House of Commons
Committee of Public Accounts

Department of Health: Securing the future financial sustainability of the NHS

Sixteenth Report of Session 2012–13

Report, together with formal minutes, oral and written evidence

Ordered by the House of Commons
to be printed 22 October 2012
Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No 148).

Current membership
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Mr Richard Bacon (Conservative, South Norfolk)
Mr Stephen Barclay (Conservative, North East Cambridgeshire)
Jackie Doyle-Price (Conservative, Thurrock)
Matthew Hancock (Conservative, West Suffolk)
Chris Heaton-Harris (Conservative, Daventry)
Meg Hillier (Labour, Hackney South and Shoreditch)
Mr Stewart Jackson (Conservative, Peterborough)
Fiona Mactaggart (Labour, Slough)
Mr Austin Mitchell (Labour, Great Grimsby)
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Nick Smith (Labour, Blaenau Gwent)
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The following Members were also Members of the committee during the parliament:
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Justine Greening (Conservative, Putney)
Joseph Johnson (Conservative, Orpington)
Eric Joyce (Labour, Falkirk)
Rt Hon Mrs Anne McGuire (Labour, Stirling)
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Powers
The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publications
The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

Committee staff
The current staff of the Committee is Adrian Jennar (Clerk), Sonia Draper (Senior Committee Assistant), Ian Blair and James McQuade (Committee Assistants) and Alex Paterson (Media Officer).

Contacts
All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is pubaccom@parliament.uk
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Summary

Ensuring a viable financial future for healthcare providers is vital if the public are to have confidence in the delivery of their local services. Yet we still do not have critical details of how the new system introduced by the NHS reforms will work so that services remain available to patients in their locality.

In 2011-12 NHS organisations in England reported a combined overall surplus of £2.1 billion. There were, however, significant variations in performance between NHS bodies. 377 NHS organisations reported a surplus in the year, but 10 NHS trusts, 21 NHS foundation trusts and three Primary Care Trusts (PCTs) reported a combined deficit of £356 million. Eleven NHS foundation trusts would not have made foundation trust status today given their financial performance, and there is a real concern that some organisations will fail. The very difficult financial situation of some NHS bodies is particularly marked in London, where two trusts reported a combined deficit of £115 million. The Department placed one of these, South London Healthcare NHS Trust, in special administration in July 2012.

The financial sustainability of hospital trusts is even more serious than these figures suggest. Up to now, PCTs and Strategic Health Authorities (SHAs) have been able to give struggling trusts additional financial support in a variety of ways that have not always been transparent. In addition, the Department has provided further significant cash injections of £1.1 billion to some trusts in the form of public dividend capital that it does not expect all of them to pay back. All this additional funding is hiding underlying financial problems, as without this help a further 31 NHS trusts and 11 Foundation trusts may not have broken even, or would have reported larger deficits.

The Department was not able to explain clearly what would trigger a trust being placed into the failure regime, and how decisions would be made about the future of a trust in financial difficulty. We were particularly surprised that the Department was unable to tell us how the process will work for South London Healthcare NHS Trust, which is already in special administration. We also fear that the new system creating central “risk pools” to deal with trusts in financial difficulties is likely to put more pressure on other health trusts who are already seeking financial savings to meet the £20 billion efficiency savings target. Any monies held in central “risk pools” means less money available to commissioners and trusts to pay for patient services and therefore yet more pressure in the system.

A number of trusts in financial difficulty have PFI contracts with fixed annual charges that are so high the trusts cannot break even. Paying these charges is one of the first calls on the NHS budget and the Department is liable for supporting all PFI payments because it underwrites the Deed of Safeguard given to contractors. It already expects to have to find £1.5 billion to bail out seven trusts facing problems with PFI repayments over the remaining life of their contracts - equivalent to £60 million a year. The guarantee provided by the Deed of Safeguard also gives PFI providers the upper hand in any attempt by trusts to renegotiate the contracts, which experience suggests can result in reduced service levels rather than greater efficiency. The priority given to meeting PFI annual charges inevitably
distorts priorities which is especially worrying at a time when resources are constrained.

The Department was unable to spell out to the Committee a clear plan to achieve financial sustainability and a clear strategy for dealing with financial failure in individual trusts. The Department could not provide adequate reassurances that financial problems would not damage either the quality of care or equality of access to all citizens, wherever they live. The incentives for Clinical Commissioning Groups (CCGs) to work collaboratively within regional health economies remain unclear. Given the scale of the challenge, it is alarming that there is a lack of comparative data that could inform a debate on reconfiguration of services particularly because the Department expects that every trust will need to reconfigure services.

Good governance is one of the key elements in ensuring financial sustainability of trusts. We are disappointed that the Department has failed to deliver on its promise to write back to the Committee, by the end of April 2012, on progress to improve governance within NHS trusts.

On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health and Monitor on the financial sustainability of the NHS.

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1 C&AG's Report, Securing the future financial sustainability of the NHS, Session 2012-13, HC 191
Conclusions and recommendations

1. The overall financial surplus of £2.1 billion reported by NHS bodies in England in 2011-12 disguises the fact that there are a significant minority of organisations in financial difficulties. On top of that, the NHS faces significant challenges in making £20 billion of efficiency savings at the same time as the system is reformed under the Health and Social Care Act 2012. Many crucial details of the new system have not yet been determined. The recommendations below highlight the actions the Department and Monitor need to take to improve the financial resilience of the NHS.

2. The Department and Monitor were unable to explain how they expect proposed “risk pools” to work. Currently PCTs and SHAs support some trusts through providing funding over and above amounts in contracts, but neither the amount of additional funding nor the reasons for it are transparent. In future, contributions to “risk pools” (money which might be levied on all NHS bodies to support failing trusts or commissioners) will add to the already difficult challenges facing trusts. This top-slicing of the NHS budgets risks destabilising otherwise healthy organisations, and creating inequities between those contributing and those in receipt of support. The Department and Monitor should clarify how “risk pools” will work from April 2013, and how they will manage the risk of creating an uneven playing field.

3. The Department has not clearly explained the circumstances in which it would apply the failure regime to hospital trusts. The fundamental objective when putting a trust into special administration is to secure provision of essential services, with insolvency the final resort. So far, South London Healthcare is the only trust to have been put into a special administration regime. There are a growing number of NHS trusts and NHS foundation trusts in financial difficulty, but it is not clear what will trigger them being placed in special administration, or exactly how the process will work including the role of Ministers. At present it seems as if the Department is inventing rules and processes on the hoof rather than anticipating problems and establishing risk protocols. The Department, Monitor and the NHS Commissioning Board must set out clear principles for intervention that explain to trusts and the public the circumstances in which they would implement the special administration regime, and what the consequences would be—including whether an insolvent trust would be allowed to fail and how Ministerial intervention will work.

4. There is a risk that, as commissioning becomes more decentralised, local commissioners will make short term and narrowly focused decisions rather than taking a strategic and joined up approach. The Department could not explain what will ensure Clinical Commissioning Groups (CCGs) work together to achieve financial and service sustainability in local health economies. The NHS Commissioning Board should set out how they will manage strategic commissioning from April 2013, and how they will promote commissioning decisions which meets patient needs across a local health economy.

5. Liabilities under PFI contracts create additional problems and cause some trusts to remain in deficit. A number of trusts in financial difficulty have PFI contracts
with fixed annual charges that are so high they cannot be financially viable. PFI payments are one of the first calls on an NHS trust’s resources. Yet individual trusts are in a weak position when seeking to renegotiate such contracts because PFI contractors have the security of a Deed of Safeguard underwritten by the Department that guarantees payments. So trusts are locked into paying unaffordably high PFI payments whilst facing a very weak position on renegotiating the contracts. The Department ultimately underwrites the payments but it is unclear how the Department will have the money to meet this commitment under the arrangements when most NHS monies will be passed to the commissioning bodies. The Department should report back to the Committee on whether it has achieved 5% savings on annual unitary charges for PFI projects as the Treasury Pilot concluded were achievable, and whether there has been any adverse impact on services.

6. **Some service reconfiguration within the NHS to reduce costs is inevitable but the relevant cost and outcome data to inform public debate is not available either to CCGs or members of the public.** Public debate about access to services and potential service reconfiguration needs to be informed by complete and easily accessible data. The Department should work with the NHS Information Centre to ensure that information on costs and outcomes is easy for members of the public to access and understand.
1 Financial pressure in the NHS

1. The Department funds Primary Care Trusts (PCTs) in England to commission health care services from hospitals and other healthcare providers on behalf of their local populations. As at 31 March 2012 hospital and community care services were provided through 107 NHS trusts and 143 NHS foundation trusts. Strategic Health Authorities (SHAs) oversee the performance of NHS trusts and PCTs. NHS foundation trusts are subject to oversight by Monitor, the independent regulator of the foundation trust sector.2

2. In 2011-12 SHAs, PCTs, NHS trusts and NHS foundation trusts in England reported a combined overall surplus of £2.1 billion. The surplus in SHAs was over £1 billion, of which around £400 million was due to a core underspend and the remainder was money which PCTs have lodged with SHAs, and which will be returned to PCTs before they are abolished as statutory bodies. While 377 NHS bodies reported a surplus in the year a significant minority, particularly among provider organisations, are facing substantial financial pressure. Three PCTs, 10 NHS trusts and 21 NHS foundation trusts reported a combined deficit of £356 million at the end of March 2012.3

3. The number of NHS trusts and foundation trusts in deficit may have been higher without direct financial support from SHAs and PCTs, which the National Audit Office estimated amounted to at least £151 million to NHS trusts and £10 million to foundation trusts in 2011-12. Without this direct financial help a further 15 NHS trusts may have been in deficit rather than in surplus.4 SHAs and PCTs also gave trusts other non-recurrent funding totalling at least £274 million, without which another 16 NHS trusts and 11 foundation trusts may not have broken even. So a total of 41 NHS trusts and 32 foundation trusts might have been in deficit at the end of March 2012. While much of this additional funding may be legitimate support for additional work, no information was available to justify why these one-off payments are made. The Department told us that if there was not the money to fund further activity commissioners would have to take action to cut expenditure by reducing referrals.5 Unless there are alternative ways of providing the care they need, this can only lead to patients waiting longer for treatment.

4. Monitor has assessed 11 foundation trusts as being in significant breach of their terms of authorisation (granting foundation trust status) because of the extent of their financial risks. Monitor is reviewing the three year plans submitted by all foundation trusts, and now has questions or concerns about the financial sustainability of a further 13 trusts.6

5. A number of NHS trusts will not be able to achieve foundation trust status by April 2014 because of the extent of their financial problems. When the Committee last reported on the issue, in December 2011, there were 20 trusts which had declared themselves unviable in their current form. Of those, ten have now merged with other organisations, and seven are

2 C&AG’s Report, para 2
3 Qq 104-105; C&AG’s Report, para 6-10 and Figure 2
4 C&AG’s Report, para 12 and Figure 3
5 Qq 51-53; C&AG’s Report, para 14
6 Qq 32, 46, 48
in the process of completing mergers. There are three trusts—Surrey and Sussex Healthcare NHS Trust; Barking, Havering and Redbridge University Hospitals NHS Trust; and Weston Area Health NHS Trust—which have not yet determined their future. A further eight or nine hospital trusts are currently considering becoming part of another organisation. This will bring the total number of trusts which are unviable in their current form to 29 or 30.7

6. Financial problems are particularly marked in London, where two trusts, South London Healthcare NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust, reported a combined deficit of £115 million in 2011-12.8 In July 2012, South London Healthcare NHS Trust became the first provider the Department has placed into special administration because of financial failure.9 In the Department’s view, the trust is not capable of recovering from its financial overspend and balancing its books, at the same time as delivery necessary healthcare services. The Department’s objective in triggering the unsustainable provider regime is to secure provision of essential services, but the Department did not rule out insolvency as a final resort. In order to make South London Healthcare viable there will, however, be changes to the range of services provided at some sites, and there will be changes to some of the organisational arrangements. The special administrator is due to report to the Secretary of State in October 2012 and he will make a final decision on the trust’s future. The Department was unable to explain what the exact decision making process will be to ensure provision of sustainable healthcare.10

7. We asked the Department what it proposed to do to resolve the financial problems at Barking, Havering and Redbridge University Hospitals Trust where, in contrast to the treatment of South London Healthcare NHS Trust, the unsustainable provider regime has not been triggered. The Department acknowledged that the problem was very serious and that it would not be solved quickly, but maintained that it continued to work with the trust to see whether that position is recoverable.11 The Department has not set out what criteria would trigger the unsustainable provider regime for NHS trusts. In future, the Department expects the NHS Trust Development Authority to address cases as they arise.12

8. In the meantime, the Department continues to support the most troubled trusts by providing a direct cash subsidy in the form of public dividend capital, for them to maintain services and pay wages. The Department provided a total of just over £1 billion public dividend capital between 2006-07 and 2011-12 to four foundation trusts and 17 NHS trusts. The Department provides support in this way because it sees no prospect, in the short term, of the most troubled trusts being able to repay a loan. Trusts in receipt of public dividend capital pay a dividend of 3.5% a year. The Department accepts that there is no

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7 Qq 179-181; Committee of Public Accounts, 60th Report of Session 2010-12, Achievment of foundation trust status by NHS hospital trusts, HC 1566
8 C&AG’s report, para 7
9 C&AG’s report, para 3.23-3.25. The special administrator for South London Healthcare NHS Trust was appointed by order made by the Secretary of State for Health, in accordance with Chapter 5A of the National Health Service Act 2006, as introduced by the Health Act 2009.
10 Qq 34-35, 83-90, 94-101
11 Qq 135-136
12 C&AG’s report, paras 3.24-3.25
foreseeable prospect of the public dividend capital money it has provided to the most troubled trusts being repaid in the short term.13

9. The Department told us that there is a very real question about the extent of public dividend capital and the risk of moral hazard, because the one thing the Department does not want to do is give the impression that organisations are rewarded for failure, or that laxity and financial indiscipline somehow mean that the Department bail organisations out.14

10. A number of trusts in financial difficulty have PFI contracts with fixed annual charges that are so high the trusts cannot break even and their ability to make savings by reconfiguring services is limited under the contract. One foundation trust, Peterborough and Stamford NHS Foundation Trust, is in significant breach of its terms of authorisation, partly because it has entered into an unaffordable PFI contract. The Department has so far identified six NHS trusts and one foundation trust which it believes will need central support to meet PFI liabilities to become financially viable. The total amount of support could amount to £1.5 billion over the life of the contracts.15

11. When each PFI contract is signed, HM Treasury issues a ‘Deed of Safeguard’ which guarantees payments to the PFI contractor and makes the annual charges a first call on NHS resources. In practice this means that the Department is committed to continue payments in the event a trust cannot do so. The Department has not estimated the size of the potential liability it is exposed to, or how much might materialise given the current financial situations of trusts. The Department was not clear as to how it could ensure appropriate funding was preserved to meet this potential liability, especially in the context of the NHS reforms when the Department will not hold resources but pass them to the NHS Commissioning Board. The security the Deed of Safeguard gives contractors weakens the incentive they have to agree to renegotiate contract terms. The Treasury is undertaking a trial exploring the scope for achieving savings by renegotiating PFI contracts. The pilot conducted at the Queen’s Hospital, Romford, which is part of the Barking, Havering and Redbridge NHS Trust, suggested that savings of around 5% of the annual unitary charge might be achieved. However, the Department was unable to tell us whether any savings had subsequently been achieved in operational PFI projects. One risk to be managed is that any savings identified by cutting services out of the contract, rather than negotiating efficiency gains, may be negated if these services have to be taken on again by the trust.16

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13 Qq 133-134; C&AG’s report, para 15
14 Qq 132, 135-136, 152
15 Qq 114, 124, 127
16 Ev 27
2 Achieving financial sustainability

12. The NHS must make up to £20 billion of efficiency savings over the period 2011-12 to 2014-15.\(^{17}\) The NHS reforms are founded on a premise that it will be possible to reduce the number of people going to hospital. The evidence so far is uncertain. In 2011-12, emergency admissions were down by about 1.5%. However, in the first part of 2012-13 there has been growth in admissions of between 2% and 3%.\(^{18}\)

13. As the role of hospitals changes and more services are provided in the community it is possible that every trust in the country will have to restructure. In the last two years of the current spending review period services will need to be reconfigured significantly to be able to deliver the scale of efficiency savings needed for the NHS to become financially sustainable. If changes are not made to concentrate and centralise hospital services, and deliver more services in the community, even greater efficiencies will be needed in hospitals to avoid waiting lists rising.\(^{19}\)

14. Implementation of the Health and Social Care Act 2012 reforms will lead to significant changes to the NHS in coming months, especially in how services are commissioned. Some trusts have built up financial surpluses, which will enable them to cope with the changes required. Others will need financial support, provided under current arrangements as public dividend capital. After April 2013, there will be “risk pools” of money, funded from trusts, available to support struggling organisations which could create inequalities between those contributing and those receiving support. We asked how these “risk pools” would be organised, but neither Monitor nor the Department was able to explain how much money would be involved, where the money would be held, or how much would be levied on trusts to pay for creating them. However, the Department and Monitor recognised the importance of ensuring that the system was properly coordinated to avoid creating multiple pots of money held by Monitor, the Department and the NHS Commissioning Board, or creating new financial pressure for otherwise viable trusts.\(^{20}\)

15. From 2013-14 Clinical Commissioning Groups (CCGs) will take over many of the PCTs’ commissioning responsibilities. The NHS Commissioning Board will become responsible for commissioning all primary care, overseeing CCGs and commissioning specialist services. As commissioning decisions become more decentralised there is a risk that it will become more difficult for providers to plan long-term services, because in each decision-making period they may have to respond to different decisions from each local commissioning group. Each CCG will have to produce a three to five-year view on future services and will have to demonstrate their collaborative arrangements with other CCGs in the area. Without properly joined up working there will be more financial instability, especially among already financially weak providers.\(^{21}\)

\(^{17}\) C&AG’s report, para 1
\(^{18}\) Qq 182-183
\(^{19}\) Qq 115, 152, 185, 189
\(^{20}\) Qq 36-44, 103, 152
\(^{21}\) Qq 167, 169
16. As changes are made, the key consideration must be the protection of services for patients. Where trusts become unviable, such as in the case of South London Healthcare NHS Trust, the responsibility of the administrator and service commissioners is to ensure that the full range of services remain available. There are likely, nonetheless, to be changes to the sites at which services are provided.\(^{22}\)

17. CCGs are central to ensuring the sustainability of services, especially where trusts enter the failure regime.\(^ {23}\) The Department assured us that it is commissioners’ responsibility to secure a range of services for the local area.\(^ {24}\) Accessibility to services and local accessibility to the full range of services are important criteria when deciding on the future of a provider.\(^ {25}\) CCGs will also need to work together locally to share the risk of commissioning for higher cost conditions, and to make sensible strategic decisions.\(^ {26}\)

18. What services are to be maintained locally, and how these will be delivered in future, may differ from the way hospital services are currently organised. More services are likely to move out of acute hospitals into the community.\(^ {27}\) In order to make these decisions, commissioners, and the public, need access to comparative data. It is very difficult without such comparative data to shape that debate and balance, for example, the convenience of a nearby hospital against the lower mortality rates that may be achievable in services concentrated in specialist centres. The Department needs to work with the NHS Information Centre to ensure this data is available in a format which is accessible to the public, allowing people to understand the evidence behind the case for reconfiguration plans. The Department told us that a lot more data will be publicly available in the future.\(^ {28}\)

19. Meeting the challenge of achieving a more sustainable health service will need effective management and governance, an issue already addressed in our report on the achievement of foundation trust status by NHS hospital trusts. The Department undertook to report by the end of April 2012 on the steps taken by successful NHS foundation trusts to strengthen governance, and how this can be applied to NHS trusts, but has not yet done so.\(^ {29}\)

20. The Department confirmed that, ultimately, accountability for the performance of local NHS bodies remains at a national level. From April 2013 the chief executive of the NHS Commissioning Board will be accountable for performance of CCGs, and the chief executive of the NHS Trust Development Authority will be accountable for an NHS trust. The Chief Executive of a foundation trust, as an accounting officer, is directly accountable to Parliament. Monitor is nonetheless accountable for ensuring that they assist and regulate foundation trusts. Where local management is failing, Monitor has so far

\(^{22}\) Qq 35, 90  
\(^{23}\) Q 84  
\(^{24}\) Q 87  
\(^{25}\) Q 86  
\(^{26}\) Qq 168, 170  
\(^{27}\) Q 115  
\(^{28}\) Qq 142-146  
\(^{29}\) Qq 153-156; Committee of Public Accounts, 60\(^{th}\) Session 2010-12, Achievement of foundation trust status by NHS hospital trusts, HC 1566
removed, or ensured the removal of, senior members of the board in 17 foundation trusts.\textsuperscript{30}
Members present:

Margaret Hodge, in the Chair
Richard Bacon
Mr Stewart Jackson
Fiona Mactaggart
Meg Hillier
Mr Austin Mitchell
Nick Smith
Ian Swales

Draft Report (Department of Health: Securing the future financial sustainability of the NHS), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 20 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

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

Ordered, That the Chair make the Report to the House.

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

Written evidence was ordered to be reported to the House for printing with the Report (in addition to that ordered to be reported for publishing on 5 September 2012).

[Adjourned till Wednesday 24 October at 3.00 pm]
Witnesses

Wednesday 11 July 2012

Professor John Appleby, Chief Economist, Health Policy, The King’s Fund, Sue Jacques, President of the Healthcare Financial Management Association, Marius Gallaher, Alternative Treasury Officer of Accounts, HM Treasury

Tuesday 18 September 2012

Dr David Bennett, Chair and Interim Chief Executive, Monitor, David Flory CBE, Deputy NHS Chief Executive and Sir David Nicholson KCB CBE, NHS Chief Executive, and Una O’Brien, Permanent Secretary, Department of Health

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Oral evidence

Taken before the Committee of Public Accounts
on Wednesday 11 July 2012

Members present:
Margaret Hodge (Chair)
Mr Richard Bacon
Stephen Barclay
Chris Heaton-Harris
Meg Hillier
Mr Stewart Jackson
Fiona Mactaggart
Austin Mitchell

Amyas Morse, Comptroller and Auditor General, National Audit Office, Gabrielle Cohen, Assistant Auditor General, NAO, and David Moon, Director, NAO, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Securing the future financial stability of the NHS (HC 191)

Examination of Witnesses


Q1 Chair: May I start by apologising to the accounting officers and officials? I think we have a series of votes starting at 3.48 pm, so we will have to abandon the main part of the session today and return to it in the first two weeks of September, when the House is sitting again. My big, sincere apologies to you all, because I know that a lot of preparation goes into it. We felt that the issue was so important that it was worth giving it time properly when we come back.

However, we have just over 30 minutes—literally, 3.48 pm is the vote—to pick both your brains. Thank you very much for coming. The focus of this bit is for you to tell us, from your perspectives and the work that you have done, what you think are the key issues around financial sustainability of the NHS and your reflections on what the Report says. It is an open session for you to try to help us in our later questioning.

I am going to start. Reading the Report, what appears to be happening is that financial instability is growing, whether it is in trusts or primary care trusts. There have been one-off rescue missions all over the place, which clearly, over time, will disintegrate, because there will not be enough money to do that very much. Looking at it, what is the biggest threat, do you think, to patient care out of this? Or don’t you think there is one? That seems to me the key issue.

Professor Appleby: I think you are absolutely right. In the end, the bottom line is, can we protect patient services and patients in what are clearly—you know this—hard financial times? The NHS’s global budget is essentially frozen in real terms; I will not quibble about the decimal-point real increase. The NHS’s global budget is essentially flat real funding for four years to 2014–15. It could well be flat real funding beyond then; we don’t know, of course, but it is not going to suddenly turn up, I don’t think. The few years going forward will be very tough. As I say, I think the bottom line is about patient services.

What the Report shows is that the vast majority of trusts and PCTs are doing all right, all things considered. I was just looking at figure 7, which has quite a telling figure, showing the gross deficit in the NHS. In 2005–06, you are looking at a figure of nearly £1.4 billion. This is in a period when there was lots of money around. There are various reasons why the NHS got itself into some difficulty there, and it has recovered from that.

You talked about the situation getting worse lately. It does seem to have got slightly worse. In the end, we are talking about a relatively small group of hospitals and organisations, but they are serious cases. I suppose the one thing that I have learned, studying the NHS all my career, is that it is very hard to generalise in these situations, when we talk about individual organisations. Thinking about what is going on in South London or in Peterborough, you can’t simply point to one thing that is the problem, for example PFI or bad management. Nearly every case seems to me to be almost unique in terms of the issues involved. That suggests to me that the system needs a flexible way of dealing with this.

Q2 Chair: What does all that mean?

Professor Appleby: I suppose what I am saying is that there is not one single solution. You mentioned the amounts of money being lent to organisations—bail-out is one phrase. That has always gone on in the NHS. Money has been moved around the system, within and between regions. There are always these back pockets somewhere in the system.
Q3 Chair: But they won’t be able to do that in the future, will they, when everything is a foundation trust? That is one of the things that comes out of the Report. I can’t remember the figure precisely for this, but there is something like £2 billion floating around in surpluses, and the ability of the old Stalinist days—I am not sure that we have moved that far from them—when that could be reshifted and taken out of surplus to bail out those in difficulties will go.

Professor Appleby: I am not sure it will, to be honest. I don’t think it should. The system is complicated. We have purchasers and providers. We have a system of relatively fixed prices that providers are able to charge for their services and so on. You have to have some flexibility in this system. Part of that flexibility, it seems to me, is the ability for organisations to obtain money when they need it, over and above the income they get in. For example, within the Health and Social Care Act there will be flexibility for Monitor, with the express purpose to protect certain patient services, to alter the tariff price. In a sense that is giving a loan to an organisation potentially. You do need these flexibilities.

Chair: Sue, do you want to come in? Sue Jacques: I think in terms of how patients will be protected, which is the most important thing, over the last few years there has been increased focus both on the amount of money that providers are paid for delivering a quality outcome for patients and the way that the contract is incentivising us not just to deal with numbers of patients, but to give a really good clinical outcome and patient experience. That has developed significantly over the last three or four years and affords a level of protection.

In terms of the membership of the Healthcare Financial Management Association—I am a jobbing chief exec in a big acute and community trust in the North-East—on the ground we are probably pretty much across the country going to have an all right year this year. It is going to get harder over the next three years. In some of the surveys that we have done, members and finance directors up and down the country are saying that we need to be able to look and quantify value as opposed to just numbers. It is how we do that within the payment-by-results mechanism, which is how we are currently paid. We need to be able to have a degree of reconfiguration, so there will be a requirement for some reconstructions up and down the country. I guess it is how we put that compelling clinical argument to local communities, which is often a little difficult to do.

Chair: I will come back on that because I do not know what value means when you are sitting as a constituent in my patch with one of these problems. Stewart has an equal problem, so I will go to him first.

Q4 Mr Jackson: I declare an interest at the outset. I am the Member of Parliament for Peterborough and, given that we have an indicative deficit of £54 million in our foundation trust, I am of the view, looking at all the papers, the Monitor report and the consultant’s report—the KPMG investigation—that we need to look further at the lessons of Peterborough, maybe under the auspices of the National Audit Office.

May I ask you two general questions? One is about acute hospital trusts generally and the other is about foundation trusts. First, do you think that our current model with clinical commissioning groups, following on from primary care trusts, having an institutional conflict with acute hospital trusts is a sustainable model? The latter are looking to get all the business they can and the former are looking to get best value for money for their patients. The two are sometimes completely irreconcilable, particularly in the case of Cambridgeshire and Peterborough where we have a large number of acute hospital trusts all seeking the same work. That is one general question.

The other question is specifically about foundation trusts, and let me allude briefly to the Peterborough situation. Monitor has been quite heavily criticised. You will know that the Health Service Journal of 28 June criticised Monitor and said that it could not have prevented the PFI disaster at Peterborough and Stamford. Can I have your expert view on whether Monitor’s governance architecture and reach is sufficient to deal with future problems like this? Effectively Monitor was told, “This isn’t going to work.” It told the trust that it was not going to work and was completely ignored.

Professor Appleby: I am not sure that I am super-qualified to comment on that. I don’t know the ins and outs of what happened in Peterborough. As I understand it—

Q5 Mr Jackson: More generally, do you think Monitor is up to the job? I guess that is the generic question.

Professor Appleby: Yes, I think so. It is a very hypothetical question. Monitor is now facing a new role in its life. It is going to become the economic regulator. One of the points I would make is that the new groups being set up to deal with different aspects of foundation trusts are actually slightly confusing. We still have NHS trusts that need, in the Government’s eyes, to become foundation trusts.

One of the issues about financial sustainability that I was going to raise is that that is one of the pressures that is exposing hospitals right at the margins, which are in financial difficulty, in that they are having to demonstrate to Monitor that they are financially robust and so on. In a sense, that is good, in one way, that it is becoming transparent.

I would not like to comment on how Monitor is actually going to conduct its role. In theory, it looks like it is okay. The thing is: in practice, what is actually going to happen? I do not know.

Q6 Chair: It is practice that matters.

Professor Appleby: I know, exactly.

Q7 Mr Jackson: I must admit that this is not the Peterborough and Stamford and the Barking and Havering show, but—

Chris Heaton-Harris: Thank heavens.

Mr Jackson: I wrote to Monitor about the disposal of capital assets at Peterborough, and it said, “It’s nothing to do with us. The trust is an autonomous body and must make its own decisions.” Do you feel that, going forward, any future legislation might be
needed to beef up its role and make it more powerful? [Interruption.]

Fiona Maqtaggart: I am sorry; I was making a rather supportive noise, because I think Monitor has had the wool pulled over its eyes in regard to Heatherwood and Wexham Park, which is another of the disasters in this Report—but do continue.

Chair: You happen to have a lot of rather concerned constituency MPs here.

Professor Appleby: It is a shame, in a sense, that you have had to abandon the second part of this, and David Bennett would obviously have been able to answer this much more directly in his role in Monitor and so on. Monitor does have very considerable powers, and it has exercised them in the past in terms of stepping in when it is not satisfied that the hospital or the foundation trust is financially sustainable or when there are issues. Boards have been replaced, for example. It retains those powers, so the power is there, plus in other parts of the system. Again, I come back to this: the trouble is that it is in practice, and we have not had the practice yet to be able to comment on it.

Q8 Chair: Sue Jacques, do you want to answer the first question that Stewart Jackson asked about the tension between what a commissioning group is trying to do and what a—

Sue Jacques: Yes. Again, I cannot comment about the specific locality that you referred to.

Chair: Why not? Do.

Sue Jacques: But I think that where you have commissioners who are in financial difficulty, it inevitably causes problems and more tensions for the provider organisation. Where you see those difficult areas that are mentioned in that Report, that is a common feature, despite the fact that overall the NHS is in balance. For economies where there is not acute pressure now, the trick will be how the commissioners, the providers, the new system and the new bodies that come into force in April work together to put something coherent around service provision within a particular locality and do not duck some of the more difficult issues, which might be about how services are provided. We are at the point where we have made efficiencies and we have tried to take waste out of the system—we are still doing some of that—but we need to transform the way and change the way that services are configured, so we need to have a coherence not just from the provider organisations or the commissioners, but a collective coherence that might run across more than one provider about what the right and optimal thing to do for health care is in that slightly wider geography. I think that achieving it will not be easy.

Q9 Mr Jackson: So, in English, what you are saying is that the clinical commissioning groups and the PCTs are going to say that more people should be treated in their homes or in the community, and the hospitals are going to say, “No, we want to keep our wards open, because we need headcount.” Is that what you are saying?

Mr Bacon: And throughput, and cash for payments.

Sue Jacques: No. I think that where you have a mature relationship between clinical commissioning groups and acute trusts, what you will find is that there is an understanding about what emergency provision needs to be provided to that population and what resource needs to accompany that. It will not necessarily be that the two organisations are fighting, if the relationship is mature, but there will be an understanding.

Q10 Mr Bacon: Why does the maturity of the relationship alter the fundamental that every time I do a procedure, the cash register goes “ker-ching!” and I get more, so that I am incentivised in a particular way because of that? How does the degree of maturity in the relationship alter this basic ker-ching phenomenon?

Sue Jacques: The payment by results rules allow you to step aside from the ker-ching, as you describe it, so you can have—

Q11 Mr Bacon: It is not in my interest if I am an acute trust.

Sue Jacques: Sorry? Mr Bacon: If I am an acute foundation trust, I want to do as much as I possibly can. I met yesterday with the community care folk in Norfolk. They are in the process of going through the foundation trust and navigating their way through the various stages. They have been doing pretty well, but their basic concern is that they have a block contract, no matter how much work they do, and they say their job is to try and keep people out of hospital and lighten the load on the acute sector.

Meanwhile, they are facing the acute sector—in this case, the Norfolk and Norwich, a PFI—which, like others, has this massive incentive to increase throughput. Their concern is that rather than being able to have the mature conversation that they want to have, the incentive for the acute trust remains what it always has been under this model, which is ker-ching for more throughput, making their job as a community care provider more difficult rather than easier.

Sue Jacques: My trust is a combination of acute and community services and has been since the beginning of April. With an acute trust, the ker-ching does not keep coming through, because we are not incentivised to do more and more non-elective work. In fact, we get paid only at 30% of tariff and we cannot cover our costs, so on the acute bit of our business, we are as concerned as the rest of the system about keeping patients out, because it makes sense, so there is a bit more subtlety to the way that payment by results works.

The reason I talk about the maturity of the system is because there is a defined amount of money to provide health care to our population. If we can sit down and look at different models and look at different risk-sharing between us, we will get a more optimal response. If we just take the rules and do not apply some of the flexibilities that are allowed within the system, and just start getting into a very contractual relationship between us, we think that that will destroy
our ability to optimise the health care for the organisation and the population that we serve.

Q12 Stephen Barclay: Building on that—I was interested in the example of Torbay where the hospital has worked with county council social services in terms of how they reduce admissions—can you talk us through how hospitals are incentivised to prevent people coming into hospital?

Sue Jacques: First of all, there is a baseline for the non-elective activity—the emergency activity. For anything over that baseline, the acute trust is sometimes paid at only 30% of tariff, so that, largely speaking, would not allow you to recover your costs. That is one incentive from the acute side.

The other incentive that was introduced last year is readmissions. There are a few rules around readmissions within 30 days, and an acute trust would not typically be paid for those readmissions, so they are massively powerful incentives to acute trusts in terms of not sucking in the work, so to speak.

Q13 Stephen Barclay: How would best practice be shared between hospitals on prevention? When you are assessing your budget, what is the methodology for deciding how much to divert away from today’s needs to prevention upstream? Can you talk us through how you go through that and what variance there might be in the system in terms of coming to that decision?

Sue Jacques: What we will do with our commissioners is sit down and agree what schemes might be helpful to keep patients well and at home and not have exacerbations. We serve a very rural, or semi-rural, population.

Q14 Chair: Where is your hospital?

Sue Jacques: County Durham and Darlington. We have a few conurbations, but we serve a very rural population. The background to health is that there are more and more elderly with a lot of long-term conditions. We will typically sit with groups of clinicians—GPs, nurses and consultants in hospitals—and they will come up with novel ways of perhaps preventing patients having exacerbations and requiring a visit to hospital. We will agree a budget and put in place a scheme and then we will trial that scheme and check its efficacy over time, after which we might decide to ditch it or slightly tweak it or put it in place.

Q15 Chair: Just to be clear, you run both community and acute services?

Sue Jacques: From April last year, yes.

Q16 Chair: So the money comes to you. It does not really deal with the point that Stewart was making. You either get it through the community arm or you get it through the acute arm, whereas if you are just an acute hospital, the money will go to another trust.

Mr Jackson: And you’ve got PFI.

Chair: Yes.

John—I think Sue Jacques’s example is not a good example—can you come back on the generality of where you will get tension between the acute trust that wants to maximise their income, which we all seem to agree about on this side of the table, and the commissioning group that wants to shift resources from the acute trust into community services?

Professor Appleby: I do not think Sue’s example is unique by any means. There are plenty of acute trusts that have invested in community services for a whole variety of reasons. I would take Richard Bacon’s point about payment by results: it was designed at a time when there was lots of money and the key objective was to treat more people. Times have changed; there isn’t as much money now. We want to do different things. I think we have different objectives now. I use the word “integration”. We want to have more integrated services. What does that mean? We are not talking solely about acute hospitals. There are other sectors of the health economy: community services, and whatever. I think we can have more examples of hospitals that are not simply defined by the bricks and mortar of their site, and so on. There will be more examples like Sue’s trust.

Q17 Chair: You have not answered the question. Answer the question.

Professor Appleby: I am not saying there isn’t a problem. I think Monitor has done some interesting work on how payment by results should be changed. Indeed, at the King’s Fund we are working on a report on that, too. There is no argument that payment by results is not necessarily serving the objectives that we want now.

Q18 Mr Jackson: Do you agree with Lord Darzi, who said that the age of the acute district hospital has gone?

Professor Appleby: Yes, I think that age probably went some time ago. Lord Darzi’s work on London was timely and useful, and we have seen some very good benefits from thinking differently about what services should be provided where—stroke care in London. London is now the best place to have a heart attack, if I can put it that way. You will get good service, which is a result of change in the way things are provided, and so on. The payment system can get in the way—there is no doubt that it can get in the way—and send out the wrong incentives. There has always been some flexibility in how hospitals are paid. We now see quite a few organisations across the country getting around some of the rules on payment by results. For example, there is a fixed price for a hip, no matter where it is done in the country. Rationally, commissioners and providers are getting together to change that. In a sense, that is against the rules, but it is completely rational and completely for the benefit of patients, and so on. That is prompting Monitor to think quite deeply about how we continue to reimburse hospitals for what they do.

Chair: When you said that things have got better in London, I was sitting here thinking that it just does not feel like that in Barking and Dagenham, I have to say to you.

Q19 Austin Mitchell: Why are so many of the financial problems in figure 12 concentrated in
London? What is the problem with London? Has it got too many hospitals? Are they too underfunded? Are there too many people? What is the problem?

Professor Appleby: The big orange blob on the map? Austin Mitchell: Yes.

Professor Appleby: There are significant problems in London. I think there is another table that shows that a couple of trusts account for quite a chunk of the deficit. Again, I go back to what I said right at the beginning: every situation, whenever I have looked at it, has been almost unique in its circumstances. The fault will possibly be a combination of the hospital engaging in a PFI that was a bit ambitious and the hospital being a bit optimistic about its future income.

Q20 Austin Mitchell: Are there more PFIs in London?

Professor Appleby: I do not know off the top of my head. But there will be a combination of things going on. What is happening in south London will have to be resolved one way or another. I suspect there will have to be hospital closures—mergers and acquisitions, as it were—to sort that out. London has had problems for years. We did a report earlier this year that must have been something like the 20th or 30th report on London’s health care system—those reports stretch back to the 19th century—when people thought there were too many hospitals in the wrong places. Some progress has been made, and it is a real shame—somebody mentioned Lord Darzi’s report, which was a real attempt to get to grips with a complicated health care system serving millions of people. It was showing some signs of success when it was stopped in its tracks, and we have lost two or three years now on that progress. Over the next two or three years, I think we will have to return to Darzi in London and really face up to the fact that we have to change the way care is provided.

Sir Robert Naylor, who is chief executive of University College Hospitals NHS Foundation Trust, talks about there being too many trusts. There are 40 or so hospitals in London, and he talks about there being, actually, a need for just 12 major multi-specialty trusts (in addition to a number of single specialty trusts) and a reorganised system of care. I think we will have to head in that direction.

Q21 Austin Mitchell: Is there a correlation between bad financial management and bad patient services? Does one lead to the other?

Professor Appleby: Yes, I think there is. The Care Quality Commission used to do traffic-light rankings for trusts on finances and care quality, and you can see a correlation.

Q22 Chris Heaton-Harris: I want to go back to the Chair’s opening question—I guess this question is for you, Sue. We discussed transfers within the NHS— they have been going on for ages, ever since the NHS began—to stabilise trusts that have significant financial problems. If you are a trust, under the new foundation terms, and you are looking after yourself—you are stable, your budgets are working out—would you feel hard done by if a trust that is less well managed ends up taking some of your budget, because you have to bail out something that is failing?

Sue Jacques: Inevitably, yes, that thought would certainly cross my mind. It is really the point that John has made: are the trusts that are in trouble really managed poorly, or is there a combination of factors and wicked issues that mean that no matter what management team you put in, it is impossible without reconfiguration to sort things out? I do not know the trusts that are in trouble sufficiently well to comment.

Q23 Chris Heaton-Harris: I did not want you to, which is why I was trying to keep names out.

Sue Jacques: Clearly, if that became normal, you could theoretically have a situation where trusts did not care as much, because they thought, “Actually, we can—”

Q24 Chris Heaton-Harris: In your current role, how would you suggest that that could be stopped from happening, so that thought would never occur to you?

Sue Jacques: There is to be an element of penalty, so that it is not just for the boards concerned themselves. It is also about boards who have responsibilities when, particularly, they agree to be foundation trusts, so that there is a negative consequence if they do not manage their situation well.

Q25 Chris Heaton-Harris: John, may I ask you the same question?

Professor Appleby: In economics, it is known as moral hazard. People do the wrong thing, because, in this situation, they know that they are going to be bailed out, as it were, so there is never really an incentive to get to grips with what the real problem is in the trust. I agree that there is perhaps something around penalties, but there is also something about support as well. Proper analysis of their particular situation is needed: whether it is Peterborough, South London or wherever, we should ask what the problem is and analyse that properly. That is what trusts need, and they have been getting that. Monitor, for example, has supplied that in the past, as well as regions and strategic health authorities. So you just have to understand what the problem is and come to a view about how it can be fixed.

If it is a PFI, a hospital may have committed itself to that in an over-optimistic way. By the way, leaving aside whether it is a good way of financing capital, most hospitals are happy with their PFI, because they have a new building, they feel that they can afford to pay for it, and so on, but in some cases, it has been a real problem. If that is the problem, there is a range of solutions and it has to be addressed. There has to be almost a case-by-case analysis.

Q26 Chris Heaton-Harris: My final question is short, and I hope the answer will not be too long. I have been looking at the different conferences that are available for NHS trusts to send management to and the different things that the Department of Health run, but is there currently a quick and easy way of spreading best practice from one foundation trust to another?
Professor Appleby: I would say no. Personally, I don’t know. There used to be something called the Modernisation Agency at the Department, which, for all its faults, was also a useful way of diffusing good practice and providing practical help to trusts. One of its main roles was to help organisations get to grips with reducing waiting times. It was not that organisations did not want to do it; it was just that they did not know how to do it. There is a role, not just for negative incentives and penalties and a big stick, but for carrots and for support as well.

Q27 Chair: Before Fiona comes in, I want to make a comment about the penalties thing again, from my own situation. The penalties penalise the institution at the expense of the patients and residents. To me, that does not seem equitable. You are penalising the institution and the only people who suffer, because either it gets into worse trouble or has to go into administration—viz South London—are the local people.

Professor Appleby: It is obviously massively self-defeating if it gets to that point.

Chair: But that is where you are, Chris is right. Dare I say it? Am I allowed to have one minute on my own trust? Ever since I have been around, it has been in deficit. Everyone thinks it is a basket case. I was just saying to Richard—

Mr Bacon: You have been around a long time.

Chair: I have been around a long time. I am on my fifth chief executive there and goodness knows how many chairs there have been.

Q28 Meg Hillier: Sorry, Chair, but it gets worse, because Hackney bailed out one of the West London trusts with money in the surplus that should have been spent on extra preventive work in Hackney, which is a very poor area. We were bailing out somewhere else. It is not just the patients in the hospital that has the deficit who suffer. It was right that the budget had to be balanced, but not at the expense of my patients. I get very angry. I have been very quiet on that, but I am very angry.

Professor Appleby: It is a very tricky situation. The moral hazard issue has to be addressed in some way. We have to make trusts aware that they have to live within their means to be sustainable—obviously they cannot run a deficit for ever. My point is that you have to analyse what the problem is there. It may be that the budgets are wrong, or that there are things beyond the power of the hospital to do anything about, so the solution will lie outside the hospital. It may be that you have to support some hospitals, because the ultimate goal—we started the session with this—is defending services for patients. That may simply be the price we have to pay to do that.

Q29 Fiona Maclaggart: My local hospital, Heatherwood and Wexham Park, has been in this situation and it has not been a basket case for years—indeed, it was allegedly a shining example that lent money to other trusts. However, I am not sure that that was true. One of the things that I am concerned about is genuine transparency and whether it is possible to see what the financial situation of acute trusts actually is. I think that it is very confusing. I would like you to tell me how to interrogate their financial systems more effectively than I believe Monitor did in regard to Heatherwood and Wexham. I would also like your comment on what figure 9 in the report tells you about the financial stability of foundation trusts.

Chair: Very quickly, because we are about to vote.

Professor Appleby: I will quickly say on figure 9 that it is in some ways to be expected. The first wave of foundation trusts were the top-performing organisations, so you would expect them to be doing well. As more trusts have become foundation trusts, we are seeing some of the, not poorly performing but slightly underperforming trusts coming through. I am not surprised by that figure.

Q30 Chair: Do you want to add to that, Sue?

Sue Jacques: I think it also reflects the fact that the environment we are working in is slightly more tricky as well. I would say that it is the combined effect.

Q31 Chair: Is there anything else you want to add?

Professor Appleby: Can I just add very quickly that I think this is a very useful report? The next few years are going to be even trickier for the health service. This sort of report is not just looking at individual organisations in isolation; if we can, we should look at health economies. We have talked here about commissioners and providers, and there is clearly a very strong relationship between those organisations, so it would be useful to try to look at their combined finances and activities.

Sue Jacques: All I would add is that I think those economies have the solution to how to succeed in future, not individual organisations working in isolation.

Chair: Interesting, when we are supposed to have a market.

Marius Gallaher: On a point of procedure, since the Department and Monitor have not been able to respond to some of these very important points, can they write to you in the interim rather than waiting until September?

Chair: No; I do not think anything is going to happen between now and September.

Mr Bacon: We are just adjourning.

Chair: We are just adjourning until September.

Marius Gallaher: It is just that the Department might feel that there were some points that it did not want to lie out there unanswered.

Chair: Order.
Tuesday 18 September 2012

Members present:
Margaret Hodge (Chair)
Mr Richard Bacon
Stephen Barclay
Meg Hillier
Mr Stewart Jackson
Fiona Mactaggart
Ian Swales

Amyas Morse, Comptroller and Auditor General, National Audit Office, Gabrielle Cohen, Assistant Auditor General, NAO, David Moon, Director, NAO and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Securing the future financial stability of the NHS (HC 191)

Examination of Witnesses

Witnesses: Dr David Bennett, Chair and Interim Chief Executive, Monitor, David Flory CBE, Deputy NHS Chief Executive, Department of Health, Sir David Nicholson KCB CBE, NHS Chief Executive, Department of Health and Una O’Brien CB, Permanent Secretary, Department of Health, gave evidence.

Q32 Chair: Good morning. I give my sincere apologies for postponing the previous sitting, when we mucked it all up. We now have to muck it up again, but presumably you are now really on top of the information. Given that we are quite tight on time, the clearer and more succinct your answers and our questions, the more we can get through. I shall start with you, Mr Bennett. We see from the Report that the number of foundation trusts in financial difficulties increased to 11 in March, out of 143. Has the figure gone up since then?

Dr Bennett: No.

Q33 Chair: It is about 11.

Dr Bennett: It is.

Q34 Chair: Would you allow them to go bankrupt?

Dr Bennett: To become insolvent? If there were no way of restructuring the trusts’ operation so that they can recover to a position of financial sustainability under their present arrangements, the final sanction would be to allow them to pass into insolvency and deal with them under special administration.

Q35 Chair: What would happen to services?

Dr Bennett: Throughout, the primary purpose would be to maintain the services. They would be maintained during insolvency as well.

Q36 Chair: Who would pay for it?

Dr Bennett: Under the new arrangements, which will come in next year, there will be a risk pool.

Q37 Chair: So that means less money directly to the trusts, and more money kept centrally.

Dr Bennett: It is an alternative way of doing what is done today.

Q38 Chair: Will a pot be kept centrally by Monitor?

Dr Bennett: We have to work out exactly how we keep it. One of the things of which we are aware is that we must not finish up with multiple pots—effectively double-counting the money.

Q39 Chair: Who will keep a central pot?

Dr Bennett: That is what we need to work out. It needs to be co-ordinated.

Q40 Chair: It is getting a bit late to work this out, isn’t it?

Dr Bennett: There is further work to be done, but the system does not come in until next year.

Q41 Chair: Next April.

Dr Bennett: Probably April.

Q42 Chair: So there are six months left to work out what you do, if a hospital goes bust. Dr Bennett: No. We know basically what we will do. There are six months to work out how we organise the risk pool.

Q43 Chair: So a risk pool will be held, which will be a top slice off a declining amount of money into the trusts.

Dr Bennett: Well, the funding of the risk pool will come from the trusts. Essentially it happens today: it is only making it more transparent.

Q44 Chair: You must have an idea in your brain how much that will be. What percentage of their money will you keep centrally in a case a hospital goes bust?

Dr Bennett: We are still working that out.

Q45 Chair: How much do you keep centrally now?

Presumably, one of your 143 could become bankrupt now?

Dr Bennett: Under the current circumstances, if a foundation trust becomes insolvent, we have to de-authorise it and pass it back to the Department, and then they fund it.
Q46 Chair: Okay. You are reviewing all the trusts that are spending over £200 million for their financial sustainability. Can you tell us where you have got on that review?

Dr Bennett: Every year, we ask the trusts to produce a forward three-year plan of their outlook. We are just now reviewing those plans. They come in, in the summer. We have identified 13 trusts about which we have questions or concerns about their plans, and we will now be sending specialist teams to look at those trusts.1

Q47 Chair: 13?

Dr Bennett: Yes.

Q48 Chair: This is a different 13 to the 11, which are in significant breach of their terms of authorisation.

Dr Bennett: That is right. We have 11 trusts currently in difficulty. We have identified 13 where we see risks. This is about digging more deeply to understand the nature of those risks. Last time we did this, 70% of the trusts that became those 11 that were in difficulty we had identified at the equivalent stage a year ago.

Q49 Chair: So that is 24 out of 143.

Dr Bennett: No. Only if all 13 were found to be in trouble. I think that won’t be true.

Q50 Chair: How many—it is a difficult question to ask. A lot of one-off money that still goes into the system—lotting it up, about £1 billion a year in one way or another—goes to rescue hospitals that would otherwise go into deficit across the piece. If you look at the ones that are about £1 million in surplus, there is a lot in there. How many of those that have got foundation trust status would be in deficit if they did not get these one-off payments? I don’t know if you want me to go through what they were, but they are in the Report. On direct financial support, the PCTs get £89 million. There is something else where they get £274 million non-recurrent costs. I don’t know what that is. They get public dividend capital and other moneys. It is about £1 billion. How many of your—we are still at 143?

Dr Bennett: We are at 144 today.

Q51 Chair: How many of your 144 would be in deficit if they had not had one-off rescue funding from the Department?

Dr Bennett: There are 21 trusts in deficit. The rescue funding from the Department does not change the number in deficit. Four trusts last year received rescue funding from the Department, but they are among those 21 that were in deficit. There is a question as to whether more trusts would be in deficit if there were not some of the one-off payments—not from the Department, but from either the SHAs or more commonly from the PCTs. The problem with that question is that there is no information collected as to why these one-off payments are made. A lot of it—maybe all of it—is entirely legitimate. So, for example, if there is an agreement between a trust and the commissioner that if the level of activity that the trust is asked to undertake is greater than that written into the contract, then the commissioners will pay for the extra activity. It is perfectly legitimate. It is agreed up front, but that appears as part of the one-off payments. Taking it away and saying there is a deficit would not be legitimate.

Similarly, there are often agreements between commissioners and trusts that they will do things to improve the services, and the commissioners will to some degree fund those improvements. Again, those entirely legitimate payments appear in that number. We cannot tell to what extent any of those payments are in a sense illegitimate. Indeed, if you took the payments away, the trusts might just stop doing things, so the costs would go down as well.

Q52 Chair: I understand that. We hope that all the money that goes to trusts is legitimate and is payment for work done. As we move forward with the £20 billion cuts that you are going to have to find—possibly more in the next spending review—the flexibility to add in money mid-year, whether for extra activity or to support a change in a particular trust, will diminish, won’t it? You must have some feel, were none of that there, as to how many more of your foundation trusts would be in deficit. It is 21 at present. If you took away all that extra money that they get—of course, legitimately—how many would then fall into deficit?

Dr Bennett: We have no evidence that there would be more in deficit. As I say, they are legitimate payments that have to be made in some way.

Q53 Chair: I understand that. If I take one example of the explanation you give, there will not be more money to fund more activity. I keep saying that to my wonderful local trust. They say get more income rather than deliver more cuts. There will not be more money to fund more activity. While it is a way in which they fund increases now, it will not happen in future. Were the money not there, what would that do to the financial viability of the foundation trusts?

Dr Bennett: If there is a need to reduce the level of activity, because there isn’t the money to fund further activity, the commissioners have to take action to reduce the number of referrals and other reasons for activity in the trust. That is what they need to plan to do.

Q54 Chair: Trusts would go into deficit, as their costs would outweigh their income. You must have in your analysis of the 144 foundation trusts which ones depended on that extra money in 2011–12 to maintain financial viability.

Dr Bennett: Sixteen trusts report that they expect to be in deficit this year. That is the expectation of the trusts.

Q55 Chair: That doesn’t really answer the question, does it?

1 Note by witness: In David Bennett’s response to Questions 46; 47; 48; 49; 109; 111 and 114 he makes reference to 13 Foundation Trusts where Monitor has ‘questions or concerns about their plans, and we will be sending in specialist teams to look at those trusts.’ For clarity, of those 13 Foundation Trusts, we have concerns about financial plans in 10 of them. The other three we are reviewing because of concerns around quality governance.
Dr Bennett: Sorry, so—

Q56 Chair: If they had not got the extra money mid-year, however legitimate that money was, how many would have been in financial difficulties? They depended on that income to balance their books.

Dr Bennett: We have not looked specifically at that.

Q57 Chair: One final question on foundation trusts: how many would not have achieved trust status out of your 144 today, given the state of their finances?

Dr Bennett: Given the current state of their finances: 11.

Q58 Chair: The Report says between 40 and 50.

Dr Bennett: That is answering a different question, I think.

Q59 Chair: If you looked at them today and they did not have foundation trust status, and you had to examine them and give that status, my understanding from the Report is that about a third would not achieve it.

Dr Bennett: I think that is looking at the EBITDA margin.

Q60 Chair: What?

Dr Bennett: The EBITDA margin—a measure of profitability—of the trusts. That number does not meet that margin target, but our overall financial assessment does not look only at that. Our overall financial assessment—our financial risk rating—says that there are 11 trusts that would not meet our criteria today.

Q61 Fiona Mactaggart: Are you confident that no trust achieved foundation trust status by enhancing its balance sheets in inappropriate ways?

Dr Bennett: When we look at a trust to determine whether it is ready to be authorised as a foundation trust, among other things we have an outside accountancy firm review the trust’s financials. We ourselves, of course, look at the trust. It will also have been examined by the Department and the strategic health authority before that.

If you are asking whether it is possible, despite all of that examination, that a trust determined to hide the figures might successfully do so, I cannot guarantee that that would not happen. We spend collectively about £250,000 per trust assessed for foundation trust status. We could spend more and be even more certain that they are not hiding things from us. We obviously have to strike a balance in doing due diligence because that is money that would otherwise be spent on patient care. We do have outside firms to do it; we could do it even more thoroughly. I cannot guarantee that it might not happen.

Q62 Fiona Mactaggart: I think it happened in the case of Heatherwood and Wexham Park.

Dr Bennett: It is certainly true that Heatherwood and Wexham Park was one of four trusts out of the 144 that got into difficulty within a year and a half of being authorised. We did not put it into significant breach until two years, but the problems were evident after about a year and a half. That happened before I joined Monitor, but I have asked the question: can we tell to what extent that shows that they had in some sense pulled the wool over our eyes during assessment? Or was it that circumstances had changed? Without spending substantial amounts of additional money on forensic analysis, it is difficult to tell which is the case. I would be more focused on sorting out the problems as they are.2

Q63 Mr Bacon: When you said £250,000, that was the figure that you spend as the Department or rather as Monitor on the assessment of the fitness to take on foundation status. Is that right?

Dr Bennett: Collectively, yes.

Q64 Mr Bacon: Per trust.

Dr Bennett: Yes.

Q65 Mr Bacon: What does that get you? It does not sound a huge amount to me in terms of due diligence. When M&A happens, people go in and spend millions on forensic accountants. What does a quarter of a million get you? When Goldman Sachs fiddled the figures for Greece so that it could get into the euro zone they were paid $300 million and they pulled the wool over lots of people’s eyes. It is true that they were people who wanted to have the wool pulled over their eyes. I am not saying that you were in that position of wanting to be misled. Perhaps you were, I don’t know. A quarter of a million does not sound a lot to me. What do you get for that?

Dr Bennett: It is certainly less than you would pay in the commercial world. Of course we do not pay our people quite as much as the Goldman Sachs bankers get paid. So we get rather more than they would for a quarter of a million but, as I say, it is about striking a balance between costs—

Q66 Mr Bacon: I understand. You said that before.

In terms of man days or woman days of effort, describe for me the totality of the enterprise that is involved in assessing whether a body is fit to be a foundation trust. How much time is involved in terms of hours or weeks of effort?

Dr Bennett: At our end we will have a team of three or four people working close to full time for around three months, interrogating the trust and looking at its performance. On top of that, as I say, we will have a due diligence exercise done by an outside firm of accountants.

Q67 Mr Bacon: Which type of outside firm? Are you talking about forensic accountants or a consulting firm like McKinsey?

Dr Bennett: No, the likes of PWC, KPMG and so on.

Q68 Mr Bacon: Accountants.

Dr Bennett: Absolutely.

2 Note by witness: For clarity, three foundation trusts have been found in significant breach of their terms of authorisation for financial reasons within 18 months of being authorised as foundation trusts. However, although there was evidence of financial difficulty at Heatherwood and Wexham Park within 18 months of authorisation, they were found to be in significant breach of their terms of authorisation two years after being authorised as an NHS foundation trust.
Q69 Mr Bacon: The people who normally do forensic auditing?
Dr Bennett: Exactly.

Q70 Mr Bacon: And that is the job they are being asked to do?
Dr Bennett: Yes.

Q71 Mr Bacon: Forensic auditing?
Dr Bennett: Well, it is a due diligence exercise, but it is a more limited due diligence exercise—I fully accept—that you would do, for example, if you were IPOing a private sector company.

Q72 Mr Bacon: Yet the consequences if you get it wrong are calamitous, huge, and expensive?
Dr Bennett: The consequences if we get the review of the quality of the trust wrong can be serious. The assessment of an applicant for foundation trust status is a very good opportunity, among other things, to look at the quality of care. Getting that wrong is a problem and we clearly got it wrong in the case of Mid Staffs.

Q73 Mr Bacon: The Ministry of Defence, as you know, has had problems with procurement for many decades. One of the recommendations of this Committee and of the NAO in the past was that it should spend more up front in determining what it was trying to do in the assessment phase and, as Sir John Bourn once put it, employ more contraception and less infanticide of procurement programmes. I don’t know the average turnover of a trust. Do you happen to know what the average turnover of a foundation trust is? I know that nine years ago it was over £200 million.
Dr Bennett: I think the average is around £300 million.

Q74 Mr Bacon: Yes, I was going to say, it has probably gone up. That is per year, isn’t it?
Dr Bennett: Absolutely.

Q75 Mr Bacon: So in a three-year period you are talking about nigh on a billion quid and you are spending a quarter of a million up front to check whether it is okay. You said it was a question of balance. It sounds to me like you haven’t got the balance right.
Dr Bennett: It is not the only time that anyone looks at the financial performance of trusts. Before they become foundation trusts they are under the management of the strategic health authority and the central NHS—going forward it will be the NHS Trust Development Authority. So they are continuously monitoring the performance of these trusts.
Chair: Once they become foundation trusts, they are much more difficult to control. That is the point.

Q76 Meg Hillier: Obviously Monitor is the financial monitor but—I throw this at Sir David—what are the consequences for patients of a trust failing? You can prune back costs, but that means stopping doing things, subject to overhead issues. Where does the NHS as a whole step in, even though they are independent trusts, because you can pass them back?
Sir David Nicholson: If you talk about the foundation trust regime as it will go into the future, where a foundation trust gets into problems and Monitor regards it as being in its regime, first it will say to us—the commissioning side of the organisation—“What are those services that need protecting as a priority?” We will set out what we think should be protected.

Q77 Meg Hillier: So they will come to you centrally, not to the locally commissioning groups?
Sir David Nicholson: Sorry, they will go to the local commissioning groups and say, “What are the services that need protecting? What are those services that nobody else can provide for those organisations?” We will set out what we think they are—sorry, the local commissioners will set out what they think they are. Monitor’s responsibility then is to put forward a set of plans and arrangements to ensure that those services are protected. That, in a sense, is why you might need the resources to help and support it. In restructuring that organisation, they then have to protect those services.

Q78 Meg Hillier: Okay. That brings me on to some other points that I want to pick up on, but the consequence for taxpayers of that, Dr Bennett, is that, if you do your job properly, services are pruned, books are balanced again and all is hunky-dory in a financial sense. Is that too simplistic a summary?
Dr Bennett: It is wrong to say that services are pruned to get the books to balance. The starting point is what services you need for that local community. The question then is how you can provide them on a financially sustainable basis. You do not just cut services. That is not the way to solve these problems.

Q79 Chair: But take South London. Where are we there? That is your first example, isn’t it?
Sir David Nicholson: That is an NHS trust, not a foundation trust, and we are taking it through the process that we have. I am sure that David will take you through it.

Q80 Chair: So where are we?
David Flory: The stage of the process now is that at the end of October the trust special administrator will produce a draft report for a subsequent period of consultation.

Q81 Chair: My understanding is that he has been offering the buildings to anyone who will have them.
David Flory: No, there has certainly been a process whereby he as an administrator has invited any organisation currently providing NHS services in England to come forward—

Q82 Chair: He has been offering the buildings to anyone who will have them.
David Flory: He has not been offering the buildings for sale; he has been asking people to put forward their proposals on how they would run some or all of the services.
Q88 Chair: You: said, though, Mr Flory, in your earlier answer, that there may be a different pattern of services. You actually said that; so it is not just about a different trust or different organisation running it. It is different. So Meg Hillier is trying to tease out from you whether that means that some services will not be provided there.

David Flory: It means that it is likely, I think, that the full range of services that are currently provided on all those sites—there will be some change in that.

Q89 Chair: There will not be the full range of services there currently are?

David Flory: They will be provided, but not necessarily on the same sites as they are provided at now.

Q90 Chair: You can’t have it both ways. Either they will be provided on all the sites or they won’t.

David Flory: They will be provided, but not necessarily on the same sites as they are provided at now.

Q91 Meg Hillier: And it will be down to the commissioners to decide that. So how many clinical commissioning groups cover the South London trust? How many would commission services from that trust? Could you perhaps do us a note on that? That drives me very big change to the service. Are you saying that that could happen, or that it couldn’t happen?

David Flory: Accessibility to services and local accessibility to the full range of services is a really important criterion.

Q87 Meg Hillier: What is your definition of accessible—or do the commissioners decide that? You could argue that we have a great transport system in London; you can now get from Croydon to Hackney very quickly on the East London line. I should think there might be some people in parts of London thinking, “We’ll bid for that.” That could be good transport links, but maybe for Mrs Jones it might not be.

David Flory: As you say, it is commissioners’ responsibility to secure a range of services.

Q84 Chair: So it is not a commissioner-led process. The administrator will decide how to carve up the existing services to other providers. It is nothing to do with the commissioners.

David Flory: It is a lot to do with the commissioners. Through the process of consultation and of formulating the options on which he will consult, there is ongoing day-to-day discussion with the commissioners. The commissioners will be involved in that process and will contribute through consultation before the final report is produced by the administrator and delivered to the Secretary of State early in the new calendar year.

Q85 Chair: What difference will all this make to the people in that area of south London who are currently served by that trust?

David Flory: The difference that it will make is that they will have confidence in the organisational arrangements that underpin the services. The existing arrangements are not sustainable. The trust is losing money and our view in triggering the unsustainable provider regime was that the trust was not capable of recovering the financial overspend and balancing its books at the same time as delivering the necessary services across south London. Therefore, the difference will be that different organisational forms will be providing services. There may be a change to the range of services at some sites and there will be changes to some of the organisational arrangements so that we and people in south London can be confident that they are sustainable and capable of providing the services they need into the future, because the current organisational arrangement is not.

Q86 Meg Hillier: Being sustainable is obviously important from our point of view. As the Public Accounts Committee, we look for value for money. However, if I am Mrs Jones in south London and I need a specialist service in south London—let’s say specialist footwear, or something, that is quite specific and very narrow—it could be that, from the administrator’s point of view, that is just not viable, and it might be much more effective to have those services all based, for argument’s sake, at Finsbury health centre, or at the Homerton hospital; somewhere the other side of the river. Financially and sustainably, that would absolutely be fine, but for Mrs Jones in south London, who is elderly, that is going to be a very big change to the service. Are you saying that that could happen, or that it couldn’t happen?

David Flory: Accessibility to services and local accessibility to the full range of services is a really important criterion.

Q92 Meg Hillier: Well, would it be the whole of south London commissioning from that trust? Could you perhaps do us a note on that? That drives me on; perhaps, Chair, I can go into issues about future commissioning arrangements. At a guesstimate it would be more than 10 commissioning groups, potentially.

Sir David Nicholson: Between eight and 10, I think.

Q93 Meg Hillier: One per borough; two per borough, roughly speaking. So you have got sometimes quite small commissioning groups, making sometimes very

3 Note by witness: We can now confirm there are 12.
localised decisions. So what might be an issue in Hackney might not be an issue in Kensington, for a health group, for example. How are you going to mediate between different commissioners saying, “We think this is important,” and others saying, “We think this is important”? Some of them may be prey to particularly loud lobbying groups. If you are the GP actually delivering the service and you’re part of the commissioning group, the pressure from a patient sitting in front of you is going to be quite challenging. How do you make that judgment? Is it a financial judgment? Is it a patient care judgment? Sir David, is that where you come in? I am confused now. If I had a problem where would we go to pursue that? There is a list of questions there.

Sir David Nicholson: I don’t know whether you are talking about when we implement the unsustainable provider system, or generally, when we are commissioning services.

Q94 Meg Hillier: Particularly focusing on the unsustainable provider; when a trust is going bust.

Sir David Nicholson: The final decision on the unsustainable provider proposals is made by the Secretary of State. It is not made locally. It is made by the Secretary of State. So the trust special administrator writes a report, sets out how he or she thinks the services should be configured, taking into account the views of commissioners, local providers and the alternatives that he has been offered. He makes a proposal to the Secretary of State, and the Secretary of State makes the decision.

Q95 Meg Hillier: So how transparent is that? Who would know along the way?

Sir David Nicholson: The trust special administrator writes a report, which is transparent, because it is published, and it goes to the Secretary of State.

Q96 Meg Hillier: So it’s published only privately; do MPs get to know—councillors, the local population?

Sir David Nicholson: First, we’ve not done this before, so I assume it will be on the website and we will send it to everybody. Taking the point you’ve made, we will make sure it is widely available to people—both the public in the locality and the providers, and the MPs and local authorities. The Secretary of State then has a short amount of time—is it two weeks?

David Flory: About a month.

Sir David Nicholson: The Secretary of State receives that. Everyone sees it. The Secretary of State has about a month to decide whether he or she accepts the whole of the report, some of it or needs to go back for the some of the rest of it. It is essentially a Secretary of State decision.

Q97 Meg Hillier: It is a very short time, so if I, as a local MP, or Mrs Jones had a problem with it, they would have a very short time to get that argument in and presumably send it to the Secretary of State.

Sir David Nicholson: The special administrator does his report in October.

David Flory: There is a few weeks’ consultation. In this case, the report is published on 29 October, I think. There is then a period of consultation before the report is finalised.

Q98 Chair: The Secretary of State has no money, Sir David, so how can he say that they must have a cataract clinic here? The money has gone out to you in your new role, and it sits in foundation trusts. It does not sit with the Secretary of State. He has no money. Una cannot advise him because he has no money.

Sir David Nicholson: I am sure that they will always have a bit of money.

Q99 Fiona Mactaggart: Is it the same bit of money?

Sir David Nicholson: If the Secretary of State makes a decision about the configuration of particular services, it is our collective responsibility to ensure—

Q100 Chair: Come off it, either you centralise or you localise.

Sir David Nicholson: We have had this conversation so many times.

Q101 Chair: It is a serious issue. If the Secretary of State decides that there will be a maternity service here or a cataract clinic there, under the current system unless he directs you, which he can’t, or directs David Bennett, which he can’t, there is no way of ensuring that it happens.

Sir David Nicholson: You are absolutely right. From 1 April, he can’t direct us. Of course, this will be done before 1 April.

Q102 Fiona Mactaggart: It is the first trial of the system and, looking at these figures, I am expecting more after 1 April. You might not be, I am.

Sir David Nicholson: This is just an NHS trust. It is not a foundation trust. If the organisation were configured in that way, it seems incumbent on the system to respond and support the service configuration that has just been described.

Q103 Meg Hillier: Can I pick up on the issue of the taxpayer? Just to finish on the accountability front, that decision is made but, of course, the Secretary of State may have no knowledge of that area and Mrs Jones’s particular problem, so it is incumbent on local people to be very on top of this. If you went round this table, some of us will have had more contact with the NHS than others but, sometimes, people go for years without contact and the next time they turn up to use the service, they will suddenly find that it has gone. They will not have realised that the consultation has gone on. They will not have tuned into it. That consultation period seems to be quite short. I appreciate that there is a financial issue. I just flag that up as a worry. The taxpayer has to bear it, but other foundation trusts will be putting into the risk pot, such as the Homerton in Hackney, which has always been balanced and very good. I want to make one little plea for Hackney, which has bailed out West London health trust, which has overspent over the years. It has never got anything back for that. It just keeps bailing out. Rather than putting the risk on individuals, it is shared but to the detriment of some,
not others. What will be the consequence for the taxpayer and for other trusts? Maybe David Bennett can pick up on the other trusts, and Sir David on the taxpayer. You are going with a begging bowl to the Secretary of State who, as the Chair points out, has no money.

Sir David Nicholson: At the moment, it is relatively straightforward because all the money is in one pot, and we can organise how we do it from that. In the new world, it is different. It is important that we all work together to ensure that we don’t all get to a place where I lop half a billion off the commissioning budget so that I can manage my risk, while David has a huge risk pool of money that he needs to do his, and Una holds some money back at the Department. Suddenly, before you know it, you have £2 billion or whatever away, and you end up forcing organisations into failure. You can absolutely see how that could happen.

We are working now under the leadership of the Department to work out a way in which we can minimise that, so that we can hold things jointly or at least identify across the whole system how much we can keep. I will keep an amount, David will keep an amount, and we will make sure that that is not the debilitating amount that it could easily be if we all went off on our own to do it.

Q104 Fiona Mactaggart: That is already happening to some extent in the present regime with strategic health authorities holding money, and money not being on the front line. How much are they holding that is not going to the front line—when they are about to be abolished—ish?

David Flory: The accounts for March 2012 show that the surplus in strategic health authorities across the country was just over £1 billion.

Q105 Fiona Mactaggart: So half of the £2 billion that you cited?

David Flory: That amount has built up cumulatively since 2006–07 and on average it has been—across SHA and PCTs—in the order of £300 million a year. On £90 billion of resource, it was a very small amount that was underspent each year, but it has cumulatively built up. When you break down the £1 billion that was in SHA accounts at the end of last year, because of the ways of working and the financing arrangements that work between SHAs and PCTs, over half of the £1 billion is in fact PCT money that is lodged with SHAs and will return to PCTs before those statutory bodies are closed down.

About £120 million of it is money that they carry forward for programmes that they host on behalf of the NHS across the country, so that expenditure will be incurred, but later than was originally intended. That leaves a core underspend in strategic health authorities across England of £400 million at the end of March 2012.

Q106 Chair: Well, it is returned; it is not spent. It is put back into other people’s budgets; that does not mean it is spent. And £1 billion is sitting around when, as we all know, waiting lists are growing and services are being cut.

Q107 Fiona Mactaggart: The point I was trying to make was that this is already in a system that is more centralised, and the risk of its happening in a more decentralised system is greater.

Sir David Nicholson: Yes. That is true. That is why it is important that we have a proper arrangement and set of agreements across the people at this table to ensure it does not get bigger.

Q108 Ian Swales: May I return to the question of PFI? How many of the 11 in difficulties have got significant PFI arrangements?

Dr Bennett: Of the foundation trusts, one.

Q109 Ian Swales: Just one. And of the 13 at risk?

Dr Bennett: There is only one where the PFI is the source of concern.

Q110 Ian Swales: But others have PFI arrangements?

Dr Bennett: They may have. Because they are not the source of concern, I have not actually looked at that number.

Q111 Mr Jackson: What do you mean by source of concern? Do you mean the primary reason why they are in financial difficulty?

Dr Bennett: Of the 11, there is one where the PFI is at the heart of the financial difficulty. Of the 13 that we are examining more closely to see whether there are underlying problems, there is one more where the underlying problem—if there is one; I am pretty sure there is—is driven by—

Q112 Chair: Which is the one?

Dr Bennett: The additional one is Sherwood Forest.

Q113 Chair: And the other one?

Dr Bennett: Peterborough.

Q114 Ian Swales: I think you are painting a soft picture there. The Report talks about 51% of trusts being concerned about PFI obligations, and the Report also says “The Department announced in February 2012 that it would make a total of £1.5 billion available to six NHS trusts and one NHS foundation trust”, so that is seven trusts getting £1.5 billion. Are those seven included in either the 11 or the 13? Or are you now saying they are not a problem?

Dr Bennett: I am only answering for foundation trusts. The 11 trusts in difficulty are all foundation trusts. One of them is in difficulty because of PFI—that’s Peterborough. Of the 13 we are looking at to see if there are problems there, those are only foundation trusts, and one has a PFI in Sherwood Forest.

Sir David Nicholson: The rest of them are NHS trusts.

Q115 Ian Swales: Right near the start, you talked about the process of insolvency and administration. Can we talk about the freedoms that the administrator has in a financial sense? We have heard about some of his requirements on future care, but what freedoms does he have in a financial sense? In the commercial
world, the administrator would have a lot of freedom about how to arrange things: who to; creditors that were not going to get paid; and what proportion you would pay to providers of loan capital and all the rest of it. What freedoms would the administrator have in the context of a foundation trust and an NHS trust?

**Dr Bennett:** I suspect that they are very similar, but certainly in the case of foundation trusts—at the heart of it, this is why it is a special administration. In a commercial administration, the fundamental objective of the administrator is to secure as much money for the creditors as possible. That is not the fundamental objective of special administrators. The fundamental objective of special administration is to secure the continued provision of essential services for the local community, but to make sure that that is done in a financially sustainable way into the future. In principle, given that objective, they can look at all possible options. I did not get a chance to answer your question about what sort of things they would do to protect the services. Some of it might be about changing who delivers those services and where. So, for example, we are increasingly seeing the possibility of moving services out of acute hospitals into the community, which in general should be an improvement for patients but can also reduce costs. So that is one example of the way in which services might be changed.

Q116 Ian Swales: My question is more specific. If a trust goes bankrupt, it will have a balance sheet where it owes people money for services or PFI commitments, loans or whatever. Does the administrator have the power not to pay any of that money?

**Dr Bennett:** I believe the legislation was settled in a such way that the Government stand behind all the creditors.

Q117 Ian Swales: That is an important point. So the Government stand behind all creditors, including PFI?

**Dr Bennett:** All PFIs have a deed of safeguard written by the Treasury. So the Treasury, at the point at which the PFI is signed, agrees to stand behind the payments.

Q118 Ian Swales: So no PFI provider is exposed to the risk of a particular trust then? Is that right?

**Dr Bennett:** I think that is right.

Q119 Chair: And is the Government you or the Treasury? Who is the Government? Again, the Secretary of State has no money.

**Una O’Brien:** I think it is the Department acting on behalf of the Treasury.

Q120 Chair: But you have no money.

**Una O’Brien:** The Department of Health receives the money from Parliament and then disperses the money to the different parts of the system.

Q121 Ian Swales: So the core of my question is this: if a trust is in trouble, there is no financial pressure that can be applied to the provider of PFI to that trust because ultimately the Government are standing behind it? So there is no possibility of renegotiating or looking again at the PFI arrangements in a particular trust? Is that right?

**Dr Bennett:** Well, you may be able to renegotiate. This is not specific to the health sector. This is true of PFIs across the whole of the public sector. You may be able to find a way of renegotiating but you have given the upper hand to the PFI investor because you have given them a deed of safeguard. They can say, “Do what you like. We’ll get the money off the Treasury in due course.”

Q122 Chair: Ian, I am sorry to interrupt you but I am quite obsessed with who actually pays. So the Department pays. You keep telling us that you are going to do it efficiently. Inevitably, in this set-up in a declining budget, you will have to hold money back to meet these sorts of bills at the expense of front-line patient care. You must. Either you will, David, or you will, Una, or you will, the other David. Somebody is going to hold money back. Yes, you are nodding.

**Dr Bennett:** Yes, clearly. But that is on an annual basis. If it is not spent because you did not have the PFI failures you thought you might have, it can be spent on front-line services.

Q123 Chair: But you have to hold back because the Treasury is not going to give the Department of Health extra money in the current climate.

Q124 Ian Swales: So to be specific, the £1.5 billion that has been promised to help these trusts achieve the assessment criteria for foundation status, that has simply come out of the NHS budgets?

**David Flory:** Yes it does. And that is over the lifetime of the PFI contracts on those six. It equates at the moment to about £60 million a year.

Q125 Stephen Barclay: Just to clarify from Ian’s question, the deed of safeguard is underwritten by the Department, not the Treasury? It would not come from Treasury reserves. It would come from the Department of Health?

Q126 Chair: Una, did you want to say something?

**Una O’Brien:** I wanted to address your point. You have asked me on a number of occasions how we are going to organise risks centrally between us. It was not quite an answer to Mr Barclay’s question. I did not want to cut across you.

Q127 Stephen Barclay: Just to clarify again, across all the different types of trusts, how many have a significant PFI element and are also at financial risk within the NHS as a whole? I am not taking foundation trusts as a separate category.

**David Flory:** We will need to answer that separately. The Department did a piece of work just on NHS trusts. It was the work that determined that six trusts would become eligible, subject to meeting certain criteria, for the PFI payment each year of £1.5 billion in total over the life of the contracts.

Q128 Stephen Barclay: Mr Flory, you are missing my point. We have established that, if a trust with a significant PFI element is likely to go insolvent, the...
liability of that sits with the Department. You can only exert voluntary pressure on the PFI. Indeed, I would be quite interested to come on to the Treasury pilots that we were told about more than a year ago, as we were about what lessons there are on the pilot. I am interested in the totality of the risk for the Department from those trusts with significant PFI that are already known to be financially vulnerable, regardless of whether it is a foundation trust or an NHS trust. What sort of figure?

**David Flory:** In the NHS trusts that finished in deficit last year, the two biggest deficits were South London, which we have talked about now as in the unsustainable provider regime and the Barking, Havering and Redbridge trust. Both trusts have significant PFI costs and are on the list of six trusts to which we have referred.

Q129 Stephen Barclay: You could give us those two as a flavour. What is the figure for those two?

**David Flory:** In terms of their potential deficit?

Q130 Stephen Barclay: The potential liability that could come to you. You must have a working assumption. My local one, Peterborough, has a PFI. In its projections for the financial year 16–17, its base plan deficit is forecast at £51.8 million. If the figures are there for Peterborough, I am sure that they are for other hospitals. We are establishing that you ultimately pick up the liability as a Department. I am trying to get a sense of the quantum of the amount.

**David Flory:** We will pick up the liability of the PFI costs, if that service were no longer being provided.

Q131 Stephen Barclay: How we got around it in the past was that when a trust like Peterborough got into trouble, some hard negotiating went on locally with the PCT. The report says on page 11, paragraph 25 that it is not clear whether clinical commissioning groups would be willing to provide financial support because they will have more flexibility. In my case, they may say that they will not prop up Peterborough, but they will give the money to Addenbrooke’s or Hitchingbrooke instead. In other words, you will not have the levers that you had previously so, ultimately, the liability is coming to you. I am trying to establish what sort of risk that is, because you will not have much flexibility on that if it crystallises.

**David Flory:** If liability on the PFIs materialises and the trust very closely and regularly to ascertain whether the position is recoverable, and whether the trust can get to a situation in which it can provide the right quality services with an underpinning sustainable financial model.

Q132 Ian Swales: Going on from that, we are hearing that ultimately the Department picks up the liability. The way in which that is partly being covered at the moment is shown at figure 15 as the public dividend capital, which is the device whereby effectively the Department is loaning money to trusts in trouble. If we look at the size of the numbers for the top three or four, are we kidding ourselves? The Government are expecting that money to be repaid with interest from those trusts. Do you actually believe it will be repaid from those trusts, or is this simply going to keep on happening? The loan figure will get higher and higher, and there will be no real prospect of repayment.

**David Flory:** On Peterborough?

Q133 Ian Swales: Peterborough is one of the big ones. Barking is one of the big ones and, not surprisingly, South London. There is public dividend capital there.

**David Flory:** The public dividend capital is provided for those. If I talk about South London and Barking, Havering and Redbridge trusts, the cash that they require to maintain services, to pay the wages and so on is provided through PDC rather than a loan, because we see no prospect in the short term of their being able to repay that money, so effectively we are putting taxpayer equity into the organisations. Those trusts have to pay a dividend—3.5% a year—as the cost of having that equity, but we have no prospect and no assumption that the money will be repaid in the short term.

Q134 Ian Swales: So how is that shown in the accounts of the NHS?

**David Flory:** It is shown in the trust account as taxpayer equity, in the same way as in a commercial enterprise it would be share capital.

**Chair:** It is not equity; it is a one-off subsidy.

Q135 Mr Bacon: It makes it sound like you have been increasing the equity, or the taxpayer has, until the taxpayer owns the whole hospital. The only thing is, we all thought we owned it already.

**David Flory:** That is why, with South London, in the decision to trigger the unsustainable provider regime, we got to the point where we just did not see the possibility of its being recovered.

Q136 Chair: And Barking, Havering and Redbridge?

**David Flory:** BHRT. The financial problem is a very serious one. It is not going to be solved in the next year or two. But we have continued to work with the trust very closely and regularly to ascertain whether that position is recoverable, and whether the trust can get to a situation in which it can provide the right quality services with an underpinning sustainable financial model.

Q137 Fiona Mactaggart: But this dividend capital is also given to foundation trusts. Do we end up owning a share of them?

**David Flory:** Yes.

**Dr Bennett:** You already do. They are still public assets, even though they are called foundation trusts.

Q138 Chair: It’s all a stupid name. It is a subsidy. It is a taxpayer subsidy, because they are not balancing their books. Calling it capital and equity—

Q139 Mr Bacon: Did some consultant or banker give you the idea to give it this posh name?
David Flory: I responded to the question of how it is accounted for. That is the way in which it is accounted for.

Q140 Mr Jackson: I am going to resist the temptation to talk about Peterborough, because there will be a separate Report on Peterborough, and I think there may even be a separate hearing. The NAO wants to produce a Report. This Report has the word “sustainability” in it. I don’t see any evidence that there is any sustainability. We are not just about value for money; we are also about learning lessons. What worries me, particularly on foundation trusts, is that during that period between 2007–10, when Lord Darzi was beginning to articulate the view that the age of the acute district hospital was coming to an end, the Government were still pressing ahead with creating foundation trusts, and although you had lots of accountants going in and looking at the detailed figures, you had no one stepping back and looking at the demography, the social background and the clinical needs in that area.

In other words, there is an endemic problem of institutional conflict between commissioners who do not want to commission services—frankly, sub-standard services, as they see it—at their local hospital and who want to go elsewhere and build an acute hospital and make it a foundation trust that expects to Hoover up all the clinical commissioning work. That has never really been properly addressed. While that is not properly addressed, surely you are not going to solve this issue. I come from the point of view of Cambridgeshire. In the Peterborough area, we have a problem with the viability of Peterborough itself. We have Hinchingbrooke down the road. We have Addenbrooke’s, which is a world famous university teaching hospital. We have lots of other good hospitals around: Boston Pilgrim, Leicester Royal Infirmary, Kettering and so on. I am worried that no one in Monitor, the Department of Health, or the strategic health authorities was stepping back and saying, “There is going to be a problem here. There are not enough bums on seats to make this hospital viable.”

On top of that, you have PFI and other massive endemic issues, such as huge immigration, presentations at A and E, and so on. So, have you learnt the lesson of looking at the health economy culture in that area? That is the first point. Secondly, what do you expect of the hit squad? A hit squad has gone into Peterborough and six other trusts recently that are at risk or are in deficit as a result of PFI. What are they going to do, Dr Bennett? They are clearly not going to make big decisions on behalf of the Treasury with regard to the contract. What will they do for sustainability for Peterborough and other PFI foundation trusts?

Una O’Brien: May I comment on your first point, Mr Jackson? I think you have absolutely gone for the jugular there. That is fundamentally the issue that we are facing with the restructuring of an industry, because while all the things that you have described are happening, it is also becoming possible to provide care in different ways. People’s expectations are rising and they want more and better care closer to home. That is something that every health care system in the developed Western world is facing: how do you restructure an industry with the legacy that you have got? In the reformed system, one crucial element that is stronger—and should support addressing the problems you have described—is giving more responsibility to people in the locality to address the ambitions and aspirations of the public for services in that area, given the inheritance, because it is made up differently in each area.

Q141 Mr Jackson: But that does not work, because people in Peterborough in 2007 said, “We want a shiny, £300 million hospital. It looks great. Oh, the finances will sort themselves. Someone will pay for it.” Let’s sign the PFI contract.” It was a completely shambolic disaster, so you cannot just leave it to people. You need someone centrally or a strategic health authority to say, “Listen. This does not make sense. There are not enough patients. There are too many clinicians, or too many wards, and we are doing too many things.” I am afraid that it leads to two things: you close national health service facilities or move them, or you hand them over to the private sector, like Hinchingbrooke. Both options aren’t particularly edifying, but do you not agree that that is the case? My point is that you cannot just leave it to local people, because they are always going to pick the tastiest fruit from the basket.

Una O’Brien: But equally, we know that trying to control things like that from the centre simply does not work. I invite David to comment more thoroughly on the role of the Commissioning Board and its relationship with CCGs in bringing together the participants in a system to address the issues that they face. I think that the role of local authorities will be significant in bringing all the parties together. Of course, many different views and perspectives need to be dealt with, but trying to address them from an office in Whitehall simply does not work.

Q142 Stephen Barclay: But what Whitehall could do is put the comparative data out there to better inform debate. I don’t know if you want to comment on Nick Seddon’s article in The Times yesterday about greater transparency and what we have learnt from heart surgery comparative data. Why is that not being done more widely? Stewart is absolutely right. I would like to see more specialist work done in bigger centres and more cottage hospitals locally. Of course—politicians will lead this—the local MP will always be out there campaigning for their local hospital, because that is what their local population tends to want. It is very hard without the comparative data to shape that debate and say, “Yes, you have the convenience of a nearby hospital, but the mortality rate is higher than if you travel a bit further.” It is a difficult debate, but what is striking is the lack of data coming out of the Department of Health to lead the debate. Why is the example of comparative data on heart surgery not being applied more widely?

Una O’Brien: I could not agree more, and the Government have made a clear commitment to much greater transparency on comparative clinical
performance. Heart surgeons have absolutely led the way in doing that.

Q143 Stephen Barclay: That is what I am saying. We are in agreement, so why has it not happened? 
Una O’Brien: It is going to happen, and I think that this is now fundamentally one of the responsibilities of the Commissioning Board, working with the information centre. We are moving into a different era, in which we will make a lot more information publicly available than was ever the case in the past, to enable those comparisons to be made. 
Sir David Nicholson: It is already happening. If you look at things like NHS Choices—now the largest health website in the world, which attracts millions of people to it every week—it provides huge amounts of data about our health system, hospitals and how our clinicians work, and we are committed to increasing that over the next period. We have done a whole set of work around it, and produced lots of data around primary care services.

Q144 Stephen Barclay: How many other specialties in addition to heart surgery produce data along the same lines? It was argued in The Times yesterday that no other specialty does. 
Fiona Mactaggart: IVF does, no one else. 
Stephen Barclay: So one. 
Sir David Nicholson: Stroke services, diabetic services—we have seen a whole series of information.

Q145 Chair: What about neurological services? 
Sir David Nicholson: Neurological services. 
Chair: But, no, you haven’t got it. 
Stephen Barclay: It is not there, that is what I am saying. 
Sir David Nicholson: All that data is either in the public domain or is about to come into the public domain over the next period. It is a vital part of the strategy—

Q146 Stephen Barclay: Could you give us a note with the breakdown of the various categories where you would expect data—where you say it is forthcoming—and the estimated dates, so that we can actually look at some of these other disciplines and at when that data will come on stream? 
Sir David Nicholson: And also that which is already available.

Q147 Mr Jackson: I just wanted to focus slightly on Peterborough now in that, obviously, this group of specialists has gone in, allegedly—or is going in. What is the ultimate sanction for an unaffordable PFI scheme? Does it need the Treasury to make a major policy shift, to say that the taxpayer was ripped off in too many of these cases and we will not honour the contract, or we will seek to rewrite the contract in that number of cases? In Peterborough’s case, of the £54 million deficit, £22 million is a structural deficit from PFI, and that is unsustainable in the short, medium or long term. What is the solution on PFI contracts? 
Dr Bennett: First, on the hit squads, I do not know what is happening on the six NHS trusts, but on one—Peterborough Foundation Trust—there is not a hit squad being sent in at present. That was misreported.

Q148 Mr Jackson: What is it then? 
Dr Bennett: At the moment, the trust is working with its commissioners to try and see what is best for it to do locally. We in particular have been working with the trust to see what it can do in terms of efficiency improvements. One of its problems was that it slipped behind in its cost-improvement programmes. The second bit that needs to be looked at locally—you are absolutely right to say that this is an issue not just for Peterborough, but for Peterborough, Hinchingbrooke, Addenbrooke’s and other hospitals in the area—is working with the commissioners to see what the realistic outlook for activity and revenue into the hospital is. We have a brand-new facility there, for goodness’ sakes we must surely find a way of making good use of it. If, when all that is done, there is still a gap between what the hospital can afford and what it actually has to pay—I am sure that there will be a gap—that has got to be funded in some way. If a solution cannot be found by the trust working with its commissioners, that is the point at which it slips into insolvency and we have to send in a special administrator to find a solution. A special administrator will immediately have to talk to the Department of Health and say, “There is a deed of safeguard here.” One way or another, some support has got to be found here.

Q149 Ian Swales: What can they do that the management cannot do in advance? What will the administrator bring that the massed ranks of NHS management cannot already do? 
Dr Bennett: First, they would check that what the trust itself is saying is the most that it can do is genuinely the most, although we are working very closely with it on that anyway. Secondly, they would be requiring the commissioners to be absolutely clear about what they could do. Thirdly, in this situation, really it comes down to discussions with the Department and the Treasury about what to do about the residual cost to the PFI.  
Stephen Barclay: So could you update us on the pilot? 
Chair: Hang on, let Stewart ask his question. 
Q150 Mr Jackson: I just have one quick one, and I think it is important to bring this up. In Peterborough’s case, for almost two years, the former Peterborough district hospital site has lain empty. It has not been demolished. It has an indicative capital value of anything up to £22 million, and nothing has been done. A very well known estate agent has been paid £800,000 of public money to take it to market. You know this, Dr Bennett, because I have written to you about it, and I have written to the strategic authority and the Department of Health, but no one seemed particularly interested. My worry is, are we using whatever levers we can to get the maximum capital receipt to offset that structural deficit? In Peterborough, that has not been the case. Why should that land have been left empty for two years? It speaks of a pretty bureaucratic and incompetent governance,
either between Monitor and the hospital or the NHS centrally.

Dr Bennett: The position with the land of the Peterborough district hospital is a part of the story of Peterborough, as I am sure you know. The fact that the land is not going to be worth what they thought it was in their original business case, because of the collapse in property values following the 2007-08 credit crunch, is a part of the story. Absolutely, of course, they nevertheless need to get the maximum value that they can for it. You did write to me last year, and we looked into it. As far as we can tell, the trust is doing its best to maximise the value. It is taking its time because it is trying to find the best deal.

Q151 Mr Jackson: But it is two years. If I had a £54 million overdraft and someone could give me £20 million, I would probably take it quite quickly.

Dr Bennett: But there isn’t £20 million on the table.

Q152 Mr Jackson: Well, there isn’t now. In fact, since I started talking about it, it has probably gone down about five grand. They have had this capital asset, and they have used it. My broader point is this: is Monitor doing everything it can, before it gets to the stage of administrators and a fire sale, to utilise capital assets that hospitals have? I think that is a very important point in looking at these deficits.

Dr Bennett: I absolutely agree that it is critical to make maximum use of the assets. We can look again at what the trust is doing, but I am reassured by the board of the trust that they are moving as fast as they can but seeking to get the best value deal.

Amyas Morse: Just looking at how efficiencies or resource efficiencies and improvements are being driven through the system, it is primarily—if I have it right, and I think I probably do—through tariff and NHS Choices, which will mean that more attractive and cost-efficient providers will get more work. At that level it makes very good sense, of course. I am not clear about this, however. Cost bases are not all flexible; there are large fixed cost bases, and I am trying to understand how we will not have lots of institutions under pressure and in difficulty that are not winning out in this—effectively, running not very dear life and not admitting that they are in trouble, which is what they are going to do.

Dr Bennett: The issue here is—there is no escaping it—that probably every trust in the country has got to restructure. The changing circumstances, as well as the points that Ara Darzi amongst others has made about the changing, maybe even disappearing, role of the DGH and so on means that changes have to be made. In some cases, trusts running with a healthy surplus can build up a cumulative service and spend that to make the changes. If they are well led, they can plan in advance and it will go smoothly. This Committee will not see those trusts. In others, maybe just because of local circumstances, but, yes, perhaps because they are less well managed as well, they will not be able to build up the surpluses in advance, but they have still got to make that change. Of course, once those trusts start getting into serious financial difficulty, it then becomes a matter of urgency to make the change and that change has still got to be paid for. If they have not been able to build up surpluses, it has to come from some central funding, which is PDC injection. It is better if they can build up a surplus and do it in a measured way,
but one way or another, that change has to be paid for. Although, as I have said, it is sometimes the case that they get into a situation where they need help, because they have not managed their circumstances as well as they could, we have to accept that there are often many reasons why different trusts find themselves in different situations.

Q153 Fiona Mactaggart: In this exchange, we have highlighted the importance of governance with particular trusts and we addressed that issue in our previous hearing on this subject. We asked the Department to report back on what steps successful foundation trusts had taken to engage higher calibre non-execs and the action that trusts with weaknesses had taken to address leadership issues. As I understand it, the Department promised to report back to us in April 2012 on this, and I have not seen such a report. Why? I will read our report. It said, “The Department of Health undertook to provide an early indication”—that might be one of those special bits of language—“of the impact of the new framework by April 2012.” We have not had it, have we?

Una O’Brien: If that is the case, I am very sorry and I will look into it later today as soon as I go back to the Department.

Q154 Fiona Mactaggart: Perhaps you could tell us and then we could have a proper written report later. Could you tell us what progress has been made on these issues of governance?

Una O’Brien: There is a lot in that. Specifically, are you asking about the...

Fiona Mactaggart: They were things that were specifically in our last report. These aren’t surprises.

Q155 Chair: David, can you help on the specifics?

David Flory: This is to do with the foundation trust report, looking at governance within the aspirant foundation trust sector. We have in place a board governance assurance framework, which—more systematically than we have done previously—works through governance issues with aspirant foundation trusts, ensuring that both the composition and capability of the boards across the piece are up to scratch, identifying gaps and supporting boards in developing and filling those gaps before progressing to be assessed for foundation status by Monitor. There is a dedicated programme to support governance development.

Q156 Fiona Mactaggart: I think the Committee really needs to know, both in NHS trusts and in foundation trusts, where progress is in terms of strengthening governance, because behind a lot of these questions and issues is actually a question of whether we are depending on these front-line trusts to deliver change, and what we are hearing is that, in too many cases, they are failing to do that in a financially sustainable way. I think the Committee needs a report from both Monitor and the NHS on what changes have been made, because without improvements it won’t be sustainable, frankly, and that is what we are concerned about.

Chair: I think that is an issue for the NAO to take up with the Departments.

Q157 Stephen Barclay: Just a quick point. Following on from our hearing last year, can you tell us where the Treasury pilot is currently trialling the scope for renegotiating PFI savings and how much it has identified in savings?

David Flory: I am afraid that I cannot. I would need to provide you with further information.

Q158 Stephen Barclay: You don’t even know where it is?

David Flory: In terms of the pilot?

Stephen Barclay: Where is it being run?

Sir David Nicholson: Barking, Havering and Redbridge is one. I would be happier to get the numbers, but it showed that not insignificant savings could be made.

Chair: I have to tell you, knowing a little about this, that what it showed is that if you cut the services, you save money. So they cut the services and have renegotiated the contracts on various services and have taken them out of those contracts and put them back on the trust, so I don’t think that it has been particularly successful.

Q159 Stephen Barclay: The specific issue that I am interested in is what impacts had been found in terms of life-cycle costs.

David Flory: I haven’t got that.

Sir David Nicholson: We’ll give you a note.

Stephen Barclay: You appreciate that life-cycle costs are the issue in terms of maintenance costs being charged up front for three whiteboards, because that is the duration of the contract, rather than one. It strikes me as such a bread-and-butter issue at the heart of PFIs. If you are running a pilot on an issue related to managing costs and it has been running for over a year, it seems a no-brainer not to address it.

Chair: I wish it had produced real savings. I don’t think it has. It is just so that you can cut services and save money.

Stephen Barclay: That’s not renegotiation.

Chair: It’s using renegotiation to cut services and therefore save money.

Q160 Meg Hillier: I want to come back on two points. First, I noticed, Una O’Brien, that you used the word “industry” twice when you were talking about the health service in the UK or in England. Is that how the Government see the future of the health service?

Una O’Brien: No. What I mean is the totality of the way that the care is delivered. Forgive me for using a word that might have been opaque in relation to my meaning. What I am really saying is—I think the Committee has heard me say this before—that it is not just the increasing recognition that care, particularly for people with long-term conditions, can be provided in better ways in different settings. It is also a deep recognition that we have got a considerable amount of avoidable illness and mortality building up in the population. For me, our discussion here on the impact of type 2 diabetes had
Una O'Brien: I worry about the term “public health”, because I think it implies something of a medical specialism whereas the public’s health as a whole—how to help people stay better for longer—from my point of view is fundamental on a medium to long-term horizon for the financial sustainability of the NHS. These two things are interconnected. So today we have talked about the more immediate pressures on a relatively small number of providers, but the big challenge for us as a country is to address the pipeline of illness—

Q161 Meg Hillier: Public health, you mean?
Una O'Brien: We have had to manage a transition whereby people—these are highly qualified, consultant-level medical professionals. The vast majority of them are already employed by PCTs. In many cases, people are moving across to local authorities and people have their individual employment rights, which have to be respected in that regard.

Q162 Meg Hillier: Public health directors are employed by local authorities and are among the best paid local government officers in the country. Has the Department of Health had any influence over that even though they are not directly your responsibility?
Una O'Brien: We will have an extremely close connection with directors of public health—

Q163 Meg Hillier: What about their pay?
Una O'Brien: We have had to manage a transition where they are highly qualified, consultant-level medical professionals. The vast majority of them are already employed by PCTs. In many cases, people are moving across to local authorities and people have their individual employment rights, which have to be respected in that regard.

Q164 Meg Hillier: I think some of them are paid more than chief executives of local councils. Does that strike you as a reasonable balance?
Una O'Brien: I don’t know about individual cases, but what I do know is that we as a country need that capability and that level of expertise available to local authorities. I think that is a good thing. Obviously we all want to bear down on public sector pay, but I don’t know about the details. If you have a specific concern, I am more than happy to take it up.

Q165 Ian Swales: Can I just ask this question, because it is of real concern to me. I don’t know what assessment you have made of the way that the new formulas are working, but a deprived area like mine is seeing large slugs of money taken out—something in excess of £10 million in Teesside—and yet we are at the wrong end of most of the public health league tables. There is a huge furor about it because apparently, for example, the new formulas give extra weight if you have an ageing population. Where you have public health issues, you don’t have an ageing population because they don’t get that far. There is something seriously wrong with the formulas, and large amounts of money are being taken out of deprived areas. It is something that the Department really needs to look at because it is setting off a time bomb under the new arrangements.

Una O'Brien: Age and deprivation in relation to the formula that goes into NHS spending are both weighted as factors. We talked about that here before. A slightly different formula is going to apply to the public health money that goes to local authorities, although the commitment is to maintain the level of spending in the local authority that was undertaken in the PCT in this final year. So I am very happy to pick up, Mr Swales, your specific case.

Q166 Ian Swales: To go back to commissioning and long-term planning, let us take the numbers in the broad South London example, with about 10 local commissioning groups. Because of how they will make their decisions, it will be very difficult for NHS foundation trusts to determine their long-term service provision because in each decision-making period they will be prey to the individual different decisions of local commissioning groups. My district general hospital, Homerton, is perhaps not a good example as it provides some of the community care services, but how can a typical district general plan for its future? Is that not the inherent risk in all such issues, apart from PFI?
Sir David Nicholson: There is no doubt that the pace of change of health care delivery systems will increase over the next period, not least as a result of technological and demographic changes.

Q167 Meg Hillier: Is that a polite way of saying they will chop and change, depending on individual commissioning groups?
Sir David Nicholson: The rate of change will go up. We need to bear that in mind. It is an inevitable consequence of the development of technology, patient experience and patient expectations that that will happen, as well as the demographics. That is all surrounded by the financial climate in which we work, so change will happen. There are two ways in which we need to mitigate the risk that you have just described and, hopefully, enhance it. We are taking all the CCGs through an
authorisation process at the moment. They have to demonstrate as a CCG their collaborative arrangements with other CCGs in the area. Urgent care is the obvious example. Very few CCGs would commission the whole of urgent care from a particular hospital. There may be six or seven hospitals. They have to show what arrangements they have in place to make that happen and what the decision-making process is, because we simply cannot have each CCG producing a different pathway of care.

Q169 Meg Hillier: So recreating what the PCTs were doing?
Sir David Nicholson: No. There is no right population to commission by; for some services, it is a population of 10,000. For some, it is 56 million. The key about commissioning is that you are flexible enough to bring people together when you need to, and that you have proper arrangements in place to enable them to do that when they need to work on a bigger population, and also to give them the opportunity to do so in respect of local services. Each CCG will have to produce as part of those arrangements a three to five-year view about what the services will look like in future. I guess that it will not be perfect, but it will give a good indication to the acute trusts in the local population of the direction of service that we will have. In those two ways, you can see how we can start to create such a system.

Q170 Meg Hillier: I know that CCGs vary in size. If there were a child with a severe longstanding disability, a lot more would have to be paid out. What is the safeguard if one goes bust and what is the effect on acute services?
Sir David Nicholson: Part of that is how they will risk share among themselves. There is no doubt that, for one particular CCG, a particularly complex patient who had cost a huge amount of money would distort its expenditure. We are looking to see how, in bringing them together, the CCGs will risk-share between themselves.

Q171 Meg Hillier: We talked about governance, transparency and data coming out, which are all very good. We have in front of us four of you who are responsible for one level of the NHS. But who is accountable, if a trust goes bust or a commissioning group goes bust? Who is held to account? You talk about risk sharing; it worries me that the accountability will be so shared that no one will ever be held liable.
Sir David Nicholson: If a commissioning group goes bust, I am accountable.

Q172 Meg Hillier: That is nice to know. What happens when a trust goes bust?
David Flory: If an NHS trust goes bust, it is me.

Q173 Meg Hillier: So your heads are really on the block. You will actually be out of a job if one of them goes bust. I am not delving in the idea that you might be out of a job, but I want to be clear.
Sir David Nicholson: May I say, I didn’t just resign over it. Inevitably, in the circumstances, across the whole range of clinical commissioning groups, against the background of the kind of changes that we are making and in the financial circumstances, CCGs will get into financial difficulties.

Q174 Chair: And a foundation trust?
Dr Bennett: If a foundation trust goes bust, in the first instance the board of the trust is accountable, but I am accountable for getting it fixed.

Q175 Meg Hillier: What about those people who, at the local level, made the bad decisions? With all respect to David, I doubt you are the one, even though it is quite right to take responsibility. We have all seen across the health service people who have made bad financial decisions and are still in jobs a year later—not always the same job, but sometimes even the same job. Is there a sanction?
Dr Bennett: I can partly answer that question. We have removed or ensured the removal of senior members of the board—usually the chair and others—in 17 foundation trusts.

Q176 Chair: But you lose that power in the new Act.
Dr Bennett: We will have that power in the future.
Meg Hillier: Is there a mark against their names?
Chair: Okay. Meg, I am going to stop you because we have also got to do neurological diseases.

Q177 Mr Jackson: Why does my parliamentary colleague Henry Smith have to put in a freedom of information request to find out how many foreign visitors are using health service facilities and whether the cost is properly recouped? Why aren’t you collecting those data? Why aren’t you strongly and robustly saying to acute hospital trusts and other providers, “It is your job to find out who you are giving clinical care to and get the money back from them if they are not UK citizens or otherwise entitled”? I would like an answer to that one.
In terms of supply of health care, are you convinced, given that under the previous Government consultants and GPs got more money for doing less work, that in accord with other countries, consultants are doing as much as they can and that clinical staff management is at an optimum? In other words, are you convinced that they are working Wednesday afternoons and at weekends? That to me is a significant issue that has not been properly addressed nationally by NHS management.
David Flory: On the first question about overseas visitors, we are absolutely aware that as a service we under-recover from other countries income for overseas visitors. We are working at national level and with guidance at local level, and are entering into more discussions with the Border Agency right now so that we share as much information as we can and make available as much information as possible to local organisations to support them. I agree that it is too patchy and variable at the moment and we are working on getting more consistency and, therefore, recovering more income.
Amyas Morse: We will be publishing a Report on the consultant contract in about November.
Q178 Mr Jackson: Sorry to interrupt, but one thing that comes across—anecdotally, I admit, as I have nothing in writing—is that one of the biggest challenges for acute hospital trust chief executives is managing consultants. They are a law unto themselves. Frankly, it is wrong to have state-of-the-art operating theatres empty for a significant part of the week, when we have a massive backlog of orthopaedic surgery and so on. I am just putting that in the mix. With an ageing population, you can’t control how many people get sick—the number of over-85s will double in the next 20 years—but you control the resource of clinicians.

Q179 Chair: I think we are getting an NAO Report on this issue. I want to move on, but I will ask three very quick questions. You said that 20 NHS trusts were in difficulty in obtaining foundation status the last time we looked at it. What figure are we on now?

David Flory: Of those 20, 17 are going through a transaction route and will not make it. Ten of those transactions have completed, and the remainder will. The three that are left—

Q180 Chair: Sorry. Say that again.

David Flory: Ten are now part of other organisations.

Q181 Chair: So they have merged?

David Flory: Yes. Seven are going down the same route, but the transactions are not yet completed. The three that have not yet determined their future were BHRT, Surrey and Sussex Healthcare NHS Trust, which is still working through its options; and Weston, which is a small hospital in Weston-super-Mare. Those are the three. South London was not on the list originally, but it clearly is now and up to eight or nine other organisations are currently considering becoming part of another organisation. The total, if we include those that have already completed the transaction, will be 29 or 30.

Q182 Chair: Twenty-nine or 30 have merged. Okay. My final question. The whole of your reforms are premised on the assumption that you will cut the number of people going to hospital. That is a hugely important premise. What have A and E figures shown over the last year? Are they up or down? What are they? A and E attendance figures increased, although admissions went down in 2011–12.

Q183 Chair: By?

Sir David Nicholson: But admissions went down during the same year.

Q184 Chair: And how are you going to persuade them?

Sir David Nicholson: Persuade who?

Q185 Chair: I suppose you have got to persuade the GPs and us that we don’t have to go to A and E. That is a difficult thing to do, but that is not to say that change isn’t happening. In almost every part of the country you can see people making some changes that are making this happen. The issue is whether we can make the big ambitious changes that some parts of London are trying to do at the moment, because that is required for that level of service.

Q186 Chair: We are persuading people, and people are making the change, although we think not fast enough to deliver. We believe that the development of 111 some time next year will be a significant step forward. We will have one mechanism—one front door, in a sense—for the NHS going forward.

Sir David Nicholson: For the last financial year, 2011–12, they were down on previous years.

Q187 Chair: I hear that, but if you don’t deliver, you don’t deliver the Nicholson cuts.

Sir David Nicholson: We end up filling hospitals full of people and spending huge amounts of money.
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Q189 Chair: Or you end up with waiting lists. Less elective surgery, blah, blah, blah—fewer hip replacements.

Sir David Nicholson: If we do not make the change that I have described in terms of the shift of service—the concentration and centralisation of services at one end, and more community services at the other—we have to drive efficiency much harder in hospitals, with all the dangers that that has, or we end up with a situation where waiting lists go up. Neither of those things is acceptable, and we have to find a way to make it happen.

Q190 Meg Hillier: It may be just worth flagging up the National Audit Office’s Report “Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland” from 29 June. I know you have not got this, but part 1, page 12, figure 2 states that the average life expectancy at birth in England for men is 78.6 years, and for women it is 82.6 years. For men, the average healthy life expectancy at birth—this is up to 2009—was 63.5 years, and for women was 65.5 years. That gives a very wide gap from the age of disability to the age of death. That surely has to be a key strategic focus in terms of older people’s care, because they will be in hospital beds if we do not get it right.

Una O’Brien: You are fundamentally right; the objective is to help people to live better for longer.

Q191 Stephen Barclay: This is a question that I have raised before. Could we have guidance from your Department that confidentiality clauses should have an express wording within them that they do not apply to whistleblowers? At the moment, although PIDA—the Public Interest Disclosure Act—means that you cannot enforce against whistleblowers, the legal risk of compliance within PIDA sits with the whistleblower. What is happening is that there is a chilling effect on whistleblowers, because they think that they cannot disclose and it is for them to prove that they fall within PIDA. I think it would be very helpful if we could have some clear guidance from the Department such that confidentiality clauses expressly exclude whistleblowing.

Sir David Nicholson: I am pretty sure that we have already done that, but I will send you a note.

Q192 Stephen Barclay: When I wrote to the Secretary of State and he wrote back on 11 July 2012, that was not the position. Has something happened since July?

Sir David Nicholson: As I say, I thought we had done it.

Q193 Stephen Barclay: Something has got to be expressly there in the guidance, because there is conflicting guidance.

Sir David Nicholson: I understand the point.

Chair: Thank you. We are going to move on immediately.

Written evidence from the Foundation Trust Network

Introduction

1. The Foundation Trust Network (FTN) is the trade association and collective voice for NHS foundation trusts and those working to achieve foundation trust status. We have 215 member organisations providing care across the acute, mental health, ambulance and community services. The FTN welcomes the opportunity to contribute to the inquiry being conducted by the Public Accounts Committee following the National Audit Office report.

2. At the time of writing, of course, we have not had sight of the NAO report’s findings. However, given the well rehearsed financial challenge and recent events reported in the media around organisational sustainability in South London, we offer our view of the issues and what we consider is needed in the system to ensure that NHS providers are able to meet the needs of patients and the public into the future.

Executive Summary

3. The headline issues can be summarised as follows:

— All providers face unprecedented financial challenges for at least the next decade. There is a need for system-wide approaches to many of the issues facing providers, especially those in difficulty.

— Business case-based solutions are necessary to address the historic problems of legacy debt and PFI burden that support greater transparency in the use of NHS resources. There is need for transparency too around the extent of commissioner investment in care out of hospital settings and service re-design—we are concerned that what money there is in the system isn’t reaching the front line.

— A mature commissioning environment which works in partnership with providers is required, with the ability to contract for services for longer term periods to support the costs of investing in service change and provide certainty around planning. This is a big ask given the stage of development of clinical commissioning groups.
— An enabling proportionate regulatory regime which doesn’t get in the way of providers’ ability to respond dynamically to changing circumstances is critical. In the design of the regulatory framework over the next six months the DH must look hard at whether the proposals will deliver a truly liberated NHS where providers can build value and offer more for less.

— Completing the well-established policy of an all-FT public provider sector is important as the means of giving all the providers that successfully achieve FT status the tools and accountabilities they need to become excellent providers of care for their communities, in the context of the new health industry.

4. We elaborate on these points in the following sections.

**Financial Challenge**

5. There is increasing public awareness of the £20 billion “Nicholson Challenge”, although the DH observed earlier this year that the challenge could rise to £50 billion by 2019–20. Providers are grappling with cost improvement plans averaging 5.7%, according to our member surveys. These unprecedented efficiency requirements are taking place against a background of significant system instability which has made the necessary local conversations around long term efficiency and service provision extremely difficult, even for those considered robust and high-performing.

**System-wide Approaches Needed**

6. The current reorganisation in the commissioning parts of the NHS has led to existing relationships being broken down and in some areas delays in tackling the key problems, as many of the issues facing providers now require a system-wide approach. Issues like integration, innovative service re-design, and improved patient outcomes (including how patients experience the entire health and social care system) are beyond the direct control of individual organisations.

7. The system immaturity (a consequence of the new Health and Social Care Act architecture) together with the prevailing financial position, puts providers in a position of high risk, as the agencies they need to relate to are not yet formed, or are not yet running at the levels of competence or capability envisaged by the “end design” of the reforms. Many of the incentives and levers planned to provide safeguards around the sustainability of services have not yet been finalised. There is an observed and anticipated danger of both commissioners and regulators being too risk-averse to support longer term systemic health and a vibrant provider sector.

**Working together on Business case-based Solutions**

8. To avoid failure, NHS organisations need to work together on solutions around what is necessary and possible for health provision in their communities—importantly including mental health as well as physical health. This dialogue includes identifying solutions to legacy debt and how to finance PFI deals. Of note, one of our members has worked with their local authority to buyout their PFI and pay a more affordable rate, with potential benefits for the whole community.

9. Sometimes though, failure will come into play. This is part of the system architecture under the Health and Social Care Act, where essential services rather than organisations are protected. In this respect, the experience of South London NHS Trust in the last couple of weeks is instructive and an important test of political appetite. As this is first use of the administration regime it must be made to work or the whole reform approach will be undermined.

10. Where organisations are in this position and the wider service needs them to continue, they should be supported with a business case-based solution that is transparent and open to scrutiny. Where alternative services are available, appropriate and desired, then the failure regime must be allowed to run its course, as the government’s provider policy prescribes.

11. Therefore what happens next in south London will be viewed with keen interest by all those in the NHS as it will signal government confidence in its own reforms. In particular it will demonstrate:

   (a) appetite for the scale of reconfiguration that is necessary in the system;

   (b) support for the government’s provider policy, predicated on a regulated but dynamic market where organisations are allowed to fail; and

   (c) an end to opaque bailouts that divert finite resources towards failing organisations at the expense of the good.

**Transparencies of Investment in Service Re-design**

12. Many of the immediate financial concerns of our members arise from the tough financial environment in general but this is compounded by certain punitive tariff arrangements which make NHS providers responsible for addressing wider NHS shortcomings and impact on their sustainability. These include the observed failure of primary care and commissioners to manage demand and invest in community-based care, the consequences of which mean providers are seeing increasing numbers of emergency admissions reimbursed at 30% of tariff.

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13. We also hear of examples of providers making savings so that the resource can support an enhanced community care service, but instead the money is retained by the PCT. Over the last two years we have been asking in respect of efficiency savings “where has the money gone?” as we are not seeing it invested in re-designed patient-facing services. Consequently all the push is to get patients out of hospital into community care through a series of ever more stringent penalties, with little pull from accessible alternative services in the community to change the pattern of demand. In these circumstances acute providers are put at significant financial risk and are unable to take out sufficient cost overhead in a sustainable way.

**Commissioning Environment**

14. What can commissioners do to ensure that their local services and key provider organisations are sustainable (as while the new NHS is committed to protecting services rather than organisations, in the transition these are likely to be corresponding or inter-related)? We consider that providers need a balanced relationship with commissioners and commissioning which:

- Understands the provider landscape in their area.
- Quickly understands the co-dependencies of services so that seemingly insignificant changes in commissioning do not compromise provider ability to deliver the full range of care expected.
- Is comfortable with innovation and risk, but recognises that this will require investment over and above “business as usual” models.
- Issues contracts for the longer term (five to ten years rather than one or two) so that providers are encouraged to invest in new models of care.

Focuses on commissioning for outcomes rather than episodes.

**Regulatory Environment**

15. The regulatory framework has a role to play in supporting the financial sustainability of NHS organisations and for NHS foundation trusts Monitor undertakes this role by issuing financial risk ratings (FRR). This has worked well, though it is worth noting that post-Act, NHS foundation trusts will need to develop their own assurance in conjunction with their governors and members so that Monitor can fulfil properly its role as a sector regulator and not have a special interest in the success of one particular section of the market.

16. The licence which Monitor is expected to apply to providers as sector regulator is about to be consulted upon, but early engagement has taken place. Our view on the proposals as presented earlier in the year is that there is a risk of an over-burdensome approach which inhibits the very behaviours that the legislation was intended to promote—such as partnerships supporting integrated care. Indeed, unless the proposals change radically they.

_July 2012_

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**Written evidence from the Department of Health**

Q157 Stephen Barclay: Just a quick point. Following on from our hearing last year, can you tell us where the Treasury pilot is currently trialling the scope for renegotiating PFI savings and how much it has identified in savings?

David Flory: I am afraid that I cannot. I would need to provide you with further information.

Q158 Stephen Barclay: You don’t even know where it is?

Sir David Nicholson: Barking, Havering and Redbridge is one. I would be happier to get the numbers, but it showed that not insignificant savings could be made.

Chair: I have to tell you, knowing a little about this, that what it showed is that if you cut the services, you save money. So they cut the services and have renegotiated the contracts on various services and have taken them out of those contracts and put them back on the trust, so I don’t think that it has been particularly successful.

**Response**

Provided by Brian Saunders

The Treasury pilot, which concluded with the publication in July 2011 of the document Making savings in operational PFI contracts, was conducted at the Queen’s Hospital, Romford, which is part of the Barking, Havering and Redbridge NHS Trust. The pilot concluded that annual savings of around 5% of the annual unitary charge were achievable. Following the publication of the Treasury document, DH arranged information sharing sessions with other trusts with PFI schemes. The Department is currently following up these trusts the amount and extent of savings subsequently achieved in operational PFI projects.
Q159 Stephen Barclay: The specific issue that I am interested in is what impacts had been found in terms of life-cycle costs.

David Flory: I haven’t got that.

Sir David Nicholson: We’ll give you a note.

Stephen Barclay: You appreciate that life-cycle costs are the issue in terms of maintenance costs being charged up front for three whiteboards, because that is the duration of the contract, rather than one. It strikes me as such a bread-and-butter issue at the heart of PFIs. If you are running a pilot on an issue related to managing costs and it has been running for over a year, it seems a no-brainer not to address it.

Chair: I wish it had produced real savings. I don’t think it has. It is just so that you can cut services and save money.

Stephen Barclay: That’s not renegotiation.

Chair: It’s using renegotiation to cut services and therefore save money.

Response

Provided by Brian Saunders

The Treasury pilot specifically considered effective management of existing contract terms, optimising the use of asset capacity and reviewing the specification of soft services, rather than life cycle costs. The report commented that life-cycle and maintenance costs of the property are bound up with the asset design, construction and management risk transferred to the Project Company at the outset—as such these costs are relatively inflexible without changes to the risk allocation of the project.

The department is however examining ways to look at this issue.

Q191 Stephen Barclay: This is a question that I have raised before. Could we have guidance from your Department that confidentiality clauses should have an express wording within them that they do not apply to whistleblowers? At the moment, although PIDA—the Public Interest Disclosure Act—means that you cannot enforce against whistleblowers, the legal risk of compliance within PIDA sits with the whistleblower. What is happening is that there is a chilling effect on whistleblowers, because they think that they cannot disclose and it is for them to prove that they fall within PIDA. I think it would be very helpful if we could have some clear guidance from the Department such that confidentiality clauses expressly exclude whistleblowing.

Sir David Nicholson: I am pretty sure that we have already done that, but I will send you a note.

Response

Provided by Tracey Eckersley

The Department’s policy on this has been clear for a number of years. Health Service Circular 1999/198: The Public Interest Disclosure Act 1998—Whistleblowing in the NHS, issued on 27 August 1999, stated: “Gagging clauses in employment contracts and severance agreements which conflict with the protection afforded by the Act will be void”. It also went on to state that: “Every NHS Authority … should prohibit confidentiality ‘gagging clauses’ in contracts of employment, and compromise agreements which seek to prevent the disclosure of information in the public interest”.

The Department reiterated this on 11 January this year, in a letter from Sir David Nicholson to Chief Executives and HR Directors of NHS Trusts, PCTs and SHAs, titled Compromise Agreements and the Public Interest Disclosure Act 1998. In the letter specific reference is made to HSC 1999/198, and the letter also states that: “Our view is that where an agreement is reached that an individual will withdraw or agree not to make a complaint about a specific matter to certain bodies, the compromise agreement should make clear the right to make a protected disclosure is not affected. It is unacceptable to require an employee not to make any ‘further’ complaint or grievance.”

“If any further complaint or grievance were in fact a protected disclosure, then any provisions within a contract or compromise agreement purporting to prevent that would be deemed void under the Public Interest Disclosure Act. Our concern however, is about the potential deterrent effect of including such clauses in either contracts or compromise agreements.”

“I would therefore ask you to satisfy yourselves that your organisation’s policies are in line with HSC 1999/198.”

A similar reminder was sent to NHS Foundation Trusts by Monitor.

1 October 2012
1.0 INTRODUCTION

1.1 This written memorandum is provided to assist the Committee by giving information on Monitor’s work to develop leadership in the Foundation Trust sector.

1.2 The Committee expressed interest in understanding work that has been undertaken to develop leadership in the aspirant foundation trust sector. This submission outlines the work that Monitor undertakes to support leadership development in NHS foundation trusts. Much of this work is also accessible to the leadership of aspirant foundation trusts.

1.3 Robust and effective leadership is essential in successful foundation trusts. As part of Monitor’s commitment to help NHS foundation trusts operate effectively and efficiently we invest time in supporting governors to understand their role and encouraging senior management teams undertake training and development.

2.0 MONITOR’S NON-EXECUTIVE DIRECTOR DEVELOPMENT PROGRAMME

2.1 As part of Monitor’s commitment to help NHS foundation trusts operate effectively and efficiently, we have designed a programme that helps Non-Executive Directors (NEDs) build upon their personal skills and develop a broad and comprehensive understanding of the NHS, including quality, finance, board dynamics and the strategic challenges facing the health sector.

2.2 The course is delivered by Cass Business School.

3.0 NHS FOUNDATION TRUSTS CHAIRS’ ACADEMY

3.1 The Foundation Trust Chairs’ Academy has three aims: to support Chairs in developing personal effectiveness; to help Chairs lead both the Trust Board and Council of Governors to higher levels of board performance; to help Chairs achieve even greater effectiveness for their Trusts and a stronger health economy as a whole.

3.2 The Academy is co-sponsored by the Foundation Trust Network and delivered by Cass Business School.

4.0 STRATEGIC FINANCIAL LEADERSHIP PROGRAMME

4.1 Monitor, the Department of Health and the NHS Institute for Innovation and Improvement have collaborated to create the Strategic Financial Leadership Programme.

4.2 It has been created to help finance directors address the challenges they are facing in the modern NHS and helps develop their skills by focusing on leading-edge developments in the world of finance and management.

4.3 An alumni programme provides continuing support via a three day development programme.

5.0 INDUCTION SEMINARS FOR NEWLY APPOINTED CHAIRS AND CHIEF EXECUTIVES

5.1 Monitor runs induction seminars for newly appointed Chairs and Chief Executives of NHS foundation trusts that have not had prior experience of Monitor’s authorisation process.

5.2 As part of Monitor’s reporting requirements, if a Chair or Chief Executive has not attended, or is not scheduled to attend, this programme within six months of their appointment, an explanation is required as to when they will attend or why attendance is not considered necessary.

6.0 ACCELERATED SERVICE LINE MANAGEMENT PROGRAMME (SLM)

6.1 Monitor first introduced SLM in 2006.

6.2 SLM sees clinical leaders managing service-lines and having the information, capability and decision rights to manage services with a large degree of autonomy.

6.3 2011–12 saw the development of our Accelerated SLM programme. It provides trusts with a framework assessment to fully understand their position in relation to SLM. It also aims to strengthen relationships between key board members and enable access to benchmarking information from around the UK and internationally where relevant.

6.4 A series of webinars about SLM have been held during 2012 to disseminate information. A conference was also jointly held with the Healthcare Financial Management Association.

7.0 RECENT PUBLICATIONS TO DEVELOP FOUNDATION TRUSTS AND SHARE BEST PRACTICE

7.1 Current Practice in NHS Foundation Trust Member Recruitment and Engagement was produced in partnership with Electoral Reform research and Membership Engagement Services. It looks at trends in
recruitment and engagement of members as well as offering best practice examples for current and aspirant foundation trusts to consider

7.2 Delivering Sustainable Cost Improvement Programmes was written jointly with the Audit Commission and identifies important lessons on delivering CIPs and provides examples of how CIPs can be delivered without compromising patient care, safety and satisfaction.

7.3 Director—governor interaction: a best practice guide in NHS foundation trusts was produced in partnership with PA Consulting. It looks at typical issues in working relationships between FT directors and governors and identifies best practice in the approach from several FTs where this works very effectively.

8.0 Conferences

8.1 Monitor runs and speaks at conferences and events aimed at developing leadership skills.

8.2 Conferences throughout the year include: Service-line Management, Sustainable Cost Improvement Programmes, leadership support for Non-Executive Directors and Robust Quality Governance. These are usually with third party organisations, such as the Health Finance Manager Association, the Kings Fund and the Foundation Trust Network.

8.3 Regular speaking slots at leadership events, hosted by third parties—eg Foundation Trust Network, Health Finance Managers Association and the Foundation Trust Governors Association covering a range of topics including the importance of clinical leadership and ensuring and maintaining a patient safety culture.

8.4 Seminars and webinars on various leadership challenges have been planned throughout 2012–13—topics include the board role in patient safety, the importance of clinical leadership in delivering sustainable efficiencies, the clinicians’ role in service delivery and CIPs.

28 September 2012