



House of Commons
Committee of Public Accounts

Financial sustainability of NHS bodies

Thirty-fifth Report of Session 2014–15

*Report, together with the formal minutes
relating to the report*

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Committee of Public Accounts

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The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Sue Alexander and Jamie Mordue (Committee Assistants) and Janet Coull Trisic (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 4099; the Committee's email address is pubaccomm@parliament.uk

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Summary

The financial health of NHS bodies has worsened in the last two financial years. The overall net surplus achieved by NHS bodies in 2012–13 of £2.1 billion fell to £722 million in 2013–14. The percentage of NHS trusts and foundation trusts in deficit increased from 10% in 2012–13 to 26% in 2013–14. Monitor found that 80% of foundation trusts that provide acute hospital services were reporting a deficit by the second quarter of 2014–15. NHS England, Monitor and the NHS Trust Development Authority recognise that radical change is needed to the way services are provided and that extra resources are required if the NHS is to become financially sustainable. The necessary changes will require further upfront investment. Present incentives to reduce A&E attendance and increase community based care services have not had the impact expected. New incentives and strong relationships are needed to promote the more effective collaboration necessary for delivering new models of care.

Introduction

In 2013–14, the Department of Health (the Department) allocated £95.2 billion to NHS England to pay for NHS services. NHS England allocated £65.4 billion of this to the 211 clinical commissioning groups in England, for them to commission health care services from hospitals and other healthcare providers on behalf of their local populations. At 31 March 2014 there were 98 NHS trusts and 147 NHS foundation trusts which provided community, mental health, acute and specialist health services. Monitor regulates NHS foundation trusts, and a new body, the NHS Trust Development Authority, supports NHS trusts that are yet to achieve foundation status. The Department has provided some £1.8 billion of additional cash support to NHS trusts and foundation trusts under financial stress between 2006–07 and 2013–14.

Conclusions and Recommendations

1. **The savings required across the NHS will be difficult to achieve solely by continuing with the same approach used in recent years.** The NHS has typically achieved efficiency savings of 1%–2% against a target of 4% set by Monitor and NHS England. These savings were achieved partly through wage freezes. NHS England, Monitor, and other NHS bodies recognise that radical change is needed to the way healthcare is provided, including making better use of community and primary care services to reduce pressure on hospitals. Making this change will require significant upfront investment, but the money available for this is reducing as the number of organisations in deficit increases. The national oversight bodies also lack the detailed and accurate cost data from local NHS bodies needed to monitor and identify cost savings achieved and whether they are sustainable in the longer term.

Recommendations: *NHS England and Monitor should collect consistent and detailed cost data across the NHS to use to set efficiency savings targets for NHS bodies and to assess whether changes to service provision, including new models of care, are achieving measurable and sustainable savings in practice.*

2. **More effective collaboration between local health bodies is needed to achieve better value for money.** The different payment mechanisms and financial incentives for local health bodies are not aligned to encourage the sort of integration required to implement the proposed new models of care. For example, community care services tend to use block contracts where payments are not based on the number of patients handled, whereas acute services are paid on the basis of activity using ‘payment by results’ tariffs. This creates a financial disincentive for acute hospitals to give up activity, and for community services to take on additional activity. NHS England and Monitor are consulting on changes to the way healthcare is paid for. However, national bodies have not done enough to improve local strategic decision making, leading to a gap between what clinical commissioning groups plan to spend and the income that trusts expect to receive.

Recommendations: *NHS England, Monitor and the NHS Trust Development Authority should require all local health economies to submit integrated strategic and operational plans that outline how they will implement locally the proposed new models of care. NHS England and Monitor should implement proposals for changing payment for healthcare, to incentivise the integration of services between local organisations by 2015–16.*

3. **The current system of paying for emergency admissions hinders, rather than helps, secure the financial sustainability of NHS bodies.** Although emergency admissions to hospitals have increased significantly in recent years Acute trusts are only paid 30% of normal prices for all emergency admissions above 2008–09 levels. This payment method was designed to discourage unnecessary admissions on the basis that commissioners would invest the remaining 70% of tariff income in ways that would improve patient care outside hospital and reduce inappropriate hospital admissions. However, for many acute providers these tariff arrangements do not cover the cost of admitting emergency patients, and therefore intensify the already difficult financial challenges the acute hospital sector faces. While NHS England and Monitor plan to change these arrangements they have been slow to act having identified this issue in 2013.

Recommendation: *Monitor and NHS England should complete their review of the national payment system for emergency admissions promptly and implement the required changes within the next year including updating the 2008–09 baseline, taking into account the impact on patient care and the finances of organisations in deficit.*

4. **The Department is not making the most of cost saving opportunities.** In 2013–14, the NHS spent £2.6 billion on temporary staff, who can be significantly more expensive than permanent employees, compared with £2.1 billion in 2012–13. There are claims that some consultants are choosing to work on an agency basis to make more money at a substantial cost to the NHS, with typical charges of £1,760 per day. Despite the NHS being the dominant employer of temporary medical staff the Department has not made best use of its position to reduce the costs involved. Some agencies do not participate in the Department’s framework contract which limits local NHS bodies’ ability to achieve value for money when hiring agency staff, particularly those needed to fill high vacancy rates in emergency departments. There is scope to make savings in the amount paid under private finance initiative schemes, which cost the NHS some £1.8 billion a year, as there are some examples where refinancing or buying out existing schemes could provide better value for money in the long run. There are also opportunities to release funds tied up in surplus capital assets that could be used for upfront investment in new models of care. For example, there are some £1.5 billion worth of unused land and premises in London alone.

Recommendations: *The Department should:*

- *require NHS bodies to use agency staff within a national framework contract unless they can demonstrate clear value for money benefits from local negotiation, and benchmark the cost of agency staff within and outside the national framework;*

- *support evaluation of alternative financing or operating options for costly private finance initiative schemes where there is a clear opportunity for improving value for money;*
- *accelerate the disposal of surplus capital assets to release cash for upfront investment in new models of care;*
- *Examine the obligations it places on consultants who are trained at taxpayers' expense and then choose to work as temporary staff at extra cost to the NHS.*

5. **There are still 93 NHS trusts that have not yet achieved foundation trust status and a significant number are unlikely to do so.** The Government's intention is that all NHS trusts should become foundation trusts. Monitor, which licences foundation trusts, tests applicants for evidence of strong governance, long-term financial viability and ability to provide quality services. The NHS Trust Development Authority is reviewing how long it will take for the remaining 93 NHS trusts to apply to Monitor for assessment, by assessing their clinical and financial sustainability. The NHS Trust Development Authority believed that there was a significant number of trusts that would need at least four years, and that these trusts would need to address significant financial challenges before they could produce a financially viable plan.

Recommendation: *The NHS Trust Development Authority should set out how, and by when, it will put forward to Monitor each of the remaining 93 NHS trusts for assessment for foundation trust status. It should prioritise its efforts on working with the minority of NHS trusts that will not achieve foundation trust status in their own right.*

1 Pressures on the financial sustainability of the NHS

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), NHS England, Monitor and the NHS Trust Development Authority on the financial sustainability of NHS bodies.¹ We also took evidence from Barking Havering and Redbridge University Hospitals NHS Trust, Barnet Clinical Commissioning Group, Medway Clinical Commissioning Group and University Hospitals Coventry and Warwickshire NHS Trust.

2. In 2013–14, the Department allocated £95.2 billion to NHS England to pay for NHS services.² NHS England is responsible for commissioning primary care and specialised services, and is accountable to the Department for its spending.³ On 1 April 2013, 211 clinical commissioning groups replaced ten strategic health authorities and 151 primary care trusts to take responsibility for commissioning most healthcare services from community, secondary and specialist providers.⁴ NHS England allocated £65.4 billion to clinical commissioning groups in England to commission health care services, on behalf of their local populations, from 98 NHS trusts and 147 NHS foundation trusts.⁵ Monitor regulates NHS foundation trusts, and another new body, the NHS Trust Development Authority, supports NHS trusts that are yet to achieve foundation status.⁶

3. The NHS must be financially sustainable in the medium to long term for it to provide sustainable services to patients. Key tests of financial sustainability include changes in the surplus or deficit of the NHS as a whole and the number and scale of organisations in financial distress.⁷ However, the financial health of NHS bodies has worsened. Between 2012–13 and 2013–14, the net surplus of NHS commissioners, foundation trusts and NHS trusts decreased from £2.1 billion to £722 million.⁸ The percentage of NHS trusts and foundation trusts in deficit increased from 10% in 2012–13 to 26% in 2013–14; and nearly a quarter of clinical commissioning groups ended the 2013–14 financial year with a less favourable financial position than they planned.⁹ The Department issued £1.8 billion of cash support to NHS trusts and NHS foundation trusts between 2006–07 and 2013–14 to help them meet their operational cash needs.¹⁰

1 [C&AG's Report, *The financial sustainability of NHS bodies*, Session 2014-15, HC 722, 7 November 2014](#)

2 [C&AG's Report, para 3](#)

3 [C&AG's Report, paras 1.2, 1.4](#)

4 [C&AG's Report, para 1.2](#)

5 [C&AG's Report, paras 3, 1.5](#)

6 [C&AG's Report, para 1.4](#)

7 [C&AG's Report, para 1](#)

8 [C&AG's Report, paras 5, 1.5](#)

9 [C&AG's Report, paras 1.7, 2.9](#)

10 [Q 241; C&AG's Report, para 3.6](#)

4. At the end of September 2014, 80% of NHS foundation trusts that provide acute hospital services were reporting a deficit.¹¹ Both Barking Havering and Redbridge University Hospitals NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust told us that one of the main reasons for the increasing number of acute providers in deficit is the payment system for emergency admissions.¹² Providers are paid 30% of standard prices for all emergency admissions above 2008–09 levels, whereas the number of emergency admissions has increased by 48% over the last 15 years.¹³ In December 2013, Monitor and NHS England reviewed the emergency payment system and concluded that adjustments to the baseline should be made when providers faced significant increases in the number of emergency admissions.¹⁴ Monitor told us it believed admissions would have increased even faster had the 30% rate not been in place, but accepted that there were problems with the payment system that still needed to be addressed.¹⁵ Monitor and NHS England noted that they had begun a review of the payment system, and planned to update the 2008–09 baseline next year.¹⁶ Monitor and the NHS Trust Development Authority assured us that planned changes would result in fewer acute trusts in deficit. In the interim we heard that, for example at Coventry and Warwickshire University Hospitals NHS Trust, the hospital and clinical commissioning group had made a local agreement to pay for emergency admissions at 2013–14 activity levels, and this was helping to address the financial challenges the hospital faced.¹⁷

5. The Department’s policy is that commissioning bodies should invest the remaining 70% of the tariff for emergency admissions into improving patient care outside hospital settings, to help reduce the number of inappropriate hospital admissions. However, alternatives to hospital care, including enhanced primary care services and discharge from emergency departments into community care, are not always available.¹⁸ Monitor accepted that much more transparency was needed around how the remaining 70% was actually spent and whether this was helping to reduce unnecessary hospital admissions.¹⁹

6. The Department told us that, between 2012–13 and 2013–14, the amount the NHS spent on temporary medical staff increased from £2.1 billion to £2.6 billion.²⁰ Many acute providers are facing cost pressures because they have a shortage of permanent consultants, particularly in accident and emergency departments.²¹ For example, Barking Havering and Redbridge University Hospitals NHS Trust told us that it had a 50% shortage of emergency consultants and was spending £1.5 million a month on temporary staff. It said it paid £110 an hour for some locum emergency consultants working a 16 hour shift, whereas the basic

11 [Qq 124-128](#)

12 [Qq 6, 11, 52](#)

13 [National Audit Office. Emergency admissions to hospital: managing the demand, Session 2013-14, HC739, 31 October 2013](#)

14 [C&AG’s Report, para 2.7](#)

15 [Qq 99-101](#)

16 [Qq 101-102, 107](#)

17 [Qq 7-10](#)

18 [C&AG’s Report, para 2.7](#)

19 [Q 101](#)

20 [Q 143](#)

21 [Q 16](#)

starting salary for a permanent emergency consultant was around £75,000.²² It costs the taxpayer £400,000 to train an emergency consultant, but some consultants were choosing to leave the NHS to become professional temporary staff.²³

7. We asked the Department about its strategy for reducing the impact on providers' costs of hiring temporary staff. It told us that it was developing a toolkit to share with providers, which aimed to predict volume so that providers could ensure they recruit enough employees to meet the numbers needed.²⁴ The Department said it was also considering ways of lowering the price of agency staff.²⁵ For example, the Department explained that it was considering how to use its national purchasing power and position as the main buyer of medical staff from the agency market to achieve a better price.²⁶ While the Department has a framework contract that seeks to achieve the best price possible by gaining sufficient volumes, some agencies do not take part in the framework.²⁷ NHS England also said it must ensure that it fills the increased number of training places in emergency medicine, to help address the shortage in emergency consultants.²⁸

8. According to the Department, 31% of providers have a private finance initiative (PFI) scheme, and the NHS spends a total of £1.8 billion each year on PFI payments.²⁹ The National Audit Office noted in its report that organisations with the highest capital charges, as a proportion of income, were the most likely to report weak financial results in 2013–14.³⁰ Four out of six trusts with deficits greater than £25 million had a PFI scheme.³¹ Some trusts have improved their financial position by refinancing their PFI. For example, Northumbria Healthcare NHS Foundation Trust, which plans to deliver a £21.5 million surplus in 2014–15, arranged a loan with Northumberland County Council to buy out its PFI scheme.³² The Department said the capital cost of refinancing PFI schemes would be significant and that it would not be appropriate in all cases to consider refinancing, but told us it was considering options for doing this, where appropriate, in a way that provides value for money.³³ One option it was exploring was renegotiating 'soft facilities management services', such as catering, cleaning or security, which make up a large cost of some PFI schemes.³⁴

22 [Qq 64-65, 74, 76, 78](#)

23 [Qq 86-90, 147](#)

24 [Qq 142, 144](#)

25 [Q 144](#)

26 [Q 148](#)

27 [Q 145](#)

28 [Q 152](#)

29 [Q 181](#)

30 [C&AG's Report, para 2.16](#)

31 [C&AG's Report, para 2.15](#)

32 [Qq 181; C&AG's Report, para 2.17](#)

33 [Qq 181-182, 184](#)

34 [Q 183](#)

2 Managing future financial risks

9. NHS England told us that the parts of the country that have deep financial pressures now are ‘almost certain’ to continue to be under financial pressure next year.³⁵ It suggested that some trusts were in deficit because the local health service was ‘out of balance’, for example because community and primary care services were not working well which places pressure on hospitals.³⁶ In October 2014, NHS England published its *Five Year Forward View*, which proposes profound changes to the way services are delivered. A key focus of the plan is a range of new models of care, which aim to limit the rise in hospital admissions; a major pressure facing the health service. These include large GP practices employing hospital doctors to provide extra services, such as diagnostics and outpatient appointments; and making better use of pharmacists for minor illnesses.³⁷

10. NHS England and Monitor currently set a target of 4% efficiency savings.³⁸ In practice, the NHS has so far delivered annual efficiency savings of 1% to 2%, but this has been partly through pay freezes, which NHS England and Monitor agreed was unsustainable.³⁹ NHS England told us that 5% to 5.6% one-off efficiency savings could be delivered from less efficient providers ‘catching up’ with the most efficient providers. Monitor and NHS England also estimated that an annual 1.2% to 1.3% of efficiency savings could be delivered through advances in technology and medicine.⁴⁰ However, NHS England suggested that it would be difficult, using current models of care, to sustain the 2% to 3% annual savings that would be needed to offer the modern health service that people want.⁴¹

11. Looking ahead to the next five years, Monitor and NHS England said that the NHS would have to achieve system efficiencies by changing the way healthcare was provided.⁴² Both NHS England and Monitor agreed that upfront investment was needed to make these changes yet, with a growing number of organisations in deficit, the money for this was limited.⁴³ NHS England and the Department accepted that freeing up some of the surplus capital assets in the NHS could create some of the required funding for upfront investment in new models of care.⁴⁴ For example, they highlighted that in London there was around £1.5 billion worth of unused land and premises.⁴⁵ Similarly, Monitor estimated in its 2013 publication *Closing the NHS funding gap* that selling underused estate across the acute and mental health sectors could yield a gain of £7.5 billion.⁴⁶ Monitor suggested that, if the NHS

35 [Q 155](#)

36 [Qq 113-114](#)

37 [Qq 111, 154-155](#)

38 [Qq 188, 193](#)

39 [Qq 159, 185-194, 196](#)

40 [Q 197](#)

41 [Qq 159-160](#)

42 [Qq 159, 193-194, 197-200](#)

43 [Qq 159, 161](#)

44 [Qq 163, 165, 172-173, 177](#)

45 [Qq 172-173](#)

46 [Q 163](#)

made better use of technologies, integration of mental and physical care and more effective prevention of illness, the residual funding requirement would be 1.5% in real terms each year—which it hoped would be less than GDP growth.⁴⁷

12. The National Audit Office found, however, that trusts do not collect and record cost data consistently enough or in enough detail for systematic analysis. For example, Monitor reported in 2013 that a lack of detailed data on employment costs collected in a consistent way made it almost impossible to distinguish between avoidable and unavoidable components of expenditure.⁴⁸ Monitor and NHS England agreed that the NHS needed a much more systematic, detailed and consistent approach to costing across the whole of the provider sector. They said that this would provide individual providers, commissioners and national oversight bodies with a much better insight into what was happening.⁴⁹

13. The NHS *Five Year Forward View* challenges local leaders to look beyond their individual organisations towards development of whole healthcare economies.⁵⁰ NHS England acknowledged that in most areas different services operated separately from one another.⁵¹ Different organisations were looking at their own deficits and surpluses, and there was not an overall long-term plan.⁵² As a result, there was a gap between what clinical commissioning groups were intending to commission and the income that trusts were expecting to receive; and many clinical commissioning groups were in surplus while hospitals were struggling.⁵³

14. The National Audit Office found that most commissioners and providers felt the new structure was fragmented, and that they thought no organisation was responsible for taking a strategic view across the whole health economy.⁵⁴ Coventry and Warwickshire University Hospitals NHS Trust suggested that following the reform to the health system, which took place in April 2013, there was no clear organisation in place for system leadership, and it was important for local organisations to work together to lead their own systems. The Trust said that it had only recently been seeing representatives from NHS England, the NHS Trust Development Authority and clinical commissioning groups coming together to provide leadership in their local health economy.⁵⁵ NHS England told us that in the past nine months relationships between different organisations had ‘come on an enormous distance’; and national bodies were ‘increasingly ensuring there was a shared point of view’ about required changes to models of care in each area.⁵⁶

47 [Q 203](#)

48 [Q 178](#); [C&AG's Report, para 2.12](#)

49 [Q 178](#)

50 [Q 141](#)

51 [Qq 111, 113, 128, 151](#)

52 [Q 23](#)

53 [Qq 110, 116](#)

54 [C&AG's Report, para 19](#)

55 [Qq 11, 17](#)

56 [Qq 140-141](#)

15. Healthcare services are provided under different payment mechanisms with financial incentives that are not aligned.⁵⁷ For example, community care services tend to use block contracts where payments are not based on the number of patients handled, whereas acute services are paid on the basis of activity using ‘payment by results’ tariffs.⁵⁸ This makes it financially difficult for acute hospitals to give up activity and for services in the community to take on additional activity. NHS England noted that it wanted to change the way it pays for all healthcare, so that it would be easier to integrate services and design the models of care set out in the *Five Year Forward View*.⁵⁹ It told us that it was planning to move away from paying for each component of care and instead moving towards paying for a ‘year of care’.⁶⁰ This payment arrangement is known as ‘capitation’ where a group of providers are paid a set amount for each person assigned to them, per period of time, whether or not that person seeks care. Monitor and NHS England noted that they would shortly publish a paper on their proposals, and that they were also consulting local clinical commissioning groups and providers on these changes.⁶¹

16. It is government policy that all NHS trusts should achieve foundation status, if they are to succeed in a financially demanding environment. Becoming a foundation trust requires strong governance, long-term financial viability and a framework to deliver quality services. The NHS Trust Development Authority told us that there were still 93 NHS trusts yet to achieve foundation status, and it was reviewing how long it would take for these trusts to achieve foundation status in the current environment.⁶² Among these trusts there is a group that will need at least four years and will need to overcome significant financial challenges before they can produce a viable plan.⁶³

57 [Q 46](#)

58 [C&AG's Report, paras 2.5-2.6](#)

59 [Qq 101, 105, 109](#)

60 [Q 178](#)

61 [Qq 110, 178](#)

62 [Q 208](#)

63 [Qq 210-211](#)

Formal Minutes

Monday 19 January 2015

Members present:

Mrs Margaret Hodge, in the Chair

Mr David Burrowes	Dame Anne McGuire
Stephen Hammond*	Austin Mitchell
Chris Heaton-Harris	Stephen Phillips
Meg Hillier	John Pugh
Stewart Jackson	Nick Smith

Draft Report (Financial sustainability of NHS bodies), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 16 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Thirty-fifth 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.

[Adjourned till Wednesday 21 January at 2.00pm]

* *Stephen Hammond was not a Member of the Committee when it took evidence in relation to this Report.*

Witnesses

Wednesday 19 November 2014

Questions

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at www.parliament.uk/pac.

Andy Hardy, Chief Executive, University Hospitals, Coventry and Warwickshire NHS Trust; **Matthew Hopkins**, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust; **Dr Peter Green**, Chief Clinical Officer, Medway CCG; and **Rob Larkman**, Interim Chief Officer, Barnet CCG

[Q1-95](#)

Richard Douglas, Director General of Finance and NHS, Department of Health; **Simon Stevens**, Chief Executive, NHS England; **Dr David Bennett**, Chief Executive, Monitor; and **David Flory CBE**, Chief Executive, NHS Trust Development Authority

[Q96-249](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/pac. AMS numbers are generated by the evidence processing system and so may not be complete.

- 1 Foundation Trust Network ([FNB0001](#))
- 2 The Department Of Health ([FNB0003](#))

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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Fifth Report	Infrastructure investment: impact on consumer bills	HC 406
Sixth Report	Adult social care in England	HC 518
Seventh Report	Managing debt owed to central government	HC 555
Eighth Report	Crossrail	HC 574
Ninth Report	Whistleblowing	HC 593
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Twelfth Report	Update on preparations for smart metering	HC 103
Thirteenth Report	Local government funding: assurance to Parliament	HC 456
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Fifteenth Report	Maintaining strategic infrastructure: roads	HC 105
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Twenty First Report	The Work Programme	HC 457
Twenty Second Report	Out-of-hours GP services in England	HC 583
Twenty Third Report	Transforming contract management	HC 585
Twenty Fourth Report	Procuring new trains	HC 674
Twenty Fifth Report	Funding healthcare: making allocations to local areas	HC 676
Twenty Sixth Report	Whole of government accounts 2012–13	HC 678
Twenty Seventh Report	Housing benefit fraud and error	HC 706
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Twenty Ninth Report	Managing and removing foreign national offenders	HC 708
Thirtieth Report	Managing and replacing the Aspire contract	HC 705
Thirty First Report	16- to 18-year-old participation in education and training	HC 833
Thirty Second Report	School oversight and intervention	HC 735
Thirty Third Report	Oversight of the Private Infrastructure Development Group	HC 675
Thirty Fourth Report	Financial sustainability of local authorities 2014	HC 833