65–74</th>
<th>75–84</th>
<th>85 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighting (£)</td>
<td>542</td>
<td>269</td>
<td>526</td>
<td>655</td>
<td>1,245</td>
<td>1,976</td>
<td>2,799</td>
</tr>
</tbody>
</table>

**Additional need**

15. The additional need adjustments for the HCHS and prescribing components are based on research published in *Allocation of Resources to English Areas* (the AREA report). The additional need adjustment takes the form of models for two service areas which are combined in proportion to their share of national expenditure:
   (a) acute and maternity (85%); and
   (b) mental health (15%).

16. The variables used in the acute and maternity model include:
   — Standardised mortality ratio (SMR) under 75 years.
   — Proportion of low birth weight babies born.
   — Standardised birth ratio.
   — ID2000 education domain scores.
   — Proportion of aged 75+ living alone.
   — ID2000 income domain scores.
   — Nervous system morbidity index.
   — Circulatory morbidity index.
   — Musculoskeletal morbidity index.

**UNAVOIDABLE DIFFERENCES IN COST**

*Market forces factor*

17. The market forces factor (MFF) is constructed by combining three separate indices:
   (a) a staff index based on variation in wages in the private sector. The University of Warwick conducted the research using 2001 to 2003 data from the New Earnings Survey aggregated into 303 PCT pay zones;
   (b) a land index for each NHS Trust and PCT using data from the Valuation Office Agency’s (VOA) valuation of the NHS estate in 2004; and
(c) a buildings index based on a rolling average of tender prices for all public and private contracts provided by the Building Cost Information Service to the VOA.

18. Each PCT’s MFF is a weighted average of the MFFs for each of the Trusts with which it commissions, calculated through a purchaser/provider matrix based on the volume of activity in each Healthcare Resource Group times the Payments by Results tariff.

19. The three indices are combined into a single MFF using national average expenditure shares:
   (a) staff (67%);
   (b) buildings (5%); and
   (c) land (1%).

20. The remaining 27% of running costs are assumed not to vary across the country.

21. Under Payments by Results, the MFF will be paid directly to providers with resulting non-recurrent adjustments to PCT allocations.

EMERGENCY AMBULANCE COST ADJUSTMENT

22. The emergency ambulance cost adjustment (EACA) reflects the unavoidable cost variations of delivering emergency ambulance services in different areas.

PRESCRIBING COMPONENT

Age and sex related need

23. The adjustment for age and sex was developed by the Prescribing Support Unit from an analysis of total prescription cost data of 120 English practices over a one-year period. The age and sex weights derived from this analysis and a separate weighting for temporary registrations are known as Age, Sex, Temporary Resident Originated Prescribing Units (ASTRO (97)-PUs).

Additional need

24. The model recommended in the AREA report was adopted.

Unavoidable cost

25. The prescribing component does not have an MFF.

PRIMARY MEDICAL SERVICES COMPONENT

26. A primary medical services component to the formula replaces the old general medical services cash-limited and non-cash limited (GMSCL and GMSNCL) components for 2006–07 and 2007–08 allocations.

27. The age and sex related need and additional need adjustments are informed by research used to derive a new resource allocation formula as part of the new GP contract introduced in 2004–05.

Age and sex related need

28. GP consultations can take place in the surgery, the patient’s own home or in a nursing or residential care home. The age-sex workload index is derived from separate analyses of consultations in the surgery and home visits, with an adjustment for nursing and residential home consultations.

Additional need

29. The modelling for the additional needs adjustment used Health Survey for England (HSE) data between 1998 and 2000.

Unavoidable differences in cost

30. The MFF is constructed by combining four separate indices:
   (a) a GP pay index intended to compensate for the fact that PCTs with higher deprivation face greater GP recruitment and retention difficulties. It is based on the Index of Multiple Deprivation from the ID2000 and the findings from a National Primary Care Research and Development Centre study, which suggests that GPs value this disamenity at £4,200 (approximately 7.5% of average salary);
(b) a practice staff index which is the same as the staff index in the HCHS component, except that PCT values unadjusted by the purchaser-provider matrix are used because primary medical services are likely to be purchased locally;
(c) a land index, which uses the average small site (up to five houses) value in each LA area, supplied by the VOA and mapped to PCTs; and
(d) a buildings index derived from building cost location factors.

31. Other costs are assumed not to vary across the country and are given an MFF of 1.

32. These separate MFFs are combined into a single MFF using weights derived from an analysis of Inland Revenue data.

**HIV/AIDS component**

33. The HIV/AIDS component has two formulas:
   (a) HIV/AIDS treatment and care which includes the number of HIV infected persons by PCT from the 2003 Survey of Prevalent HIV Infections that are Diagnosed (SOPHID).
   (b) HIV prevention, which uses the number of 15 to 44 year olds in each PCT and 2003 SOPHID.

**Supplements to the Formula**

**English Language Difficulties Adjustment**

34. The English Language Difficulties Adjustment (ELDA) predicts the costs of providing interpretation, advocacy and translation (IAT) by multiplying national average IAT costs by estimates of the number of people experiencing language difficulties.

**DCLG Growth Area Adjustment**

35. The Growth Area Adjustment uses variant population projections produced by the Department for Communities and Local Government (DCLG) and Anglia Polytechnic University (APU), which estimate the impact of the additional Growth Area dwellings on the population of PCTs in the four Growth Areas.

**Weighted Capitation Targets**

36. The weighted capitation formula is used to calculate relative population shares. It does not determine a monetary value.

37. Weighted populations are calculated for each adjustment for each component and converted into an index. To calculate the weighted population for each component, the unweighted or crude population is multiplied by these indices.

38. The components are then combined using national expenditure weights to create unified weighted populations. These are converted into monetary targets and normalised to the revised resources available after supplements to the formula have been funded.

39. The two supplements to the formula are added as monetary adjustments to targets.

**Distances from Targets**

40. Targets are subtracted from baselines to produce DFTs for each PCT. DFTs inform the distribution of extra resources for unified allocations.

**Pace of Change**

41. PCT allocations for 2006–07 and 2007–08 have been determined on the basis that:
   (a) average PCT growth is 9.2% in 2006–07 and 9.4% in 2007–08. This is in line with the 2004 Spending Review NHS revenue settlement;
   (b) no PCT is more than 3.5% under target by the end of 2007–08
   (c) no PCT receives less than 8.1% growth over the two years; and
   (d) no PCT moves further under target or further over target in relation to their 2006–07 opening position.
CHOOSING HEALTH WHITE PAPER

42. The 2006–07 and 2007–08 allocations separately identified around half of the £1 billion promised in November 2004 by Secretary of State for the Choosing Health White Paper. The allocations included £211 million in 2006–07 and £131 million in 2007–08 (£342 million in total in 2007–08). These funds should support the implementation of the Choosing Health White Paper. The remainder of the funds are held centrally, and it is planned to issue them in due course.

Further supplementary evidence submitted by the Department of Health (Def 01C)

RURAILITY IN THE RESOURCE ALLOCATION MODEL

OVERVIEW OF THE MODEL

1. Allocations to PCTs are made up of four separate components, each with their own formula (with some elements shared across formulas): HCHS, Prescribing, Primary Medical Services and HIV/AIDS. The Market Forces Factor and Emergency Ambulance Cost Adjustment are then applied to some services to reflect differing unavoidable costs of provision. In addition, there are currently two supplements to the formula, namely the ODPM Growth Area Adjustment (introduced for 2006–07 to 2007–08 target allocations), and the English Language Difficulties Adjustment (introduced for 1999–2000 allocations).

2. The current approach to resource allocation is described in some detail in Resource Allocation: Weighted Capitation Formula, 5th Edition (Department of Health, 2005), and is available on the Department of Health website.1 The HCHS and prescribing formulae were last fully reviewed in 2002 by a team led by the University of Glasgow and ISD in Scotland. Their report, Allocation of Resources to English Areas, was published in December 2002.2

THE SUPPLY FACTORS

3. 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. 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. 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.”

4. There are a number of supply factors in the model (for detail, see Annex 1 below). They are included in order to adjust the target allocations for the impact of access to hospitals on their utilisation. For example, the acute and maternity model includes factors such as: distance to general practice, distance to hospital, access to private providers, and distance to maternity hospitals. The statistical research showed that greater distance from hospital or a general practice was associated with lower utilisation of services. Thus, these supply factors are included in the model to measure the effect of access variables and thereby leave isolated the role of need variables, but are not included in the formulae when calculating target allocations. Rural areas therefore receive target allocations that are greater than their historical utilisation would suggest, as the formula in effect increases the allocations to offset the reduced usage associated with being more remote from providers. This enhancement might be regarded as a sum to support rural PCTs seeking to provide services to offset poor access.

5. The approach taken in the research underpinning the formulae was to use data at small area level, ie ward level. Distance from locations of treatment was based on calculations of straight-line distances between the relevant Trust HQ and the average grid reference for each age group in each ward in each practice, derived from the postcode of residence of the individual patients. Similarly distance from practice was derived using postcode and grid reference for the relevant practice. The use of straight-line distances was judged to be a realistic and reasonable simplification.

THE EMERGENCY AMBULANCE COST ADJUSTMENT

6. One component in the resource allocation formulae is the Emergency Ambulance Cost Adjustment (EACA). Research on rurality commissioned and presented to the Advisory Committee on Resource Allocation (ACRA) in 19973 found a significant relationship between rurality and ambulance cost per journey for emergency and urgent cases.

2 Summary (http://www.dh.gov.uk/assetRoot/04/13/77/70/04137770.pdf), and Full (http://www.dh.gov.uk/assetRoot/04/13/77/68/04137768.pdf)
3 “Resource Allocation in Rural Areas”, Operational Research in Health Ltd (ORH) for the Department of Health, 1996–97
7. The emergency ambulance cost adjustment was introduced for 1998–99 allocations. It reflects the unavoidable cost variations of delivering emergency ambulance services in different areas.

8. EACA uses three drivers to produce a single EACA index: a rurality index,4 a scale effect, and a case-mix effect. This approach was based on an earlier study (reported in RARP 14).5 The current measure for rurality, used in the formula, is based on a geometric weighted mean of population density. The effect of rurality in the formula is that a 1% increase in rurality (ie actually measured as a 1% decrease in population density) leads to a 0.23% increase in costs per journey.

9. The EACA adjustment only adjusts for the estimated impact of rurality and other factors on supply costs. It does not attempt to adjust for differing levels of need related to emergency ambulance services for rural/urban PCTs.

FURTHER WORK

10. The Advisory Committee on Resource Allocation (ACRA) commissioned research on the staff Market Forces Factor, which is the geographical adjustment for unavoidable cost differences in NHS staff. The researchers have been asked to investigate whether rurality has a discernible impact on specific staff costs for providers. The results of the research will be reported back to ACRA in January 2007, who will report with recommendations to Ministers.

11. The Department of Health, on behalf of ACRA, is also tendering for research on the need formula. As rurality may have an impact on the relative needs of populations, the research specification requires researchers to investigate whether the formula should adjust for rurality.

Professor Barry McCormick
Chief Economic Adviser
Department of Health
20 November 2006

Annex 1: The models in the current formula


Appendix 7

Acute and Maternity Model including Additional Morbidity Indices and Supply Variables

<table>
<thead>
<tr>
<th>Term</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>−0.152</td>
</tr>
<tr>
<td>Supply variables</td>
<td></td>
</tr>
<tr>
<td>Mean waiting time</td>
<td>−0.101</td>
</tr>
<tr>
<td>Distance to general practice</td>
<td>−0.047</td>
</tr>
<tr>
<td>Distance to hospital</td>
<td>−0.021</td>
</tr>
<tr>
<td>Outpatients seen &lt; 13 weeks</td>
<td>0.160</td>
</tr>
<tr>
<td>Residential/nursing homes</td>
<td>−0.003</td>
</tr>
<tr>
<td>Access to private providers</td>
<td>−0.034</td>
</tr>
<tr>
<td>Number of hospital beds</td>
<td>0.013</td>
</tr>
<tr>
<td>Distance to maternity hospitals</td>
<td>0.023</td>
</tr>
<tr>
<td>Other variables</td>
<td></td>
</tr>
<tr>
<td>Proportion of ethnic minorities</td>
<td>−0.013</td>
</tr>
<tr>
<td>ID2000 employment domain</td>
<td>−0.158</td>
</tr>
<tr>
<td>Standard needs variables</td>
<td></td>
</tr>
<tr>
<td>SMR under 75 years</td>
<td>0.070</td>
</tr>
<tr>
<td>Proportion of low birthweight babies born</td>
<td>0.013</td>
</tr>
<tr>
<td>Standardised birth ratio</td>
<td>0.108</td>
</tr>
<tr>
<td>ID2000 education domain</td>
<td>0.008</td>
</tr>
<tr>
<td>Proportion of aged 75 + living alone</td>
<td>0.026</td>
</tr>
<tr>
<td>ID2000 income domain</td>
<td>0.103</td>
</tr>
<tr>
<td>Additional morbidity indices</td>
<td></td>
</tr>
<tr>
<td>Nervous system morbidity index</td>
<td>0.225</td>
</tr>
<tr>
<td>Circulatory morbidity index</td>
<td>0.548</td>
</tr>
<tr>
<td>Musculoskeletal morbidity index</td>
<td>0.375</td>
</tr>
</tbody>
</table>

4 The rurality index calculates population density, and was based on standard health authority (HA) boundaries and referred to 1991 Census resident populations. Unit cost data and journeys data were based on the KA34 ambulance return.

5 The current formula is \( A^{0.23}B^{1.17}C^{0.99} \), where A is the rurality index, B is the total number of journeys, and C is the proportion of emergency journeys.
This is the full acute and maternity model. However, only the needs variables and the additional morbidity indices are included in the formula used to determine resource allocation. The supply variables and other variables included above, however, are important as they affect the coefficients of those variables included in the resource allocation formula.

### Mental health model including additional morbidity indices and supply variables

<table>
<thead>
<tr>
<th>Supply variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance to mental health hospital</td>
<td>−0.072</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of ethnic minorities</td>
<td>−0.034</td>
</tr>
<tr>
<td>ID2000 education domain</td>
<td>−0.046</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard needs variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMF under 65 years</td>
<td>0.358</td>
</tr>
<tr>
<td>Proportion of aged 60+ claiming IS</td>
<td>0.338</td>
</tr>
<tr>
<td>ID2000 housing domain</td>
<td>0.034</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional morbidity indices</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-social morbidity index</td>
<td>0.636</td>
</tr>
</tbody>
</table>

This is the full mental health model. However, only the needs variables and the additional morbidity indices are included in the formula used to determine resource allocation. The supply variables and other variables included above, however, are important as they affect the coefficients of those variables included in the resource allocation formula.

### Prescribing model including additional morbidity indices and supply variables

<table>
<thead>
<tr>
<th>Supply variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance to general practice</td>
<td>−0.018</td>
</tr>
<tr>
<td>Distance to hospital</td>
<td>0.022</td>
</tr>
<tr>
<td>Residential/nursing home places</td>
<td>0.008</td>
</tr>
<tr>
<td>GPs per head</td>
<td>0.028</td>
</tr>
<tr>
<td>One-partner practice</td>
<td>−0.047</td>
</tr>
<tr>
<td>Two-partner practice</td>
<td>−0.022</td>
</tr>
<tr>
<td>Dispensing practice</td>
<td>0.022</td>
</tr>
<tr>
<td>Training practice</td>
<td>−0.011</td>
</tr>
<tr>
<td>Fundholder in 1998</td>
<td>−0.011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of ethnic minorities</td>
<td>−0.010</td>
</tr>
<tr>
<td>ID2000 education domain</td>
<td>−0.008</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard needs variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of AA and DLA claimants (standardised)</td>
<td>0.043</td>
</tr>
<tr>
<td>Proportion of IB and SDA claimants (standardised)</td>
<td>0.108</td>
</tr>
<tr>
<td>Low income scheme index</td>
<td>0.046</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional morbidity indices</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory morbidity index</td>
<td>0.298</td>
</tr>
</tbody>
</table>

This is the full prescribing model. However, only the needs variables and the additional morbidity indices are included in the formula used to determine resource allocation. The supply variables and other variables included above, however, are important as they affect the coefficients of those variables included in the resource allocation formula.
Further supplementary evidence from the Department of Health (Def 01D)

In providing oral evidence to the Health Select Committee Inquiry into NHS deficits on 21 November, I said I would respond in writing on two specific queries raised by Dr Richard Taylor MP, and that I would do so at or before the officials’ evidence session of the Public Expenditure Inquiry.

Question 1: Under the new PFI contract in Worcestershire, does the trust have to pay a supplement if bed occupancy rates exceed 90%?

I believe this question relates to the PFI contract in operation at Worcester Acute Hospitals NHS Trust (Worcester).

It is not an accurate reflection of the contract to suggest that this, or indeed any, PFI trusts are in any way penalised for going beyond a certain level of bed occupancy. Under the PFI contract for Worcester, the contractor is supplying the full range of “soft” and “hard” facilities management services, namely estates, accommodation, supplies and stores, catering, laundry, linen, switchboard, porter services and so on. These will be provided for the full life of the contract (that is, around 30 years). The cost of these services accounts for between 40% and 50% of the monthly unitary payment made by the trust to the contractor.

The payment mechanism under a PFI contract contains a volume element under which the quantity of variable items such as meals taken or linen provided is directly related to the throughput of patients.

At Worcester, the price to be paid for these services under the contract was based on an occupancy level of around 85%—a combination of the planning norm at the time and what the trust expected in terms of activity. Beyond this level, between 85 and 90%, the payment mechanism operates on a “Price per item” basis, which means that the price increases by the number of extra units of a particular service consumed (e.g. extra meals, linen items used and so on).

Above 90% occupancy levels, in order to simplify the treatment, the parties agreed that a flat surcharge would come into operation, and that this should be based on a proxy formula. Consequently, in respect only of those patients above the 90% occupancy threshold, charges of £15 per inpatient day and £10 per day case will be levied. The practice referred to by Dr Taylor reflects the simple application of a mechanism contained within all PFI contracts. It is a matter of trusts paying more, for a higher level of service consumption in accordance with clear contractual terms.

The Committee should also be aware that exactly the same principles would apply if this scheme had been funded using public capital. In that case, it would be trust directly providing, and paying for all the facilities management services. The total cost would increase with rising occupancy rates in exactly the same way.

Question 2: “We are told that the detailed accounts for 2005–06 show that the SHAs’ Revenue Resource Limit . . . was raised by £433.8 million. Where did that money come from?”

I believe that the variance of £433.8 million referred to by Dr Taylor has been calculated by comparing the planned total Revenue Resource Limit for SHAs for 2005–06 against the final actual value as recorded in the financial returns from the NHS.

It is, however, potentially misleading to compare the plan and final values for SHA Revenue Resource Limits. The difference of £433.8 million does not indicate a real increase in overall funding from the Department to the NHS. At the time they submitted their plan returns to the Department, the SHAs would only have been able to account for those items of income of which they were certain. The plan values will not have been final for two main reasons. First, not all central budget values would have been finalised, and second, it is likely that the SHAs would not, at that stage, have agreed the final split of resources between themselves and the PCTs in their economy.

The final allocation of central budgets and the agreement of the overall economy financial position would have been determined by a number of Revenue Resource Limit adjustments.

It is also important to remember that this variance only relates to the SHA sector. The true position can only be understood by looking at the overall relationship between SHAs and their PCTs.

Richard Douglas
Director General of Finance & Investment
Department of Health

23 November 2006
Letter to the Committee from the Secretary of State for Health (Def 01E)

I am writing to apologise for a mistake I made in answering question 742 at the Health Select Committee hearing on 21 November 2006, regarding the NHS target for hospital doctors by 2007.

I said that the NHS plan target for hospital doctors was to get to 74,590 by 2007. In fact, the figures I used were based on projections for the 2002 Spending Review, of how many clinical staff we intended to employ, rather than NHS Plan figures that refer to 2004 employment intentions. It is fair to say, however, that comparison of the two sources leads to similar conclusions that employment for clinical staff increased well in excess of our projections.

I am sorry that I quoted the wrong source for the figures.

Patricia Hewitt
24 November 2006

Evidence submitted by Breakthrough Breast Cancer (Def 70)

1. INTRODUCTION

1.1 Breakthrough Breast Cancer is the UK’s leading breast cancer charity and is committed to fighting breast cancer through research and education. Breakthrough has established the UK’s first dedicated breast cancer research centre, in order to realise our vision: a future free from the fear of breast cancer. Breakthrough campaigns for policies that support breast cancer research and improved services, as well as promoting breast cancer education and awareness amongst the general public, policy makers, health professionals and the media.

1.2 Breakthrough works closely with specialist breast care nurses, specifically through our Service Pledge for Breast Cancer, a tool designed to enable health professionals and patients to work together towards improved local breast cancer services. There are currently 13 Service Pledge sites in England and Wales.

1.3 Breakthrough welcomes this inquiry into NHS deficits. Our memorandum focuses specifically on the effects of deficits on specialist breast care nursing posts and the subsequent impact on patient care.

2. THE CONSEQUENCES OF NHS DEFICITS ON PATIENT CARE

2.1 The effect on care

2.10 Breast care nurses play a key role in the care of women and men who have or fear they might have breast cancer.

“They provide information, physical and psychological care and give practical advice to patients and carers from diagnosis to treatment, rehabilitation and beyond. Many breast care nurses also have skills in areas like prosthesis fitting and lymphodema management.” RCN, 1999.

“Many people who have been diagnosed with breast cancer point to their breast care nurse as the most important contact they have within the health service” Royal College of Nursing (RCN) and Breast Cancer Care, “Time to care; maintaining access to breast care nurses”.

“Having a named, dedicated breast care nurse during my treatment made a huge difference to me. I was able to receive practical help from someone I trusted and who I knew was available to me and my family. Having the support of a breast care nurse made my diagnosis much less intimidating and my treatment much less confusing. It also gave me confidence that I was being treated as an individual.” Chrissie Osbourne, member of Breakthrough’s Campaigns & Advocacy Network (Breakthrough CAN).6

2.11 The importance of the breast care nurse has been made explicit by the National Institute of Health and Clinical Excellence (NICE).

“. . . on-going contact with a trained and experienced breast care nurse can reduce patients’ anxiety, depression and physical symptoms up to a year after treatment. A nurse who is involved in the patient’s treatment appears to be able to offer more effective help than support organisations which do not have access to clinical information about the individual.” Improving Outcomes in Breast Cancer Guidance (2004).


6 Breakthrough CAN is a community of individuals who campaign for improvements in the care, treatment and research of breast cancer throughout the UK.
2.12 Consultants and other health professionals also recognise the importance of the breast care nurse.

"Breast care nurses are indispensable members of the breast cancer multidisciplinary team. Breast cancer is a complex disease, multimodality treatment is driven not just by clinical efficacy but increasingly by patient choice. Breast cancer surgeons and oncologists have neither the skills nor increasingly the time to ensure that treatment fulfils not just the outcome profiles for the disease but also meets the physical, cosmetic and emotional needs of patients. Breast cancer was the first field in which specialist nurse were widely employed. The improvements in standards of care for patients with breast cancer were seen almost immediately. Their success can be judged by the fact that nearly all services dealing with cancer care now deem specialist nurses as a requirement not a luxury. Breast care nurses are the essential link between clinicians and patients without whom both would be disadvantaged. They act as patient advocate and advisor and often as advocate and advisor to surgeons and oncologists.

On a personal note she keeps me honest and forthright in my dealings with patients. When I am tempted to take the “easy” option she will remind me of my wider obligation. When pressure of work builds she ensures that every patient gets the attention they need and deserve. I am old enough to have treated women with breast cancer in an environment without breast care nurses. I would not willingly go back to those dark ages.” (Christopher Hinton, Consultant Surgeon, Princess Royal Hospital, Telford).

2.13 Evidence collected from an email survey of primary care trusts (PCTs) carried out in June 2006 by the Association of Breast Surgery (ABS) at the British Association of Surgical Oncology (BASO) found that of the trusts who responded 66% said that breast care nurse posts were under some form of threat. 23% of respondents reported that breast care nurses were under threat to return to general ward duties, 7% reported that there was a threat of breast care nurse redundancies, whilst 17% reported that those leaving their posts were not being replaced by new breast care nurses.

2.14 Breakthrough believes these threats to specialist nursing posts are damaging to patient care continuity and high-quality breast cancer treatment.

2.15 Breakthrough believes that 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 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.

2.16 Every year 10,000 women subsequently diagnosed with breast cancer in England are given a “routine” (non-urgent) referral and can wait up to 17 weeks for an appointment with a specialist. A report by Breakthrough, “Left in the Dark” (2003), found that women find waiting for a diagnosis emotionally distressing and want to start treatment as soon as possible. This waiting time for a diagnosis may be lengthened with a fall in the numbers of dedicated breast care nurses.

2.17 Breakthrough is aware that other specialist nurses are experiencing similar threats to posts. These include Multiple Sclerosis nurses, Parkinson’s disease specialist nurses, prostate cancer nurses and diabetes nurses. Groups representing these nurses have already submitted evidence to this inquiry highlighting their concerns about the threat to specialist nursing posts and the impact on patient care.

2.2 The number of job losses

2.20 It is hard to quantify the extent of the threat of redundancies and job losses amongst breast care nurses because workforce figures are not held centrally. Breakthrough is currently working with the RCN and Breast Cancer Care to carry out a survey of breast care nurses across the UK to gain a national picture of NHS deficits, threat to posts and the impact on patient care.

3. Recommendations for Action

3.1 All those involved in the health service including the Department of Health, NHS Trusts, professional bodies and individual professionals, should recognise the vital role of the breast care nurse.

3.2 The Department of Health should ensure short term financial considerations do not result in a significant reduction of breast care nurses. The Department of Health should consider conducting an audit to find out how many of these posts have been lost and/or unfilled or may soon be under such threats.

Vicki Nash
Breakthrough Breast Cancer

October 2006
Evidence submitted by the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions (Def 62)

Health Committee Inquiry into NHS Deficits

1. The Council of Deans for Nursing and Health Professions represents the health and nursing faculties in its 86 member universities throughout the United Kingdom. It seeks to maintain and enhance the quality of nursing and allied health profession education, and acts as a forum for the exchange of information and good practice.

2. The Council submitted evidence for the Health Committee inquiry into the healthcare workforce and gave oral evidence at the Committee's session on 29 June 2006. At this session the Council's witness, Professor Dame Jill Macleod Clark, highlighted the fact that some Strategic Health Authorities (SHAs) had deliberately used savings from education and training budgets in 2005–06 to help offset projected deficits in the overall SHA health economies. Following this session, the Council submitted information on this issue to the Committee.

3. Information has now become available from unaudited accounts of the SHAs and the report “NHS financial performance 2005–06”. Thus the Council of Deans would like to submit further evidence on this issue to the Committee’s inquiry into NHS deficits.

4. The report “NHS financial performance 2005–06” states that the unaudited accounts show a net overspend in 2005–06 of £512 million, this being the difference between gross overspends of £1,277 million and gross surpluses of £765 million. However, Strategic Health Authorities themselves recorded a surplus for the year of £524 million. In its evidence to this Committee, the Kings Fund stated:

   “Although the net deficit of £512 million is an improvement on earlier forecasts, this is almost entirely due to much larger underspends than forecast by Strategic Health Authorities—primarily on the NHS staff training budget—and not the result of improvements in trust and primary care trust finances.”

5. The report NHS financial performance 2005–06 states that the SHA surplus “reflects the approach increasingly taken by SHAs of holding any surpluses generated by PCTs and NHS Trusts, rather than leaving the surplus with individual organisations”. It makes no mention of expenditure on education and training, which is surprising as funding for education and training, known as the Multi-Professional Education and Training (MPET) budget distributed by the Department of Health constitutes a large proportion of the budgets held by SHAs.

6. Information was requested from each SHA by the Shadow Secretary of State for Health under the Freedom of Information Act about “workforce development” underspends in 2005–06. We understand this term as referring to the budgets made available via MPET to the Workforce Development Directorates (WDDs) or Workforce Development Confederations (WDCs) in each SHA. The information provided by each SHA shows (Table 1) that “workforce development” contributed £150.473 million (29%) to the total SHA underspend. It also shows very wide variations between individual SHAs. For example Cumbria and Lancashire SHA shows a workforce development underspend of only £2k with a total SHA underspend of £33.079 million, whereas Hampshire and the Isle of Wight SHA shows a workforce development underspend of £20 million, compared to a total underspend of £4.419 million.

7. Up to now the MPET budget has been clearly identified as a separate budget and has been ring-fenced. The ring-fencing has been increasingly notional over the last two years. In particular any surplus from MPET has frequently been “brokered” into SHA budgets at the end of a financial year and it is arguable and variable as to whether these brokered sums have re-appeared in MPET budgets in the following year. The difference in this last year is that it would appear that in many instances WDDs/WDCs have been required by SHAs to make savings from their budgets to help offset deficits in the overall SHA health economy. This was particularly the case where substantial deficits were forecast.

8. The Council of Deans has examined SHA board papers from a number of SHAs. These demonstrate the clear understanding that “underspends” from MPET funding were required to contribute to reductions in overall SHA health economy deficits. They also indicate that these SHAs had required the WDDs/WDCs to underspend and in some cases had imposed specific financial targets for this. The extracts from the board papers are attached as Appendix A.

9. In case 1 (Avon, Gloucestershire and Wiltshire SHA) board papers show:

   “The WDC has taken significant measures to achieve £7.8 million, which has contributed to the overall AGW wide financial position.”

   and

   “... the SHA set the WDC a savings total of £10 million to contribute to achieving a balanced LDP (Local Development Plan) and to avoid cost-shifting to the service. This meant further reductions in education commissions had to be made.”

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8 Ev 69 (HC1204-II, 2005–06).
9 Not printed here.
10. In case 2 (Hampshire and the Isle of Wight SHA) board papers show:

“The Workforce Development Directorate—has by far the largest annual budget of £136 million. Breakeven has been forecast, which is a net position after making an increased contribution of £20 million to the Central Risk Reserve.”

The unaudited accounts for Hampshire and the Isle of Wight SHA for 2005–06 show an initial annual budget for the WDC of £136.728 million, a subsequent transfer to “Central Risk Reserve” of £19 million, leaving a revised budget of £117.728 million and a final expenditure of less than this at £117.430 million.

11. In case 3 (North West London SHA) board papers show:

“As the main education and training allocation budget was not notified until mid October 2005, commitments were kept to a minimum. As a consequence an element of natural slippage has materialised.

All budgets have been further scrutinised to assess the contribution that can be made to assist the sector position. An estimated £8 million underspend on the education and training budget is now forecast. Budgets are under constant review to identify the potential for an increased surplus to assist the sector position.”

The final workforce development underspend for 2005–06 was £9.011 million.

12. In case 4 (Thames Valley SHA) board papers show:

“At the end on Month 11 there is a £5.6 million underspend and this is expected to remain the same for Month 12 . . .

The SHA has still not received confirmation of allocations for 2006–07 but continues to work within the proposed budget. There are still huge financial pressures across the health economy and the committee has been asked to find a further £300K in support from the Workforce budget.”

The final workforce development underspend for 2005–06 was £8 million.

13. In case 5 (North and East Yorkshire SHA) the workforce development underspend is identified as totalling to £7.552 million, which is made up of brokerage generated in 2005–06, further underspends in 2005–06 and brokerage not repaid from the SHA in 2004–05.

14. The MPET budget has three major elements—MADEL (Medical and Dental Education Levy), which provides funding for postgraduate medical and dental education, largely through funding for “training” posts for junior doctors, SIFT (Service Increment for Teaching), which supports trusts in the provision of undergraduate medical education placements, and NMET (Non-Medical Education and Training), which funds nursing and allied health profession education. The Council of Deans believes that savings in MPET budgets have tended to be targeted towards the NMET element of the budget as these do not have such a direct financial impact on other local NHS budgets. This is more difficult to evidence directly.

15. In case 1 (Avon, Gloucestershire and Wiltshire SHA) the forecast variance in the PG medical and dental budget is stated as 2.04%, whereas the variance in the “other healthcare professions” budget is 6.28%.

16. In case 4 (Thames Valley SHA):

“The bulk of the underspend is from the NMET budget.”

and

“EMS (a member of the committee) asked for the money to be delivered from genuine savings and not by shifting costs to Trusts.”

17. The Council believes that the examples quoted in paragraphs 9–16 above, taken together with the table of underspends in education and training budgets in all SHAs, demonstrate that there has been a deliberate policy at local and national level to generate savings from these budgets to offset anticipated deficits in the overall SHA health economy.

18. The Council is further concerned since Lord Warner, Minister of State for Reform, has confirmed that for 2006–07 the MPET budget allocations to SHAs are to be amalgamated with the other centrally distributed budgets into a single budget, thus eliminating any remaining protection of MPET budgets from being raided for other purposes. Universities UK, the Council of Deans and the Council of Heads of Medical Schools all wrote to Lord Warner on this issue. His response to Universities UK contained the following:

“In 2006–07, because of the very tight financial situation, SHAs will receive an MPET budget as part of their total allocations and they will have to decide on how they will use the totality of the funds available to them to meet local needs and priorities and contractual commitments”.

19. This approach is confirmed in the report NHS financial performance Quarter 1 2006–07, issued on 11 August. This states (paragraph 1.4) that “The NHS as a whole is forecasting a small surplus (of £18) after including a £350 million contingency created by the SHAs”.

"The NHS as a whole is forecasting a small surplus (of £18) after including a £350 million contingency created by the SHAs”.

20. This approach is confirmed in the report NHS financial performance Quarter 1 2006–07, issued on 11 August. This states (paragraph 1.4) that “The NHS as a whole is forecasting a small surplus (of £18) after including a £350 million contingency created by the SHAs”.

21. The approach is confirmed in the NHS financial performance Quarter 1 2006–07, issued on 11 August. This states (paragraph 1.4) that “The NHS as a whole is forecasting a small surplus (of £18) after including a £350 million contingency created by the SHAs”.
It explains in paragraphs 2.8 and 2.9: “In line with the principle of devolving both money and accountability to the NHS we have this year given the SHAs responsibility for the management of budgets that had previously been allocated to NHS organisations centrally by the Department of Health. These budgets are stated to include “specific public health programmes, medical education, non-medical clinical training, GP performance reimbursement, clinical excellence awards and services such as walk-in centres, out of hours and NHS Direct”. It states that they (SHAs) will spend £5.5 billion on these services and so far (our emphasis) have set aside a further £350 million which has been used to create a contingency fund, which will be held centrally by the NHS bank.

20. This means that the centrally distributed budgets, of which education and training is by far the largest, have been put together and then £350 million has been deducted to create the contingency fund, which is to be held centrally by the NHS Bank. The implications of the “so far” in the last sentence in paragraph 19 could be that it is anticipated that this contingency fund may be increased by further savings from this budget.

CONCLUSIONS

21. This evidence has demonstrated that education and training budgets were the subject of targeted savings by many SHAs in 2005–06 to offset deficits in their wider health economies.

22. In 2006–07, education and training budgets, together with other central budgets, have been reduced before distribution by £350 million to provide the contingency fund. The absence now of any ring-fencing of education and training budgets will continue to expose this funding to being further raided for the short-term demands of the wider health economy.

23. It is unclear how the Department of Health intends to hold SHAs to account for their spending and performance in this area.

FURTHER COMMENT

24. The Council of Deans would welcome the opportunity to give oral evidence to the Health Committee on these issues.

Paul Turner
Executive Officer
Council of Deans for Nursing and Health Professions

August 2006

Table 1

Information provided under the Freedom of Information Act on “workforce development” underspends and total surpluses in each Strategic Health Authority in 2005–06.

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Total underspend (£000s)</th>
<th>Workforce development underspend (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avon, Gloucestershire and Wiltshire</td>
<td>11,418</td>
<td>8,535</td>
</tr>
<tr>
<td>Bedfordshire and Hertfordshire</td>
<td>19,318</td>
<td>3,500</td>
</tr>
<tr>
<td>Birmingham and the Black Country</td>
<td>31,295</td>
<td>13,000</td>
</tr>
<tr>
<td>Cheshire and Merseyside</td>
<td>3,169</td>
<td>3,000</td>
</tr>
<tr>
<td>County Durham and Tees Valley</td>
<td>46,738</td>
<td>6,000</td>
</tr>
<tr>
<td>Cumbria and Lancashire</td>
<td>33,079</td>
<td>2</td>
</tr>
<tr>
<td>Dorset and Somerset</td>
<td>5,510</td>
<td>2,256</td>
</tr>
<tr>
<td>Essex</td>
<td>11,127</td>
<td>2,828</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>10,041</td>
<td>101</td>
</tr>
<tr>
<td>Hampshire and Isle of Wight</td>
<td>4,419</td>
<td>20,000</td>
</tr>
<tr>
<td>Kent and Medway</td>
<td>15,442</td>
<td>2,273</td>
</tr>
<tr>
<td>Leicestershire, Northamptonshire and Rutland</td>
<td>6,233</td>
<td>1,067</td>
</tr>
<tr>
<td>Norfolk, Suffolk and Cambridgeshire</td>
<td>15,737</td>
<td>3,500</td>
</tr>
<tr>
<td>North Central London</td>
<td>22,578</td>
<td>6,363</td>
</tr>
<tr>
<td>North East London</td>
<td>18,981</td>
<td>1,100</td>
</tr>
<tr>
<td>North East Yorkshire and Northern Lincolnshire</td>
<td>28,426</td>
<td>7,551</td>
</tr>
<tr>
<td>North West London</td>
<td>21,923</td>
<td>9,011</td>
</tr>
<tr>
<td>Northumberland, Tyne and Wear</td>
<td>17,173</td>
<td>5,600</td>
</tr>
<tr>
<td>Shropshire and Staffordshire</td>
<td>10,390</td>
<td>1,400</td>
</tr>
<tr>
<td>South East London</td>
<td>16,637</td>
<td>8,184</td>
</tr>
<tr>
<td>South West London</td>
<td>13,573</td>
<td>2,600</td>
</tr>
</tbody>
</table>
### Table: Strategic Health Authority

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Total underspend (£000s)</th>
<th>Workforce development underspend (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South West Peninsula</td>
<td>13,270</td>
<td>2,145</td>
</tr>
<tr>
<td>South Yorkshire</td>
<td>27,308</td>
<td>8,991</td>
</tr>
<tr>
<td>Surrey and Sussex</td>
<td>12,238</td>
<td>5,371</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>17,751</td>
<td>8,000</td>
</tr>
<tr>
<td>Trent</td>
<td>30,096</td>
<td>6,500</td>
</tr>
<tr>
<td>West Midlands South</td>
<td>9,181</td>
<td>10,594</td>
</tr>
<tr>
<td>West Yorkshire</td>
<td>50,993</td>
<td>1,001</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>524,044</strong></td>
<td><strong>150,473</strong></td>
</tr>
</tbody>
</table>

% of underspend attributable to training underspend: **29**

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**Supplementary evidence submitted by the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions (Def 62A)**

### Current Position on Central Budgets and MPET (Education and Training) Funding for 2006–07

1. The document NHS financial performance 2006–07 Quarter 1 2006–07, published on 11 August referred to these budgets as 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, NHS direct.

   It stated: “The SHAs have undertaken to deliver savings by the better targeting and management of resources using their local knowledge. They will spend £3.5 billion on these services and have so far (my emphasis) set aside a saving of a further £350 million which has been used to create a contingency fund . . . The contingency fund will be held centrally by the NHS Bank on behalf of the SHAs.”

2. Board papers from East Midlands SHA (28 September 2006) show the national position in the “bundle” of central budgets for England as follows:

<table>
<thead>
<tr>
<th>Central budget bundle</th>
<th>England (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>3,734,249</td>
</tr>
<tr>
<td>Quality and outcomes framework</td>
<td>978,500</td>
</tr>
<tr>
<td>Clinical Excellence Awards</td>
<td>170,000</td>
</tr>
<tr>
<td>Remaining central budgets</td>
<td>1,226,885</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,109,624</strong></td>
</tr>
<tr>
<td>Reduction</td>
<td>650,000 (10.64%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,459,634</strong></td>
</tr>
</tbody>
</table>

3. Discussions with DH officials have not entirely clarified the discrepancy between the positions described above as regards the savings to be made from the central budget bundle.

4. However, my current understanding is that:
   - The detailed budgets totalled to £6,109 million and £650 million has been cut from this bundle, (note—in compiling this detailed budget we believe there was a 4% real terms cut in the MPET budget, after allowing for planned growth).
   - £150 million was required to fund a deficit on the budget.
   - The balance of £500 million was to be found by SHAs to fund their own contingency.
   - £350 million was the saving identified by SHAs by the end of Q1.
5. If this is the case, we can anticipate attempts to make further savings from education and training budgets in what remains of this financial year and evidence about this is coming to light from some SHAs.

One SHA sent an email to Trusts and Universities last Friday 20 October, which starts: “I wanted to let you know prior to formal notification early next week that the SHA needs to reduce by a further £13 million, this year’s MPET allocation”.

Paul Turner
Executive Officer
Council of Deans for Health Professions

24 October 2006

Further supplementary evidence submitted by the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions (Def 62B)

HEALTH COMMITTEE INQUIRY INTO NHS DEFICITS

A note on the commissioning of education in nursing, midwifery and the allied health professions following the oral evidence from RT Hon Patricia Hewitt MP on 21 November 2006.

In response to Question 780 from Dr Naysmith, Patricia Hewitt said:

“You are absolutely right about the impact on newly qualified staff. 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”. (my emphasis).

Students on nursing, midwifery and allied health professions pre-registration courses who qualified in summer 2006 entered their programmes in September 2003. The decisions about the numbers of students to be commissioned for the academic year 2003–04 were made earlier during 2003. Our clear recollection is that at that time the decisions on the numbers of students to be commissioned, although the ultimate responsibility of the then 28 Workforce Development Confederations (WDCs), were in practice driven by the Department of Health in line with the NHS Plan.

This is demonstrated by the Department of Health press release 2003/0067, issued on 17 February 2003.10

The press release is headed ‘Record funding for thousands more training places announced’. It states

“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 . . .”

It announced also the funding allocation for each WDC for 2003–04, showing the increase compared with 2002–03.

Our recollection is that once these decisions had been announced, WDCs were expected to seek agreement with their contracted higher education institutions (HEIs) to expand their commissioned student numbers to meet the targets agreed with the Department of Health. There was, at that time, little or no input on local commissioning numbers from individual NHS trusts, except to the extent that they were involved with their WDC and the HEIs as to how to provide placements for learning in practice for the increased student numbers.

Thus the numbers of students commissioned in 2003 was the result of the then policies of the Department of Health, which have come to fruition as those students qualify 3+ years later.

This emphasises the long-term nature of such decisions and reinforces our concern about a likely ‘boom-bust’ scenario if reductions in commissions are made now that will affect the numbers of newly qualified staff in 2009–10 and thereafter.

Paul Turner
Executive Officer
Council of Deans

28 November 2006

10 www.dh.gov.uk/publicationsandstatistics/Pressreleases
Evidence submitted by Haywards Heath Healthcheck/Action Plan (Def 68)

SUBJECT: WEST SUSSEX HEALTH PCT/PRINCESS ROYAL HOSPITAL (PRH)

This letter concerns the recently announced Surrey and Sussex £100 million deficit, and the cuts in services that this will bring about.

The enclosures to this letter demonstrate, as the Rt Hon Nicholas Soames has said, gross mismanagement by the Surrey and Sussex SHA, and the West Sussex Health Scrutiny body.11

This £100 million deficit is against an increase in NHS spending in the South East 2000–06 of £5 billion and an increase in the SSHA 2004–07 budget by £737 million. “There is more money going into the [West Sussex] National Health Service than ever before”, said the Chairman of the SSHA in 2005.

The purpose of this letter is to highlight to you the problems we are facing, and to ask for your support in highlighting in Parliament that, contrary to his assertion that these are government problems in Surrey and Sussex, the problems described stem from bad governance and gross mismanagement.

I have written separately to the Secretary of State; with this letter I am asking if the enclosed information can be presented to the Health Select Committee.

The Taylor Report on West Sussex Health Authority 2000, and Audit Commission Report on Surrey and Sussex 2005

2000 KEY TAYLOR FINDINGS WERE THAT THE THEN WSHA:

— Did not provide strategic co-ordination and leadership, or financial leadership. Was negligent, in that the then £20 million deficit had not led to urgent service configuration changes.
— Lacked collaboration and coordination on Intermediate Care, Community Service, and shared Support Services; Lacked focus, co-ordination, and leadership on management issues, and suffered from a lack of empathy with partner organisations.
— Suffered from chronic conditions of “…Meeting-itis, Process-itis, Paperitis, and Appeasment-itis. The failings have led to the loss of good people”.

2003–04 MASSIVE INCREASES IN GOVERNMENT NHS FUNDING

— The £100 million deficit is against an increase in NHS spending in the South East 2000–06 of £5 billion.
— An increase in the Surrey and Sussex Health Authority (SSHA) 2004–07 budget by £737 million. “There is more money going into the [West Sussex] National Health Service than ever before”, said the Chairman of the SSHA in 2005.

2005 KEY AUDIT COMMISSION FINDINGS

The key Audit Commission findings demonstrate that many of the failings highlighted in 2000 by the Taylor Report are still failings in the organisation of the present West Sussex NHS organisations.

As the Rt Hon Mr Nicholas Soames identifies in a speech in the House of Commons on 11 October 2006:

“No one paid any attention to his [Mr Taylor’s] warnings and this continuing, wilful mismanagement of the NHS has now led to colossal debts of well over £100 million”.

It is unacceptable that to remedy this deficit Mid Sussex is expected to accept cuts in local hospital services when no consideration has been given by the West Sussex NHS authorities or the Health Scrutiny Committee to accessibility of the alternative hospital services.

M Bright
Haywards Heath Healthcheck/Action Plan

October 2006

Evidence submitted by the Healthcare Financial Management Association (Def 63)

The Healthcare Financial Management Association (HFMA) is the professional association for finance managers and staff in the healthcare sector.

It seeks to represent, support and provide high quality, independent and objective advice to its members and the wider healthcare community. It aims to promote best practice and innovation in financial management and leadership across the UK health economy and through its local and national networks.

HFMA has over 3,000 members who work in all levels of finance mainly in the NHS. It has four key objectives:

- To explain the work of healthcare finance professionals to a wide variety of audiences including the government, the media, other key stakeholders and the general public.
- To develop education and training programmes to improve the financial competence of finance and non-finance staff.
- To provide member services including support through its local branch structure and technical advice through its national committees.
- To develop partnerships with key organisations to enable the Association to take forward its many objectives.

The Association is a UK-wide organisation with 14 local branch committees offering a range of support to local members. The evidence here relates to the NHS in England.

Q1 The size of the deficits and the savings which each trust has to make in 2006–07

(a) Deficits

The final audited net deficit for 2005–06 was £547 million (excluding foundation trusts). This marks an increase of £35 million from the unaudited position of £512 million, which was the result of gross deficits of £1,277 million and surpluses of £765 million.

The size of the net deficit is a clear concern. However it should be remembered that the deficit represents just 0.8% of the revenue resources available to the NHS.

The most recent published figures from the Department of Health covering quarter one for 2006–07 suggest that the NHS as a whole is forecasting a small surplus after including a £350 million contingency created by the strategic health authorities. According to the Department, forecast gross deficits for the year totalled £883 million compared with £1.2 billion in 2005–06. 120 organisations are forecasting deficits compared with 174 in the provisional outturn figures for 2005–06.

(b) Savings

It is difficult to be precise about the level of savings that organisations need to make in 2006–07 to meet the Department’s requirement to achieve a net break-even position across the NHS. However it is clear that all organisations—not simply those that incurred deficits in 2005–06—need to achieve demanding efficiency targets.

NHS inflation has always run at higher levels than general inflation, fuelled in part by the regular introduction of new, higher cost treatments and drugs. But the pay reforms of recent years, have added to the financial pressures.

The tariff for 2006–07, which covers activity included in the payment by results regime, was only increased by 1.5% after building in a 2.5% efficiency requirement. In the face of demanding cost pressures, this efficiency requirement is extremely challenging.

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 (usually assessed over three years).

For some organisations the challenge can be even starker as a result of the resource accounting and budgeting regime. Under RAB, trusts making a deficit in one year can have their income the following year reduced by a corresponding amount. This can cause a “double whammy” impact as trusts are still required to eliminate the deficits from their balance sheets. The regime does not cause the financial difficulties in the first place, but it has the effect of compounding the problems of organisations in deficit, although SHAs in some areas have shielded trusts from this income reduction.

The upshot of all this is that organisations face a range of efficiency savings depending on their financial starting point. According to our members, savings targets of 4%–5% in acute trusts are typical and in some organisations the targets are even more challenging.

PCTs also face significant efficiency savings. The announcement towards the end of 2005–06 that the purchaser parity adjustment—introduced to protect PCTs’ purchasing power under the new tariff—would be halved had a significant impact on PCTs’ income assumptions and forced PCTs to identify new efficiencies and redraw service plans. It was only at the very end of January that PCTs were informed of the decision to halve the PPA. This affected their allocations for the financial year starting just two months later. And PCTs were completely unprepared for this announcement and had been planning on the basis of receiving 100% of the PPA as in the previous year. The HFMA fully supports the calls made in the Lawlor review of the tariff setting process for earlier publication of the tariff and welcomes the Department’s commitment to publish the tariff for 2007–08 in mid-December.
Q2 The reasons for the deficits, including:

(a) 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)

As the HFMA pointed out in its Policy Statement earlier this year Laying the financial foundations for success—10 point plan to build a financially stable future for the NHS, the current financial problems are not the result of one single issue nor are they solely the result of actions taken over the last 12 months. In previous years the extent of the underlying problems facing some organisations have been masked by non-recurrent funding and brokerage. In reality the current problems are the result of a cocktail of factors and in some cases the problems have been building up for several years. The higher than expected cost of pay reform has clearly been a factor and there have been other cost drivers such as meeting access targets.

However part of the reason for the deficits is the NHS framework that in the past has required organisations to aim for absolute financial balance—neither making a deficit nor a surplus. Given the size of budgets involved and the volatility in some healthcare costs (and volatile income as a result of the new tariff), this is a major challenge. Back in 2003, while praising the contribution of the NHS finance function, former NHS chief executive Sir Nigel Crisp likened the task of balancing the NHS budget to “landing a jumbo jet on a postage stamp”. The inability of organisations to plan any contingency or reserves has clearly made the achievement of financial balance a hugely complicated and time consuming activity. Even small changes in costs or an unforeseen cost pressure can make the difference between balance and deficit. The HFMA welcomes the Department of Health’s new operating framework which stresses the importance of planning for surplus. But this new regime did not apply in 2005–06.

Our members tell us that their ability to plan has been further hindered by the late announcement of key central allocations and even details about the tariff, leaving commissioners and trusts to plan services (including staffing levels) that will be achievable within a balanced position, without a clear idea of their income for the year.

There has also been a tendency for managers and non-financial board members to see the financial position as the sole responsibility of the finance director. This is often accompanied by an expectation that the finance director will sort out the financial position at the year-end. Instead managers and especially boards need to take collective responsibility for financial issues. This collective ownership for finance is a key ingredient for financial success and has been missing in some organisations in recent years.

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

Turnaround teams identified a number of issues on the back of the baseline assessment last December. Their conclusions included:

— The capability of management was inadequate to deal with the challenges of their current financial position, although they could manage the organisation effectively in a steady state, they would need support to deliver turnaround.

— The quality of information would impede the turnaround process.

Feedback from trust and PCT finance directors suggests that the turnaround teams have indeed created the capacity for turnaround to be effected. A key message from organisations going through turnaround (HFMA Briefing: Case studies in turnaround—September 2006) is that turnaround requires a full-time dedicated team to drive the recovery. Most organisations would not have the management capacity to oversee a project of this scale while continuing to oversee the day-to-day running of complex organisations.

On balance, feedback of trusts’ experiences of the turnaround teams is positive. They highlight the benefits of having an independent, external input to provide robust challenge to trust proposals—often bringing in experts from other sectors such as retail to share best practice.

In terms of information, the HFMA agrees with the baseline assessment regarding the quality of information. The need for timely accurate information on finance and activity was one of the key points raised in the Association’s Policy Statement Laying the financial foundations for success.

For instance the accuracy of reference cost submissions has improved in recent years, but significant further improvements are still needed, both to improve the accuracy of the national tariff and local decision-making. However in some cases this will require an investment in costing systems and skills. In particular the HFMA believes there is a role for auditors in providing an opinion on the quality of reference cost submissions.

Any assessment of value-for-money needs to reflect savings identified as well as the costs of employing turnaround directors and turnaround teams. It is impossible to say at this stage whether the employment of turnaround teams and turnaround directors will prove to be value for money. Any such assessment would need to take account of whether the identified planned savings materialise and whether these savings are realised faster than if the NHS had taken an “in-house” approach to turnaround.
(c) the relationship between the funding formula, the allocation of funds to trusts and the size of their deficits or surpluses

It is difficult for the HFMA to express a view on this as it has undertaken no country-wide analysis. Figures from the Department of Health suggest there is no strong correlation between the size of a PCT’s surplus/deficit and either its allocation growth or its distance from target (how far it is away from receiving its fair share of funding as calculated by the resource allocation formula). However in most circumstances it would seem reasonable to assume that organisations receiving above average growth will find it easier to cope with pressures, such as the unavoidable costs associated with pay and drugs, than those receiving below average growth.

Q3 The consequences of the deficits, including: the effect on care; the number of job losses; and the effects of “top-slicing”, in the current and future years

(a) Effect on care

The turnaround process should not of itself lead to a reduction in standards of care. Organisations involved with turnaround report that clinical engagement is a prerequisite to turnaround success and staff are widely involved in identifying opportunities both to improve care and reduce costs.

For instance, members tell us that in some organisations, using lean thinking principles and other quality management tools, managers are identifying ways to reduce length of stay, which has benefits for patients while having the potential to improve an organisation’s financial position. However what is clear from turnaround organisations is that the key is to turn these improvements into real cash savings. For instance improved length of stay could lead to a greater throughput of patients attracting greater income. However within a fixed financial envelope (the health economy’s budget), financial savings from reduced length of stay may need to be realised by reducing the number of beds. There needs to be greater understanding that changes in the way services are delivered do not necessarily equate to a reduction in levels of care.

Similarly, the redesign of care pathways will mean greater numbers of patients treated away from hospitals in more appropriate community settings. Changes such as this will deliver better and more cost-effective care. However they may need to be accompanied by a rationalisation of the acute hospital estate.

(b) Job losses

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. This does not directly convert into compulsory job cuts. Many of the savings are being realised through natural turnover and through a reduced reliance on agency staff. Our members stress that it is important to distinguish between a reduction in the number of posts and compulsory redundancies. However, given the amount of expenditure tied up in staff costs, it is inevitable that in some organisations compulsory job losses may be needed.

(c) Top-slicing

Top-slicing tends to act against organisations’ ability to plan for the medium to long term. Top-slicing of all PCTs’ budgets may in fact create problems in previously financially balanced organisations—effectively spreading the problems over a wider cohort of bodies. However the HFMA recognises the need to bring the NHS back into balance quickly and accepts that top-slicing has been necessary to meet this short-term goal of restoring the financial position in 2006–07. But top-slicing can only provide a short-term solution and must be seen as a one-off. (It should be pointed out that the proposed solution to the RAB problem would require a top-slice to create a buffer against future deficits incurred by trusts.)

Q4 The period over which balance should be achieved

Local circumstances and the scale of problems will dictate how long different organisations will need to put in place a sustainable recovery. The key will be for recovery plans to be realistic—based on robust assumptions—and achievable. Forcing an organisation to pursue an unrealistic recovery trajectory is unlikely to lead to a sustainable and viable organisation. The HFMA will be looking to support finance managers in the pursuit of sustainable and long-term financial balance. Long-term viability may require wider reconfiguration of services or higher expenditure in the short term in invest-to-save programmes. Members also tell us that their organisations need to be given the space to recover rather than facing additional pressures and delivery targets.

Head of Policy, HFMA
Steve Broom
October 2006
Healthcare Chaplaincy in the NHS and the NHS Deficit

The current deficits experienced by NHS Trusts have had a direct effect on chaplaincy provision, which has been part of NHS budget since the inception of the Service.

Chaplaincy does not seek exemption from cuts that may be required within Trusts as Chairmen and CEOs try desperately to balance the books.

However we do ask:
— that the cuts are proportionate;
— that cognisance is given that the majority of chaplaincy departments are historically understaffed and are probably the smallest department in any Trust;
— that chaplaincy is not considered a “soft” target by finance driven managers who might miss the holistic nature of the care the NHS is mandated to provide; and
— that a core standard for chaplaincy provision be set.

The most celebrated case to date is Worcester NHS Trust where the Board planned to decrease the chaplaincy provision by 70%. The reason given was that this saving (estimated at £100k) would contribute to the overall savings the Trust was forced to make.

There are other cases where vacancies have not been filled. Chaplaincy teams are stretched and chaplains working far more than contracted hours in order to provide something approaching an adequate service to patients, staff and relatives.

Some hospitals now have no emergency on call at all or it is only available during the week. As a result staff in, for example, A&E departments are not referring people to chaplains as they do not know if there will actually be a chaplain on call.

Chaplains (and other staff) in some Trusts are being encouraged to take unpaid leave in order to “balance the books”.

Whilst there are a number of Trusts where Chaplaincy has been protected or received a small percentage cut there are also a significant number where one or all of the problems mentioned above apply. This is detrimental to the spiritual and religious care (from all Faiths) that the patient, their relatives and staff of the Trusts require, as outlined by Department of Health Guidelines, *NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff*. November 2003.

There is little evidence that Trusts have suddenly become “anti chaplaincy”. The reasons behind the problems highlighted above are always ascribed to the deficit.

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 and no chaplain will be on call, or by the time a chaplain races from one site to another it will be too late. That patient will have been denied their human rights as well as the holistic care that the NHS is committed to. The present situation is incredibly worrying and does not serve the users or the staff of the NHS well.

I hope this information informs your deliberations.

*Reverend Father Edward J Lewis*
The Hospital Chaplaincies Council
24 November 2006

Supplementary evidence submitted by The NHS Confederation (Def 36A)

The NHS Confederation welcomed the original announcement of the Committee’s inquiry into NHS deficits and were pleased to submit written evidence in June 2006.

Since we submitted that evidence to the Committee, the situation has changed sufficiently that additional important issues have arisen. For example, it is clear from a recent LGA survey that NHS deficits have had some effect on other local services, just as local authority financial difficulties in other areas of the country have had an adverse effect on NHS services.

The NHS is actively involved in a range of partnership arrangements with local government—from children’s trusts to budget pooling with social services or full integration of staff in care trusts. Many PCTs work with voluntary organisations, social services and, increasingly the commercial sector, to get people out of hospital quickly by delivering care that spans organisational boundaries.
These sorts of collaborations are set to rise because of the health white paper on care out of hospital. Because of this interconnectivity, it is no wonder that alarm bells started to ring after recent articles claimed that the “shockwaves” of the current NHS financial situation were being felt in social services departments and amongst the voluntary sector.

For example, when the chief executive of Wiltshire took early retirement, he cited NHS financial problems being transferred to social care as his reason. Fortunately his experience does not ring true across the country. As the Association of Directors of Social Services explained, his situation represented an “extreme” example of the current situation.

The financial climate has led to the NHS, in a minority of areas, withdrawing from some joint projects with their partners in social services and the voluntary sector, as they invest in services that have a higher priority for healthcare. A small number of NHS organisations have told us that social services departments have had to make changes in the eligibility criteria for services like home care and this is having an impact on health services.

We would very much like to opportunity to give oral evidence on this matter to the Committee and suggest that we potentially do so with representatives from local government in order for the Committee to be presented a balanced view.

Dr Gill Morgan DBE
Chief Executive, NHS Confederation
October 2006

Evidence submitted by Rotherham PCT (Def 61)

BACKGROUND

Rotherham PCT was formed on 1 April 2002, serves a population of 250,000 people, spends approximately £320 million and is co-terminous with Local Authority boundaries. There are five Foundation Trusts and an ISTC within reach of the PCT’s population.

At its formation the PCT inherited a financial plan that indicated a likely deficit of £6 million in 2002–03 if all targets were to be met. This did not materialise. The PCT was able to work with the local Trusts, Metropolitan Borough Council, General Practitioners and South Yorkshire Strategic Health Authority during that year and subsequent years to, in 2005–06, deliver a surplus in excess of £4 million that was able to be used by the Strategic Health Authority to support other parts of the South Yorkshire health economy.

The PCT has during this time with the help and support of the different organisations, teams and individuals managed to deliver against agreed targets and to build a reputation as a good place to work.

The PCT staff and Board believe that we can continue to improve and that opportunities exist for making more effective use of resources. There are a number of financial risks being faced by all PCTs and the financial expenditure regime (for PCTS) is more volatile than previously existed in the NHS.

ANALYSIS

How did Rotherham PCT manage to generate a surplus when other PCTs have gone into deficit or moved further into deficit?

The glib answer would be good management. The real answer is a little more complicated and with all things could also be put down to luck—being in the right place at the right time—and taking opportunities that presented themselves.

There is no doubt that some of the national priorities and agreements have created some financial pressures for the PCT. However, the PCT has also benefited from some “one off” transitional support for the early movement to Payment by Results (PbR) and the adoption of Primary Medical and Dental Services (PMS and PDS) contracts.

The PCT Board and Professional Executive, in particular the Chairman and Chief Executive, have since inception regarded the achievement of financial balance as the top priority. This support and challenge has been essential to delivery of good financial performance.

What has Rotherham PCT done?

The PCT has developed a flexible approach to financial management and its strategy has several strands. These strands are:

1. Raising awareness and saying “no”.
2. Managing critical risks eg PbR based activity, Prescribing, etc.
3. Developing an “invest to save” mentality.
4. Fundamental review of all budgets.
5. Regular budget reviews by Chief Executive and Directors.
6. Educating and training managers.
8. Vacancy management.
9. Using alternative funds to redesign or change services.

The underpinning assumptions that support this flexible approach include:
1. Effective use of public money is the responsibility of every individual responsible for committing and using those resources.
2. The financial regime is whatever it is eg Payment by Results.
3. Mistakes are essential for learning, progress and improvement.
4. We can learn from others and improve.

Once the support, training and development, awareness raising and behavioural and cultural issues had started to be addressed Rotherham PCT’s approach focused on risks. Why was this thought necessary?
1. PbR related activity and prescribing are variable.
2. Management of variation improves health and use of resources (see 10 High Impact changes).
3. Analysis and accurate forecasting are critical to the development of action plans.
4. Continuing to do what we have done in the past will mean that we will continue to get the same results.
5. Clarity and focus on specifics delivers results.
6. The status quo is not an option.
7. Plans must include an ability to respond to issues that arise during the year.

Rotherham’s systematic review of risks identified the following major financial risks in 2005–06:
1. PbR (60% of PCT expenditure—1% change £1.8 million):
   (a) Non elective activity.
   (b) Case mix/coding changes.
   (c) High cost—low volume treatments eg Bone Marrow Transplants.
   (d) Specific treatment requests < £10,000.
2. Prescribing (12% of PCT expenditure—3% change £1.2 million):
   (a) New drugs including research.
   (b) Shared care.
   (c) Branded products.
   (d) Wasted repeat prescriptions.
3. Continuing care (single case >£100k).
4. Free Nursing Care.
5. nGMS/PMS:
   (a) Quality and Outcomes (25% overachieved against national plan—£1.6 million).
   (b) Enhanced Services.
   (c) Out of Hours contract.
6. nGDS/PDS:
   (a) Patient charges income (30% reduction in early pilots—£500k).
7. nGPS:
   (a) Large sites—new pharmacies.
   (b) Prescription growth.
8. Agenda for Change.
9. Pooled budget risk share:
   (a) Learning disabilities.
   (b) Intermediate Care.
10. Non recurrent funding:
   (a) SRB.
   (b) NRF.
   (c) HAZ.

11. Vacancy management.

The resources used and the cost driver for each of these were then discussed to develop a real understanding of the situation and to focus the finance teams and senior staff to be able to influence GPs—usually the first point of contact with the NHS.

As a result of this assessment the PCT decided to:

1. Create a specific function with general managers, data analysts, finance staff and contract managers to target the PbR risks and completely change their work priorities.
2. Refocus management accounts to concentrate on the areas identified as more risky and some routine management accounting functions were stopped.
3. Focus prescribing advisors on specific drugs and drug categories in the larger Practices to reduce variation and to issue clear prescribing guidelines and protocols.
4. Renegotiate certain agreements with the Local Authority.
5. Undertake some specific negotiation training.

Using the PbR risk, as an example, the type of work being undertaken in Rotherham includes:

   — the management of admissions including the route of admission (60% plus of emergency admissions are via A&E), identifying changes in coding practice in secondary care that had no impact on the care provided eg introducing co-morbidities changes the HRG and payment, tariff perversities:
      (1) Without complications tariff worth more than with complications at 40% particularly for 0 and 1 day length of stays eg A20, A29, D21, D33, E20, E24, E29, F07, F17, H39, L22, N10, tariff perversities.
      (2) without complications worth more than with complications J04 and J05, counting activity that previously did not count, multiple admissions for same patient over a 12 month period, no procedure for surgical admissions, admission rates for Out of Hours service—one GP admitting five times as many as others, two or more outpatient appointments on the same day for the same specialty often minutes apart, multiple admissions from Nursing Homes in hot weather for dehydration.

   — This work has lead to investment in case managers, triage services, education programmes for Nursing Homes and work on the introduction of admission and discharge criteria.

   — Rotherham PCT believes it can further improve its use of resources. There will be more challenges over the next few years but the performance between 2002–03 and 2005–06 provides a platform for further improvement.

*Andrew Spring*
Rotherham PCT
*June 2006*

**Supplementary evidence submitted by the Royal College of Nursing (Def 27B)**

**The Impacts of Training and Education Budgets Cuts**

The RCN has been monitoring the impact of the cuts in the SHA training budgets on nursing development and patient care. In August the RCN released figures from an online survey of 550 nurses that showed that 83% (463) believe training has been reduced or cut as a result of financial pressures in the NHS.

More than eight out of 10 nurses who took part in the survey (463—86.70%) believe patients are at an increased risk from the reduction in training and that the reduction is affecting their career development (422—84.40%).

**Newly Qualified Nursing Recruitment**

The RCN has been monitoring the number of newly qualified nurses unable to find employment.

A snapshot survey of newly-qualified nurses in September 2006 revealed 70% had been unable to find a nursing position.
Additionally:
— Neither newly qualified nurses nor students appear to be confident about finding work. Of those graduates who are still looking for a permanent nursing position, 86% are “not sure” they will find one; while 66% of students do not believe they will find a post when they complete their studies.
— Both groups believe the current situation will put people off wanting to become nurses in the future (92% of graduates and 87% of students).
— Nearly 40% of students say the “current situation” has made them think about changing courses.
— 85% of the graduates still searching for a Band 5 post say they would consider retraining or searching for work in another sector if they continue to experience problems.
— Nearly a quarter of graduates say they have been offered work as a Healthcare Assistant. Of those who are still searching for a Band 5 post, around half say they would accept a Healthcare Assistant post if they continued to experience problems.

**Job Losses Update**

The RCN has been keeping an update on the number of proposed post losses in the NHS. As of October 2006:

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Total post losses proposed since January 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>South West</td>
<td>1,766</td>
</tr>
<tr>
<td>South Central</td>
<td>1,877</td>
</tr>
<tr>
<td>South East Coast</td>
<td>1,255</td>
</tr>
<tr>
<td>London</td>
<td>3,164</td>
</tr>
<tr>
<td>West Midlands</td>
<td>2,974</td>
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<tr>
<td>East Midlands</td>
<td>360</td>
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<tr>
<td>East of England</td>
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<tr>
<td>North West</td>
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<tr>
<td>North East</td>
<td>1,274</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>1,865</td>
</tr>
<tr>
<td>NHS Direct</td>
<td>460</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,485</strong></td>
</tr>
</tbody>
</table>

*How have the figures been compiled?*

The RCN has been monitoring the impact of financial deficits on the NHS for over one year. Financial impacts and the resultant predicted numbers of post losses have been drawn from three sources:

1. weekly reports from Regional activists and staff (many of whom have regular contact with senior trust staff);
2. a trawl of a select number of Trust and SHA board papers (eg to seek confirmation of verbal proposals or reports on post reductions); and
3. local press reports (which are then confirmed through the other two sources where possible).

To date, only two NHS Trusts have publicly refuted RCN figures or press statements. However, the figures are constantly changing as Trusts respond to RCN and public pressure; as cost improvement plans roll out; and as initial announcements turn into final action plans. RCN has adjusted the number of predicted posts loss upwards and downwards as needed.

*What do the figures show?*

The figures shown on the attached charts represent a running tally of the total number of posts which NHS Trusts have proposed to remove as part of public announcements or consultations arising from tackling financial deficits. In some cases, NHS Trusts have already carried out redundancies where people holding posts have had their contracts terminated. There are also a number of Trusts who have required staff to be redeployed from one type of post to another during organisational change.

In some cases, the total number of posts which will eventually be removed from the compliment will be subject to consultation and negotiation—in any event the full scale of the losses will not be known for some months yet. However, there is a clear trend from the data—specialist and niche services are being impacted (ie services which are key to achieving elective activity are less likely to be hit); specialist practitioners are being required to carry out alternative duties in other clinical areas to address staff shortages; and employment opportunities for newly qualified nurses in some parts of the country have been reduced.
Impact of Nursing Shortages on Patient Outcomes

Recent research in the UK corroborates US research findings that show that registered nurse numbers have an impact on patient outcomes. The UK study, led by Professor Anne Marie Rafferty, surveyed 3,984 nurses and 118,752 episodes of patient care in 30 English NHS acute trusts. It concluded that case matched patients in the hospitals with the lower quartile nurse: patient ratios had a 26% higher mortality rate. The RCN believes appropriate nurse staffing levels must be maintained throughout all trusts in order to ensure good patient outcomes. We have recently published guidance on acute general ward staffing levels which includes the most up-to-date methods and knowledge on undertaking ward staffing reviews, principles for ward staffing reviews, and a recommendation that the skill mix ratio for the ward establishment must not fall below 65% registered nurses: 35% health care assistants unless or until a thorough ward staffing review takes place.

Royal College of Nursing

November 2006

Evidence submitted by Worcestershire Acute Hospitals NHS Trust (Def 66)

Background

Trust has an annual turnover £250 million and operates services from the Worcestershire Royal Hospital, which was financed under the PFI initiative and opened in 2002, the Alexandra Hospital Redditch, and Kidderminster, which is mainly a Treatment Centre and includes an independent sector treatment centre.

The Trust’s historic deficit was £31.8 million as at 31 March 2006. This included the 2005–06 overspend of £4.95 million after £5 million support from the SHA.

Size of Deficit

The Trust’s underlying deficit at the end of 2005–06 was £20 million. One of the prime causes of this deficit is above average expenditure of £12 million. The reasons for this are as follows:

- Additional costs of £7 million from the operation of a new PFI financed hospital, which are not reflected equitably in the national tariff and therefore for which the Trust does not receive sufficient income.
- Additional costs of providing services across the three hospital sites in Worcester, Redditch and Kidderminster.
- Specialties which productivity indicators show as being relatively high cost, and in particular obstetrics and gynaecology.
- The costs of recent pay reforms for consultant contract and agenda for change, which are now approximately £3 million higher than the additional funding received.

The other prime cause of the deficit is the relatively low income received by the Trust for the services it provides, which in 2005–06 was £8 million below average. The Worcestershire PCT is currently funded at £13.6 million less than its weighted capitation position. The relative lack of funding historically for the new PCT’s predecessors has meant that lower than average prices have been paid for the services provided by the Trust.

The Trust’s position for 2006–07 worsened for three main reasons—changes to Payment by Results, the efficiency target, and the 2005–06 overspend. The impact was as follows:

- The national efficiency target of 2.5% reflected in the tariff (which was an increase from the expected 1.7%) reduced income by £5.1 million.
- The introduction of a 50% tariff for non elective growth (above a threshold) reduced expected income by £3 million.
- The introduction of more short stay tariffs reduced income by £1.3 million.
- The introduction of a 2.5% discount to the tariff reduced income by £4.6 million.
- The overspend of £4.9 million from 2005–06 was carried forward for recovery in 2006–07 in accordance with Resource Accounting and Budgeting rules.
- The staged movement towards PBR tariff increased income by £2 million.

In gross terms the £20 million at 31 March 2006 therefore increased by £16.9 million to £36.9 million.

NHS West Midlands has supported the Trust Board’s view that this could not be delivered in one year, and agreed non recurrent support of £10 million, plus further support of up to £5.6 million to reduce the in year burden of the 2005–06 overspend carried forward and to cover expected redundancy costs incurred as part of workforce downsizing. This support is repayable over the next three years with interest (estimated at £1.4 million in total).
After taking account local changes this left the Trust with the need to deliver savings totalling £18.7 million in 2006–07 and a further £13.7 million in 2007–08, to achieve recurrent financial balance by 31 March 2008 and make provision to repay the support.

**Independent Reviews**

There have been a number of reviews of the Trust’s financial position. The most recent was in 2005–06 when a reputable firm of management consultants, brought in with the agreement of the SHA, concluded that the Trust was relatively efficient and that the scope for improved efficiency was in the order of £6 million.

**Turnaround Status**

Although the Trust has been designated a turnaround trust and is working closely with the Turnaround Director for the West Midlands, the Trust does not have an externally appointed turnaround team. It has however, contracted with a private sector organisation to provide support for a limited period of time to the Trust’s executive team and Board to deliver its Recovery Plan.

**Consequence of Deficit**

To date the Trust has identified £16 million of its £18.7 million savings target for 2006–07. A key component of the Recovery Plan is a staff reduction programme, as follows:

- The reduction of up to 675 posts with the aim of saving £16.2 million recurrently in a full year.
- Posts in corporate departments have been reduced by 25% and clinical areas are being reduced by up to 15%.
- To date 330 posts have been identified, which will be removed from structures saving £8.4 million a year. As at 9 October 2006 there were 450 vacancies, which are being held to generate savings whilst the permanent reductions take effect.

Pay and non pay savings have been sought as far as possible through improved efficiency and productivity to minimise the impact on services.

However, service reconfiguration is essential and options are being considered, particularly for obstetrics, gynaecology and paediatrics. Moreover, 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.

*John Rostill*
Chief Executive, Worcestershire Acute Hospitals NHS Trust

*October 2006*

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**Evidence submitted by Worcestershire Mental Health Partnership NHS Trust (Def 65)**

1. **Background**

The Worcestershire PCT, the Trust’s main commissioner, is currently funded below capitation target by £13.6 million. Its predecessor organisations South Worcestershire, Redditch and Bromsgrove and Wyre Forest PCTs had relatively low levels of investment in mental health services. Local Variations in NHS Spending Priorities published by the King’s Fund in August 2006, shows Redditch and Bromsgrove and Wyre Forest PCTs in the lowest 15 PCTs for spending per head, out of a total of 303, on mental health problems weighted for need, age, costs and distance from allocation target.

The Trust became a specialist mental health, learning disabilities and substance misuse services organisation when the community services were transferred to the newly formed PCTs in April 2002. The Trust and its predecessor organisations had a consistent track record of achieving in-year financial balance until 2005–06 despite the Worcestershire health economy position and an underlying deficit in the Trust.

The Trust currently has a turnover of £56.5 million of which £8.7 million relates to support services that serve the Trust and the Worcestershire PCT.

The Trust had a £3 million underlying deficit in 2005–06.
The deficit emanated from:

- Costs of £1.0 million that had been funded non-recurrently in 2004–05 not being funded in 2005–06.
- Additional £0.9 million unfunded cost pressures eg Agenda for Change, Consultant Contract, European Working Time Directive and Superannuation Indexation.
- Efficiency Savings required of £0.75 million.
- Medical locum costs £0.4 million due to the PCTs not being able to fund additional posts to comply with Royal College of Psychiatrists’ guidance.

2. CURRENT DEFICIT

As a result of a further 5% efficiency target imposed by commissioners due to the top-slicing of PCTs by the SHA, the recurrent deficit grew to £5 million in 2006–07.

In addition the Trust will incur a further penalty under the Resource Accounting and Budgeting (RAB) Regulations for a deficit in 2005–06 of £1.6 million. Non-recurrent measures were required in 2005–06 to bridge a gap of £1.6 million whilst service modernisation was fully implemented. The Trust was unable to get audit agreement to an accounting treatment that would have achieved financial balance.

A comprehensive savings plan has been developed to bring the Trust into recurrent financial balance in 2007–08 by agreement with the SHA. This is more comprehensive than the previous plan due to the increase in the deficit. The size and nature of the changes, some of which require public consultation, mean that the savings cannot be achieved in full in 2006–07.

The financial challenge for 2006–07 is £6.6 million in total, of which £5 million is recurrent.

The SHA would not provide support from the West Midlands Bank as the Trust is not designated as a “turnaround” organisation.

The Trust is projecting a £3.1 million deficit for 2006–07 and is continuing to seek solutions and non-recurrent support.

3. CONSEQUENCES OF DEFICIT

The Trust’s approach to its savings plan was not simply to cut services but to take the opportunity to modernise services basing its strategy on evidence-based practice and the 10 high-impact changes for mental health. The strategy has been developed in partnership with clinicians and service users.

Key components of the plan include:

- The use of home treatment as opposed to inpatient beds which has led to the closure of 33% of adult inpatient beds.
- The development of a new bed model to balance local access with efficiency.
- Intensive day recovery services to replace traditional day hospitals.
- Changes to ECT provision.
- Reducing delayed discharges in older adult services which will lead to bed reductions.
- Rationalisation of the estate.

The Trust has operated a vacancy freeze since April 2004 to create capacity to absorb staff displaced as a result of service change and minimise redundancies. The Trust is not predicting any redundancies at this point.

The Trust continues to drive for efficiency by reducing bank/agency and locum medical spend to a minimum, and making support services as efficient as possible.

4. CONCLUSION

The Trust is relatively efficient with a reference cost index of 99, slightly below the national average of 100.

Despite a financially challenging environment the Trust has sought to sustain and develop high quality services. The Trust achieved three stars in 2004–05, and has recently been rated by the Healthcare Commission as “good” for quality of service for 2005–06.

*Dr Ros Keeton*
Chief Executive, Worcestershire Mental Health Partnership NHS Trust

*25 October 2006*
Evidence submitted by Worcestershire PCT (Def 67)

BACKGROUND

Worcestershire PCT was formed from the former Redditch and Bromsgrove, South Worcestershire and Wyre Forest PCTs. The aggregate starting recurrent revenue allocation of the three organisations for 2006–07 was £617 million.

Each of the Worcestershire PCTs delivered financial balance in 2005–06.

SIZE OF AND REASONS FOR THE DEFICIT

The initial combined Local Delivery Plans of the three PCTs envisaged that the additional resources available in 2006–07 (£51 million) would:
- meet the costs of inflation;
- meet, on a recurrent basis, the full year impact of the cost pressures experienced in 2005–06;
- meet the forecast increase in costs associated with the additional acute sector activity necessary to achieve waiting times targets;
- ensure that all other national targets would be delivered; and
- enable a number of local service development priorities to be put in place.

The response of each of the individual PCTs to the requirement to make contributions to the local NHS Bank and the phased withdrawal of the Purchaser Parity Adjustment, amounting to approximately half of the PCT’s growth funding (see below), was to:
- scale back service developments to those necessary solely to deliver national targets; and
- require all service providers not operating under the Payment by Results regime (including PCT provider services) to generate cost reductions of 5%.

As part of the process for developing cost reduction plans, the PCTs shared their proposals with the Overview and Scrutiny Committee. The Committee took the view that nine of South Worcestershire’s nineteen savings schemes would need to become the subject of full public consultation. These included the proposed closure of a ward and other facilities at Evesham Hospital. Given the length of time needed for the consultation process this decision had the effect of reducing significantly the level of savings achievable in the current financial year. In view of this position and the need to avoid prejudicing any future public consultation on broader and longer term proposals by a new Worcestershire PCT a decision was taken not to proceed with the nine schemes in question. This approach was endorsed by the SHA.

Against this background and despite taking the actions outlined above, the PCTs’ collective budget deficit stood at £11 million at the beginning of the financial year. This has subsequently grown to £16 million based on the position at September. The causes of this deterioration are:
- further growth in the forecast cost of acute sector activity;
- a worsening of the financial position in relation to the costs of commissioning specialised services;
- Primary Care prescribing costs running ahead of budgeted levels (set at 5% above 2005–06 outturn costs); and
- the anticipated reduction in Central Budget allocations, as recently notified.

This position has been formally reported to the Strategic Health Authority as part of the normal reporting and performance management arrangements.


At the beginning of 2006–07 (before their contributions to the local NHS Bank) each of the Worcestershire PCTs was funded at a level below its capitation target, as follows:

- Redditch and Bromsgrove PCT £3.3 million
- South Worcestershire PCT £4.2 million
- Wyre Forest PCT £6.1 million

Total £13.6 million

The resources “lost” through the Bank contribution and the variation in PPA funding arrangements were as follows:

- Bank:
  - Redditch and Bromsgrove PCT £5.2 million
  - South Worcestershire PCT £9.1 million
  - Wyre Forest PCT £3.3 million

Total £17.6 million
### Consequences of Deficits

In addition to the specific savings schemes targeted within the PCT’s own Provider function (some of which require a reduction in staffing through natural wastage and redeployment) a strict vacancy control policy is in place. The total job loss target by March 2007 is in excess of 100 whole-time equivalent posts. It is anticipated that this will be achieved without the need for redundancies.

The PCT’s Management Team reviews the impact of staff turnover (and non-replacement) on clinical services on a routine and regular basis. It is judged that none of the measures put in place will jeopardise the delivery of key service targets or have an adverse impact on clinical risk.

**Worcestershire PCT**

*October 2006*

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**Evidence submitted by Professor John Appleby, King’s Fund (Def 69)**

**INITIAL ANALYSIS OF UNAUDITED ENGLISH NHS, 2005–06 ACCOUNTS FOR THE NHS DEFICITS INQUIRY**

**INTRODUCTION**

This is a note of a brief analysis of NHS organisations’ unaudited accounts for 2005–06. It attempts to get behind some of the headline financial outturn figures reported by the Department of Health.\(^\text{12}\)

As any finance director would warn however, an organisation’s accounts tell only a partial story of its financial and management decisions and history. Without interviewing finance directors, it can be impossible to uncover the underlying reasons for changes in plans, spending and budgets, or why a particular budget line was over or underspent.

Having carried out this initial analysis, an overall suggestion is that it would be immensely useful for the Department of Health to provide some sort of annual “account of the accounts”, in part to elucidate some rather opaque accounting jargon and in part to simply explain the financial story that lies behind the bald numbers.

The accounts for the three main NHS organisations—the 28 Strategic Health Authorities (SHAs), 303 Primary Care Trusts (PCTs) and 235 Trusts—are organised in different ways reflecting the different functions of these parts of the service. Below they are analysed separately. It should be noted that Foundation Trusts (FTs) are not included in this analysis; FT accounts are assessed by Monitor, the FT regulator.

1. **Strategic Health Authorities**

   The headline unaudited outturn for 2005–06 reported that SHAs ended the 2005–06 financial year with a gross underspend (ie the total of all underspends, excluding any overspends) of £524 million, with no SHA reporting a deficit.

   These headline figures are the conclusion of a number of adjustments and changes to the accounts during the year. At the start of the year, SHAs have planned spending against a number of budgets—the most significant budget line being the Workforce Development Confederation budget which represents around 90% to 98% of their total spend.

   **Planned spending**

   Overall, SHAs planned spending indicated an end of year underspend of just £71.5 million, with around half planning a balanced budget, one an overspend of £55 million and the rest a gross underspend of £126.5 million.

   **Net operating costs: Outturn against plan**

   In the event, the outturn for SHAs’ net operating costs (ie their actual spending net of any income) was a small surplus of £18.7 million. This figure is net of “miscellaneous income”—mainly from the NHS/Department of Health—amounting to £397.5 million, however.

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\(^{12}\) Theo Georghiou, Research Officer, King’s Fund, provided computer support to extract data from the 6,000+ spreadsheets covering the 566 NHS organisations’ accounts.
It is impossible to determine the nature of this income from the accounts. It may include, for example, surpluses from SHAs’ local PCTs and trusts lodged with the SHA.

There was considerable variation across SHAs in the amounts reported for miscellaneous income—from zero in two SHAs through to £74.3 million in one SHA (see figure 1).

**Changes in Revenue Resource Limits**

A significant change in the year are adjustments to SHAs’ initial revenue resource limits (IRRL—the budget against which the headline financial position is reported).

Overall, SHAs’ RRLs were raised by £433.8 million during the year, with all bar two having their limits increased. It is impossible to tell from the accounts what use these additions to the IRRL were intended for.

So, SHAs’ planned underspend of £71.5 million plus their net operating underspend of £18.7 million (which includes miscellaneous income of £397.5 million) plus the upward adjustment to their revenue resource limit of £433.8 million provided the eventual headline underspend of £524 million. Figure 2 shows how these elements of the budget came together for each SHA to produce their overall financial position.

**Workforce Development Confederation**

The WDC budget is the largest element of SHA spend. Against planned spend, overall, SHAs were overspent on this budget by £72.3 million—a result of a gross overspend of £127.4 million and a gross underspend of £55.1 million. This overspend against planned spending is perhaps contrary to some commentators’ opinions concerning the source of SHAs’ surpluses in 2005–06. However, it may be the case that some or most of the increase in SHAs’ IRRLs was destined for the WDC budget but that in the event was not used as such (see earlier point on changes to the IRRLs).
SUMMARY POINTS: SHAs

— It is impossible to determine the nature of SHAs’ “miscellaneous income” from the accounts. It may include, for example, surpluses from SHAs’ local PCTs and trusts lodged with the SHA.

— Overall, SHAs’ RRLs were raised by £433.8 million during the year, with all bar two having their limits increased. It is impossible to tell from the accounts what use these additions to the IRRL were intended for.

2. PRIMARY CARE TRUSTS

The headline unaudited outturn for 2005–06 revealed that PCTs ended the year with an aggregate gross deficit of £603 million, with a net deficit of £476 million.

Changes in Revenue Resource Limits

Over/underspends are based on PCTs’ total commissioning plus providing costs set against their final revenue resource limit (RRL). PCTs start the year with an initial RRL (IRRL) which is then subject to change, for example, as special allocations (eg drug misuse monies) are distributed, or as money is allocated out central budgets (eg for QoF payments to GPs), or MFF adjustments linked to payment by results.
In total, the net adjustment to PCTs IRRLs during 2005–06 amounted to £2.350 billion. Around 90% of PCTs had their IRRLs increased. The change in all PCTs’ IRRL is shown in figure 3.

Figure 3

![Change in PCTs’ Initial Revenue Resource Limits (2005/6)](image)

It is to be expected that there will be some adjustment to PCT IRRLs during the year but it is interesting that for the majority of PCTs, changes in their IRRLs closely match net operating costs over/underspends as measured against their planned spending (see fig 4).

Figure 3

![Over/under spends against plans vs changes in PCTs’ initial revenue resource limits](image)
Breakdown of headline over/under spending

The accounts provide information on which PCT budget lines are over/underspent. Figure 4 shows breakdowns for over/under spending on net and gross operating costs for commissioning and providing. Figure 5, 6 and 7 show further breakdowns by budget line in absolute terms and in terms of percentage total spend (for each budget line). Note that these figures relate to PCTs’ planned spending before any adjustments to their RRL.

Figure 4

Overspend against plans: Commissioning and provision budgets: net and gross

Figure 5

Over/underspend against plan: Net commissioning operating costs
Figure 6

Over/under spend against plan: Net commissioning operating costs: per cent of total spend

Miscellaneous Activity & Non Activity costs
Total G/PMS, APMS and PCTMS Expenditure
Total Prescribing expenditure
Non NHS Service Agreements
NHS Service Agreements

Per cent of total spend

-25.00% -20.00% -15.00% -10.00% -5.00% 0.00% 5.00% 10.00%

NB: “Reserves/earmarked developments” underspend amounted to over 317%. Excluded from the figure as dominates other percentages.

Figure 7

Overspend on net providing costs

9.3% of total non pay spend nonpay
7.0% of total pay spend pay

(£000)

-400,000 -350,000 -300,000 -250,000 -200,000 -150,000 -100,000 -50,000 0

Savings programmes

PCTs planned to make cost improvement savings totalling £1.218 billion in 2005–06 (around 1.8% of net commissioning and providing total spend). In the event, PCTs reported savings of £1.176 billion.

There was no significant correlation between either the size of PCTs’ planned savings programmes and their final financial situation or between the latter and the extent to which planned savings were met or not.
Planned financial support

In total there was £216 million of planned support included in PCTs’ final financial positions in 2005–06 for 34 PCTs—£10 million from the NHS Bank (3 PCTs) and the remainder were, as the budget line states “internally generated” (31 PCTs), that is, from the local health economy within an SHA and agreed at the beginning of the year (akin to upfront brokerage).

Points: PCTs

— A handful of high overspend PCTs do not seem to have received increases in their RRLs that might have been expected given the general picture in fig 2.
— The accounts do not reveal the timing during the year of changes to IRRLs so it is impossible to know whether adjustments were made for reasons such as brokerage (which was not allowed in 2005–06).
— It is not clear why there is such a large difference across PCTs in the size of the RRL adjustments.
— The bulk of PCTs’ total operating cost over/underspend is accounted for in absolute terms by commissioning over/underspends.
— Within commissioning, the bulk of the over/underspend is accounted for by PCTs’ service agreements (ie their purchasing of secondary and other care). As a percentage of total spend however, overspends on miscellaneous services and activities, non-NHS service agreements and G/PMS etc recorded proportionately higher overspending against plans.
— Prescribing budgets were underspent by £314 million (out of a total spend of £7.44 billion). It is impossible to tell from the accounts what lies behind this underspend. However, it may be linked to reductions in drug prices during the year.
— Overspends on provision for pay (£352 million) and non-pay (£200 million) represented 7% and 9.3% of their respective total spends.
— For all budget lines there is considerable variation in over/underspends between PCTs.
— There is little or no correlation between the size or proportion of over/underspend on any one single budget line and over/underspends on PCTs’ total net operating costs.

3. Trusts

For the 235 NHS trusts (excluding Foundation Trusts) the unaudited headline net overspend for 2005–06 was £560.5 million—made up of a gross overspend of £674.4 million (68 trusts, 29%) and a gross underspend of £113.9 million (155 trusts, 66%). The remaining 12 (5%) trusts broke even.

Planned financial support

The headline over/underspend figures above include planned financial support for some trusts—either provided by the NHS Bank or the Department of Health or “internally generated” (ie agreed at the beginning of the year and generated from within local SHA health economies). In total, £288.3 million was used to support trusts’ financial positions—£10 million of which came from the NHS Bank/DH.

Without this support, trusts’ gross deficit would have been £926.7 million (94 trusts) and their gross net underspend would have been £87.9 million (130 trusts). Figures 8 and 9 compares these over and underspends before and after planned financial support.
46 trusts received some level of financial support—of between 0.4% and 10.6% of total trust income. Although a number of trusts had plans for financial support, 16 did not, in the event, use this support. Conversely, however, nine trusts did not plan for financial support, but in the event did receive internally generated financial support amounting to £26.4 million—somewhat puzzling given that such support should, by definition, be planned at the beginning of the year).

Overall, there is no apparent relationship between trusts’ final outturn figures and the level of planned support received.
Savings Programmes

Trusts’ planned savings of £1.47 billion in 2005–06. In the event, savings totalled £1.3 billion—equivalent to 3.6% of total trust expenditure. Savings ranged from zero in five trusts to 10.5% in one trust.

There is no connection between the size of savings (as a proportion of total expenditure) and trusts’ total turnover. And there is also no connection between the savings achieved and trusts’ final outturn position. However, there is a weak positive association between trusts’ failure to achieve their planned savings and their overall under/overspend position. If planned savings had been achieved, the total net deficit could have been reduced by around a third, to £385.7 million.

Income and expenditure

In the aggregate, trusts’ recorded a surplus on their operations of £286.4 million (that is, income of £36.8 billion minus expenditure of £36.5 billion—numbers having been rounded). The overall deficit position of £560.5 million is the result of this surplus being offset by additional items of income and expenditure—primarily the payment of public dividend capital (PDC) of around £600 million. For individual trusts, however, the headline over/underspend outturn is the result of the interplay of various elements of their income and expenditure, and not just their PDC payments.

While there is, by definition, a strong positive relationship between trusts’ total operating surplus and their final under/overspend position, there is no apparent link between either the variance in planned income or expenditure (or any element of trusts’ incomes and expenditure) and their final outturn position.

In other words, there was no single primary cause of deficits—for example, such as actual income failing to match planned income, or total actual expenditure being above planned spend. And while there are significant differences between, for example, trusts’ planned spending on pay and their actual spending, with the former being nearly 3% (£674.8 million) higher than the latter, neither this nor any other element of their income or expenditure (such as the need to pay PDC) was significantly related to trusts’ headline level of over or underspend.

Trusts with operational PFI schemes

Since 1997 there are 27 non-Foundation Trusts with major operational PFI schemes (with an average value of £99 million).13 Although only accounting for 11% of all trusts, these hospitals accounted for 25% of the total net deficit in 2005–06, with nearly half recording a deficit compared with 23% of trusts without major operational PFI schemes.

Further, more in-depth, analysis would be needed to ascertain the extent of the connection between the existence of a PFI scheme and the propensity to incur a deficit.

Summary Points: Trusts

— Without planned financial support from the NHS Bank/DH or generated within local health economies, trusts’ total net deficit would have been £926.7 million rather than £560.5 million—accounting for 42% of trusts rather than 29%.

— Some trusts apparently received “planned support” that did not appear to be planned.

— No single income or expenditure budget line over/underspend is associated with trusts’ overall financial outturn. For example hortfalls in planned income from service agreements are not, on average, correlated with trusts’ deficit position (however, at an individual trusts level, such a situation may be a significant contributory factor to its deficit).

— There was a weak connection between trusts failure to achieve their planned savings and their overall financial outturn.

— If all planned savings had been achieved, the total net deficit of £560.5 million would have been reduced to £385.7 million.

— Of the 11% of trusts with operational PFI schemes half reported a deficit which in total accounted for 25% of the total net deficit across all trusts. It is not clear from the accounts whether this is clear evidence that the existence of a PFI scheme increases the propensity to incur a deficit.

13 A further 15 schemes have reached financial closure with work started on site (average value £306 million), and there are a further 41, less major, schemes either operational or having reached financial closure and with an average value of £29 million. A list of these trusts is appended.
APPENDIX

LIST OF OPERATIONAL PFI SCHEMES SINCE 1997
(Source: http://www.dh.gov.uk/assetRoot/04/13/99/31/04139931.pdf)

Prioritised Capital Schemes approved to go ahead since May 1997 (England)

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Scheme</th>
<th>Capital Value £m</th>
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</thead>
<tbody>
<tr>
<td><strong>PFI Schemes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PFI Schemes that are operational</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>North Cumbria Acute Hospitals NHS Trust—Carlisle</td>
<td>67</td>
</tr>
<tr>
<td>South East Coast</td>
<td>Dartford &amp; Gravesham NHS Trust</td>
<td>94</td>
</tr>
<tr>
<td>South Central</td>
<td>Buckinghamshire Hospitals NHS Trust</td>
<td>45</td>
</tr>
<tr>
<td>London</td>
<td>Queen Elizabeth Hospital NHS Trust</td>
<td>96</td>
</tr>
<tr>
<td>North East</td>
<td>County Durham &amp; Darlington Acute Hospitals NHS Trust</td>
<td>61</td>
</tr>
<tr>
<td>Yorkshire &amp; the Humber</td>
<td>Calderdale &amp; Huddersfield NHS Trust</td>
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</tr>
<tr>
<td>North West</td>
<td>South Manchester University Hospitals NHS Trust</td>
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</tr>
<tr>
<td>East of England</td>
<td>Norfolk &amp; Norwich NHS Trust</td>
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<td>West Midlands</td>
<td>Hereford Hospitals NHS Trust</td>
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</tr>
<tr>
<td>London</td>
<td>Barnet &amp; Chase Farm Hospitals NHS Trust</td>
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</tr>
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<td>West Midlands</td>
<td>Worcestershire Acute Hospitals NHS Trust</td>
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<td>County Durham &amp; Darlington Acute Hospitals NHS Trust</td>
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<td>London</td>
<td>King’s Healthcare NHS Trust</td>
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<tr>
<td>South West</td>
<td>Swindon &amp; Marlborough NHS Trust</td>
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<tr>
<td>Yorkshire &amp; the Humber</td>
<td>Leeds Community &amp; Mental Health Services Teaching NHS Trust</td>
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<td>Bromley Healthcare NHS Trust</td>
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<td>Avon &amp; Western Wiltshire Mental Health NHS Trust</td>
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<td>East Lancashire Hospitals NHS Trust—Blackburn</td>
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<td>West Midlands</td>
<td>University Hospitals Coventry and Warwickshire NHS Trust—Walsgrave</td>
<td>379</td>
</tr>
</tbody>
</table>

**28** Total operational PFI Schemes **2,759**

Evidence submitted by Jacqui Fletcher, University of Hertfordshire (Def 64)

**BACKGROUND INFORMATION**

1. This submission represents information collated from 21 tissue viability organisations both national and regional (please see appendix 1).

2. Information has been collected from across the country to evidence the statements made via the regional groups. It is accepted that this is not a comprehensive survey and that there will be many other examples of where the provision of a Tissue Viability service results in cost savings for the NHS.

3. Tissue viability nurses (both Nurse Specialists and Nurse Consultants) deal with a wide range of wounds including Pressure Ulcers (bed sores), Leg Ulcers, Diabetic Foot ulcers, complex surgical wounds and fungating wounds. In addition to management of these patients with wounds their workload includes prevention and education. They work in both the primary and acute setting and unlike other specialist such as Infection Control Nurses they work independently rarely being attached to any medical colleague.
4. Pressure ulcers affect approximately 1.5% of the hospital population, leg ulcers 1–2% of the UK population, and 50% of non traumatic amputations of the lower limb occur in people with diabetes. 85% of which will previously had ulceration. These figures highlight how wounds are a huge problem within the NHS and, as the population ages and develop increasingly complicated health problems, it is likely that these figures will increase.

5. The Department of Health spends more than £631 million per annum on the provision of medical consumables items to Primary and Secondary care, this includes dressings, incontinence aids, stoma appliances and chemical reagents (PaSA 2006). An estimated £373.4 million of this is on dressings alone (SDMA 2003). These costs include only the items supplied through members of SDMA so the actual spend will be considerably higher for bandages and dressings as primary care provision is mainly via prescription items. In addition it is estimated that a further £112 million per annum is spent on equipment for Pressure Area Care (PaSA 2005). The cost of litigation relating to pressure ulcer development must also be considered, figures from NHSLA suggest that in excess of £16,732,992 has been spent over the last 10 years on litigation related to pressure ulcers and this figure is rising.

ATTEMPTS TO REDUCE THE DEFICIT

6. Tissue Viability services attempt to reduce the NHS Deficit by providing evidence based, cost effective care ensuring that the patient receives a high standard of quality care wherever the service is delivered.

7. Cost saving activities include initiatives to:
   — reduce actual spend;
   — reduce inpatient episodes;
   — increase in-patient throughput;
   — generate income; and
   — facilitate a well educated and motivated workforce (see appendix 2).

THE REASONS FOR THE DEFICITS

8. Factors affecting the delivery of a high quality cost effective tissue viability service include:
   — The effect of the pay awards, Nurses Specialists have been awarded bands ranging from 5–8D. Nurses Consultants from 7–8D this is confusing and demoralising for staff.
   — The piece meal approach to appointment and delivery of tissue viability services, some regions have acute services but no primary care, others visa versa. This does not assist in seamless delivery of patient care. Some areas do not have tissue viability nurses at all and procurement decision are made on cost alone, whilst this may initially appear to reduce the costs if the products are not fit for purpose as is the case with some “cheap” products, costs escalate as more product is used or expensive alternatives are sought in an attempt to achieve satisfactory outcomes.
   — Withdrawal of support for education has considerable negative effects, which impact both on the tissue viability nurse who needs to maintain their knowledge, and also on the general staff who need to have a good level of education to provide quality care at ground level. Changes in the way in which education is funded centrally combined with inability to release staff because of low staffing numbers related to attempts to reduce the deficit, is increasingly leading to poor decisions being made at a clinical level. Ultimately a poorly educated work force costs money in terms of their clinical choices (see appendix 3). This has resulted in senior clinical nurses having to spend more time in clinical practice as generic nurses are lacking in expertise. Lack of education has already increased tissue viability nurses workload this additional burden reduces the time to work strategically and address financial issues.
   — Threats to jobs and focus on the deficit increasingly take senior clinicians away from their workload, in their absence it is likely that costs and mistakes may increase.

9. The current UK population is estimated at 60.2 million, 16% of which are aged 65 years and older, (Office of National Statistics, 2004). Current levels of tissue viability service provision are likely to be ineffectual within the next five years as the population continues to age and the percentage of those over age of 65 years increases. Tissue Viability Nurses play a major role in both the prevention and management of chronic wounds which increase with the elderly population, specifically, pressure ulcers, leg ulcers and diabetic foot ulcers, furthermore the rate of complications for surgery increase in the elderly, all of which are costly to manage.

10. The tissue viability nurses in the UK are committed to providing a high quality service to patients whilst maintaining a cost effective delivery process. In order to do this appropriate funding has to be made available to ensure that all health care professionals have access to appropriate education, and that service provision is equitable across acute and primary care and through all regions. Clinical staff should be actively
involved in procurement decisions as cheap is not always cost effective and long term costs need to be given due consideration as short term savings frequently lead to long term problems particularly in relation to litigation.

CONCLUSIONS

11. Wound care is a high spend area within the NHS; however with good, well supported clinical staff, savings can be made without reducing the quality of care delivered to patients.

12. Education is fundamental in supporting clinicians at all levels and as such should never be seen as a value added service.

13. Tissue viability nurses are committed to providing cost effective service delivery using a range of innovative approaches and practices.

FURTHER COMMENT

14. The Tissue Viability Nurses would welcome the opportunity to give oral evidence to the Health Committee on the issues raised.

Jacqui Fletcher, on behalf of the Tissue Viability organisations listed,
School of Nursing and Midwifery, University of Hertfordshire
October 2006

APPENDIX 1

ORGANISATIONS REPRESENTED

The Leg Ulcer Forum
The Tissue Viability Nurses Association
The Tissue Viability Society
The Wound Care Society
The All Wales Tissue Viability Nurses Association
The National Association of Tissue Viability Nurse Specialists (Scotland)
Bedfordshire and Hertfordshire Tissue Viability Nurses Forum
Eastern Tissue Viability Nurses
East Midlands Tissue Viability Nurses Association
Essex Tissue Viability Nurses
Greater Manchester Tissue Viability Nurses
North East Tissue Viability Nurses
Northern Ireland Tissue Viability Nurses
Northern Tissue Viability Professionals Forum
North West Tissue Viability Nurses
Southern Alliance of Tissue Viability Nurses
Southern Leg Ulcer Alliance
South West Tissue Viability Nurses
Tissue Viability Nurse Consultants Group
Tissue Viability Nurses Forum (South)
West Midlands Tissue Viability Nurses

APPENDIX 2

COST EFFICIENCY ACTIVITIES—EXAMPLES

1. Tissue Viability nurses from across England work collaboratively with NHS PaSA to reduce spend on all related categories by centralisation and bulk purchase discounts. Tissue Viability Nurses work as clinical guidance groups to ensure that cost reduction is not made simply by buying “cheap” products which ultimately may not prove to be cost effective if they require more frequent changes, cause pain to the patient on removal or are not effective or have safety issues associated with their usage (for example triggering incident reports to MHRA). See for example http://www.hesmagazine.com/story.asp?storyCode=%2033054 for a regional initiative.

2. The majority of Tissue Viability Nurses implement dressing formularies, these rationalise and control product availability and allow education to be focussed on a smaller group of products. For example one small acute trust in the South has projected savings of £22,544.87 in one year simply by changing to a formulary.
3. Provision of education to ensure products are used appropriately and correctly, a Greater Manchester Trust was able to demonstrate a 50% reduction in hospital spend following education on a category of products led by the tissue viability team.

4. Reduction in in-patient stay by usage of advanced wound management technologies. An acute Trust in the West Midlands show reduction in bed days of between seven and 14 days. They were able to show a cost saving on one inpatient episode for the total care including management as an out patient of £10,070 following changes in patient management by the Tissue Viability Nurses.

5. An East Midlands Acute Trust are able to demonstrate significant reduction in amputation rates for diabetic patients using a multi disciplinary approach and appropriate conservative wound management facilitated by the Tissue Viability Nurses.

6. A London PCT was able to reduce the frequency with which patients were admitted by introduction of a Tissue Viability Nurses led community wound care clinic using an evidence based approach to wound care. In the first four months 28 inappropriate referrals to secondary care were prevented and 17 hospital admissions averted.

7. A North East Acute Trust generates sufficient funding by research activities to support staff salaries, improved patient care and provision and support for education to a range of health care professionals. Furthermore involvement in research means that patients frequently have access to treatments and equipment that may otherwise be beyond the budget of the Trust.

8. Tissue viability nurses work collaboratively with commercial organisations to provide structured, validated education. The support generated from commercial organisations allows the clinicians to access a range of speakers and reasonable venues which would normally be outside of their budget.

9. Tissue viability nurses/consultants are actively involved in research, presentation and publication activities to develop their speciality.

APPENDIX 3

AN EXAMPLE OF HOW LACK OF EDUCATION INCREASES COSTS

A large scale RCT was carried out by The University of York as an HTA report (Nixon et al 2006) the research compared the cost effectiveness of alternating overlays with alternating mattresses. One of the findings of the report was that equipment was frequently out of use and additional equipment had to be provided because the equipment regularly malfunctioned, with 577 faults reported on 354 mattresses/replacements. On closer examination, on 149 occasions (39.4%) the fault related to simple user error. If the clinicians using the mattresses had been better educated they would have been able to rectify the problem without taking the equipment out of service, requesting a replacement and generating a service call. Examples of the fault included mattresses being left in the static mode and connectors not being properly attached. These simple problems would result in both considerable additional costs and also the placing of a patient at increased risk of pressure ulcer development should replacement equipment not be available.

Supplementary evidence from Mervyn Stone (Def 07A)

Dr Naysmith asked what the consequences would be of equality ie if all the weighting were dropped in the weighted capitation PCT funding formula so that a PCT’s funding would be simply proportional to the estimate of its GP-registered population. In response, DoH’s Director of Finance and Investment claimed that there would be adverse consequences:

(i) for PCTs with aged populations (since there would then be no weighting for the high health costs of the top age-bands); and

(ii) for PCTs with above average deprivation.

The following table presents evidence that, from an overall statistical viewpoint, PCTs with aged populations would actually benefit if there were no weighting for any socio-economic factor, including age-profile itself.

As in my written evidence (Ev 183–192 (HC 1204-II)) to the NHS Deficits Inquiry, a PCT’s target index is the per capita ratio of the formula-derived “unified weighted population” to the estimate of the population for which the PCT is responsible (this ratio has a national population-weighted average equal to unity). The difference between the target index and unity is a measure of the PCT’s per capita loss if weighting were dropped—a loss if the target index exceeds unity, a gain otherwise.
The age profile index is the ratio of the purely age-profile weighted population of a PCT to its actual population (this ratio has a national population-weighted average of unity because the PCT age-profile weighted populations are made to add up to the national population.) The age-profile index can be used to divide PCTs into two classes—the aged with an index greater than unity and the youthful with an index less than unity.

The double dichotomy (by outcome and agedness) gives the following table, based on the data for the 2003–06 formula.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Aged PCTs</th>
<th>Youthful PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain</td>
<td>100 (67%)</td>
<td>74 (48%)</td>
</tr>
<tr>
<td>Loss</td>
<td>49 (33%)</td>
<td>81 (52%)</td>
</tr>
<tr>
<td>Total</td>
<td>149 (100%)</td>
<td>155 (100%)</td>
</tr>
</tbody>
</table>

Table 1 shows that two-thirds (67%) of aged PCTs would gain if there were no weighting at all, compared with less than half (48%) of youthful PCTs. For the aged PCTs, the average gain (defined as “unity minus target index”) is 0.033 (or 3% of unity). For the youthful PCTs, the average is −0.020 (2% of unity) with the minus sign representing a loss. The 5% difference in these averages is statistically significant at the 0.1% level. The two averages are not equal in magnitude mainly because youthful PCTs tend to have larger populations.

AGE VERSUS DEPRIVATION

After adjustment for the age-profile factor, there are 18 more factors that DoH incorporates (one after the other) to arrive finally at the target index for each PCT. The last five of these factors are:

- Market Forces Factor (MFF).
- Emergency Ambulance Cost Adjustment (EACA).
- HIV/AIDS.
- Prescribing.
- General Medical Services Non Cash-Limited (GMSNCL).

The 13 factors preceding these five are either socio-economic factors associated with deprivation or health-related combinations of socio-economic factors associated with deprivation. When these have been incorporated (but not the last five) we have a 14-factor partial index (adjusting the PCT population either up or down) that can be said to reflect the influence of both the age-profile factor and the 13 deprivation factors. Define the deprivation index component of the formula as the ratio of this 14-factor partial index to the initial age-profile index. The partial index is therefore what you get when you multiply the PCT population by the product of age-profile index and deprivation index. The battles in individual PCTs between the typically opposing influences of the age-profile index and the deprivation index go a long way to explain why the statistical evidence of Table 1 negates claim (i)—the last five factors do the rest. Figure 1 and Table 2 reveal the markedly negative correlation between the two indices—aged PCTs with above average age-indices tend to have below average deprivation indices and, when the product of the indices is used to multiply the PCT population, it is the deprivation index (with its larger range of variation) that typically wins the battle.
Table 2

AN INFLUENTIAL ASSOCIATION

<table>
<thead>
<tr>
<th>Deprivation index</th>
<th>Aged PCTs</th>
<th>Youthful PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above average</td>
<td>39 (26%)</td>
<td>92 (59%)</td>
</tr>
<tr>
<td>Below average</td>
<td>110 (74%)</td>
<td>63 (41%)</td>
</tr>
<tr>
<td>Total</td>
<td><strong>149 (100%)</strong></td>
<td><strong>155 (100%)</strong></td>
</tr>
</tbody>
</table>

A graphical exposition of how it all works out for individual PCTs is now freely available via the paper “Fathoming the PCT funding formula with Excel graphics” (UCL Department of Statistical Science Research Report 267, www.ucl.ac.uk/stats/research). Download the PCTgrapher.xls worksheet, enable the macro and select Broadland to see a PCT that gets a 4.2% boost from its age-profile index of 1.042—only to have that favour progressively whittled away to a 14-factor index of 0.89 and a final target index of 0.84 (16% below equality). In 2004–05, Broadland’s deficit was 3.6%.

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Further supplementary evidence submitted by Mervyn Stone (Def 07B)

These graphs exhibit the sequential construction of the per capita target index used between 2003 and 2006. They were downloaded from the Excel file on the URL page: www.ucl.ac.uk/stats/research/resrpts/abs06.htm#267
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