The Government's Response to the Health Select Committee's Report on NHS Deficits

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
February 2007

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Introduction

1. This Command Paper sets out the Government's response to the Health Select Committee's First Report of Session 2006-07 on NHS Deficits.

2. The Government welcomes the Committee's Report and the valuable contribution it makes to the wider debate on NHS finance. Many of the recommendations resonate firmly with actions already being taken by the Department of Health to improve financial management both centrally and within individual NHS organisations, whilst ensuring a sustained return to overall financial health across the NHS.

3. Since 1997, the Government has invested an unprecedented level of funding in the health and social care system. The level of available funding for the NHS doubled between 1997-98 and 2006-07 (£34.7 billion to £84.4 billion in 2006-07), and will effectively treble by the end of 2007-08. In fact, under the current administration, the NHS has enjoyed average annual real terms growth of 6.3% – more than double the level of historic annual growth before 1997.

4. It is a fact that every NHS organisation received an above inflation funding increase in 2006-07, and will do so again next year. A great deal has been achieved with this unparalleled level of investment in terms of service transformation and delivery of improved patient care. It is also a fact that the majority of NHS organisations have delivered these high quality improvements for patients, whilst remaining in financial balance or better.

5. Moreover, by allocating the vast majority of centrally held funds through the central budget bundle, thereby devolving far more of the increased funding directly to the NHS and complementing three-year allocations to PCTs, the NHS now has much greater flexibility to meet both national targets and local needs. The Government believes that ring-fencing budgets and micro-management of the NHS is not the solution to produce better financial health.

6. Returning the NHS overall to a financially sound position has been a key priority in 2006-07. At the start of the year, the Secretary of State set out three clear financial objectives. Progress against these targets is reported on a quarterly basis in the NHS Finance Reports laid before Parliament:

   i) to deliver net financial balance across the NHS (i.e. that after the reduction in resources to cover the 2005-06 deficit, the sum of gross surpluses and gross deficits is zero);

   ii) to see an improvement in the financial performance of all organisations which reported a deficit in 2005-06; and

   iii) to achieve recurrent monthly run rate balance (where monthly recurrent expenditure is covered by monthly recurrent income) across as many NHS organisations as possible by 31 March 2007.

7. These financial objectives are to be delivered whilst also ensuring that Public Service Agreement targets (e.g. on elective waits, cancer waiting times, patient choice and booking, access to sexual health services, MRSA and reducing health inequalities) are also achieved.

8. We accept that not every organisation will regain financial balance in 2006-07. The Department continues to work closely with those organisations, acting through the SHAs and turnaround teams as appropriate. Action plans have been agreed with SHAs to ensure that financial performance continues to improve. We continue to work with the NHS to improve the data quality of NHS financial information. The appointment of the NHS Financial Controller has strengthened our strategy to improve financial management and performance within the NHS.

9. All areas of the country have seen significant improvements in service delivery, yet we accept that there are some difficult decisions ahead for a number of deficit organisations. However, all NHS organisations need to continue to look at the way they provide services to patients to ensure they are delivering the best possible value for money. We recognise that this may require NHS organisations to make tough decisions to ensure funding is being used in the best possible way.

10. The Government believes that NHS deficits have arisen for a variety of reasons and over a number of years. It is not possible to attribute deficits to any one factor taken in isolation. Independent Government auditors have agreed with our assessment that there is no single, simple cause of deficits, just as there are no single, simple solutions for eradicating them.

11. In his report on NHS Financial Performance 2005-06, published in June 2006, the Department's Director of Finance commissioned further detailed analysis from the Department's Chief Economic Advisor, asking him to consider factors that may have caused the emergence of deficits in 2004-05 and contributed to their geographical distribution. The Chief Economist's report, entitled 'Explaining NHS deficits, 2003-04 to 2005-06', discusses a range of evidence concerning NHS deficits and explores potential explanations for the timing, geographical patterns, and organisational structure of deficits.

12. The Department accepts that in past years a number of the accountancy rules operating in the NHS may have served to mask underlying financial problems. In recent years therefore, we have increasingly tightened the NHS financial regime to prevent this – and our actions may have exposed the real financial position in many organisations. For example, from 2006-07 we have stopped the movement of money round the system by abolishing both brokerage and planned support. All NHS organisations now have to address underlying financial issues and take steps to ensure that they live within their means.

13. We believe it is important to consider deficits in the current financial context. The Department will publish the Quarter 3 NHS Finance Report on 20 February 2007. On the basis of results reported by individual organisations, we expect the NHS as a whole to deliver net financial balance as planned by the end of this financial year.

14. Strategic Health Authorities have successfully identified savings of at least £450 million from their prudent management of the central budget programme which are available to offset the deduction made to NHS resources this year in respect of prior year overspends. These central programme savings have not yet been applied to individual organisations but are held as a central reserve within the NHS. Taking this central reserve into account, at this stage of the year, the NHS is forecasting a net surplus of £13 million.

15. Deficits continue to be concentrated in a minority of organisations – 50% of the gross deficit is to be found in just 6% of organisations at Quarter 3. By far the majority remain in financial balance or better and are delivering improvements to access and quality. For example, waiting times remain at record low levels, cancer patients are being treated faster, and although A&E attendances are increasing patients are still being seen within targets.

16. There has been a huge improvement in the financial position of the NHS since the end of last year. We can see this by considering the movement in the net deficit. At the end of 2004-05, this stood at £221 million, and increased to £547 million by the time of the 2005-06 final accounts. If this trend had continued on a straight-line basis, we might have expected a deficit of around £750 million by the end of the current year. However, the forecast net surplus of £13 million at Quarter 3, and our expectation to at least achieve financial balance by the end of the year, shows just what a significant improvement there has been.

17. To give the NHS greater certainty and more time to plan, the Department issued the 2007-08 NHS Operating Framework in December 2006 – much earlier than in previous years. It is also our aim to agree 2007-08 financial plans with the NHS by the end of March.

18. In terms of financial management, we are deliberately moving towards a more rules based system which will bring some much needed rigour and transparency to the NHS. The Operating Framework instructs the NHS to build a sustainable financial position in 2007-08, based on achieving financial balance in 2006-07. This will be especially important as we move into the new Spending Review and allocation period. In 2007-08, the NHS will therefore have to deliver:

    a. A net surplus of at least £250 million as organisations generate surpluses to recover historic overspending;

    b. A significant reduction in the value of gross deficits;

    c. A majority of organisations operating in recurrent balance throughout the year.

The Government's response to the Health Select Committee's recommendations and conclusions

Resource Accounting & Budgeting (RAB)

It is difficult to assess how long the NHS has been overspending, as deficits were hidden in the past. Deficits were revealed by policy changes which increased transparency, in particular the switch in accounting procedures to RAB. RAB has led to the double deficit problem. As a result of RAB the in year deficit for 2005-06 was exaggerated by £117m.

We agree that as presently operating RAB is not a suitable accounting regime to use within the NHS. We recommend that an alternative to, or refinement of, RAB be introduced. It is fundamental that the regime chosen does not reduce trusts' income at the same time as requiring them to pay back any deficit owed.

19. In *The NHS in England: the Operating Framework for 2007-08*, the Department announced changes to the financial regime to ensure it is fit for purpose for the future. The proposed changes were supported by the *Audit Commission Review of NHS Financial Management and Accounting* published in July 2006. The Audit commission made recommendations on a number of aspects of financial management including the application of the RAB regime to NHS Trusts.

20. The RAB system was introduced across Government to ensure that public sector organisations manage and account for their use of resources in a way that requires a focus not only on short term cash flow but also managing longer term commitments. As a cross Government system RAB will continue to apply to the Department of Health, and, as confirmed by the Audit Commission, it remains appropriate for primary care trusts.

21. In the past we applied RAB to the NHS for three very good reasons:

    - The regime provided a strong disincentive to overspending. An overspend/deficit in one part of the NHS has to be matched by an underspend/surplus elsewhere in the system so that the NHS as a whole can balance;
    - RAB means we do not need a large buffer at the centre;
    - The regime has brought commercial discipline to the management of income and expenditure.

22. The Audit Commission concluded that the RAB regime is incompatible with the NHS trust financial regime and should not be applied to those organisations. The Audit Commission report also recommended that individual NHS trusts which have had income reductions as a result of RAB adjustments should have the resources returned to them and that the Department create a buffer to absorb the impact.

23. The Department accepts the rationale of the Audit Commission report and the comments of the Health Select Committee in respect of the applications of the RAB adjustment for NHS trusts. RAB as it is currently applied to NHS trusts provides a strong disincentive to overspend, however it will become increasingly unsustainable as we move forward with the programme of reform for three reasons:

- Inconsistent application across strategic health authorities, with some taking deductions down to individual trusts and others absorbing at SHA level;
- Income deductions are inconsistent with the principles of payment by results;
- The system is not applied to Foundation Trusts.

24. At this stage, it is not possible to commit to changing the RAB regime for NHS trusts or to reverse the impact of past RAB reductions for two reasons:

- A resource buffer would need to be created from existing resources. No additional resources will be provided by Government for these purposes;
- It needs to be demonstrated that NHS trusts have the financial discipline to operate outside the RAB regime and will respond appropriately to the incentives and disincentives created by cash controls similar to those applied to foundation trusts.

25. In this context, the Department is looking seriously at the case for reversing the impact of past RAB deductions for NHS trusts for delivery of financial balance in 2006-07 and at the future application of the RAB regime for NHS trusts.

SHA Reserves

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

26. We agree that the top-slicing of PCT allocations to create SHA reserves is a temporary expedient, with 2006-07 contributions being returned to the originating organisations as soon as possible. It has been for SHAs locally to agree with their organisations the level of contribution to, and the subsequent application of, these reserves. Contributions will reflect local financial circumstances, based on an underlying principle of fairness. We expect SHAs to maintain the integrity of the allocations system, with PCTs entitled to repayment of any contributions over a reasonable period not usually exceeding the three-year allocation cycle. SHAs have been asked to ensure PCTs with the greatest health need are the first to be repaid. The return of any top-slice is linked to the speed of the financial recovery within the NHS as a whole.

27. The NHS is required to achieve overall financial balance in 2006-07 and individual financial plans were agreed with each of the ten Strategic Health Authority Chief Executives. Delivery of these financial plans by individual organisations has been and continues to be managed locally by each of the SHAs, monitored by the Department.

28. From 2007-08, the return of funds to the originating bodies is dependent upon the financial recovery of historic deficits across the NHS. Equally, the return of reserves to the individual organisations that supplied them, is dependent upon those NHS Trusts which have borrowed under the loans and deposits scheme generating a sufficient surplus to repay the amount borrowed and/or PCTs delivering an underspend.

29. One of the key objectives in the 2007-08 Operating Framework is for delivery of a net surplus across the NHS of at least £250 million as organisations generate surpluses to recover historic overspending. This underpins the 2007-08 financial planning assumption and will support the return of top-slices to the originating organisations.

30. As the 2007-08 Operating Framework makes clear, as a consequence of the return of the NHS to overall financial balance, SHAs will not generally require the scale of contribution to strategic reserves seen in 2006-07. Reserves should largely only be used to moderate over a reasonable period of time the impact of RAB deductions to PCTs or support locally agreed revenue investment linked to service change. Where continuing contributions are required, they must be subject to clear and transparent rules covering purpose, the accounting treatment of reserves, and the timescale for repayment.

Contingency

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

31. There are no plans to create a central contingency in 2007-08. However, as discussed in our point on RAB, the Department accepts the rationale of the Audit Commission's report and the comments of the Health Select Committee in respect of the applications of the RAB adjustment for NHS trusts. If, at a later stage, it were possible to change the RAB regime for NHS trusts, or to reverse the impact of past RAB reductions, the NHS would be expected to create a resource buffer from its existing resources. No additional resources would be provided by Government for these purposes.

Examining trust accounts

The Department should consider examining the accounts of all trusts within a single health economy. The Department's data on this subject should be published as soon as possible.

32. The Department welcomes the Committee's suggestion, and although this may be a matter more appropriately managed by the ten Strategic Health Authorities, we will work with them to examine wider options for considering and reporting financial data on a health economy basis. The Committee will be aware that much of the financial information published to Parliament in the quarterly NHS finance reports is already reported at an aggregate SHA economy level, which effectively records an overall or net position for all organisations within an SHA area.

Failure strategy

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

33. Whilst there is currently no formal "failure strategy" in place for NHS Trusts, all trusts are subject to performance management by their strategic health authority and are required to submit comprehensive and frequent financial reporting to the Department of Health. During 2005-06 as the financial position of a number of NHS Trusts worsened, Department of Health intervened by deploying turnaround teams to those organisations in financial difficulty, working with the trusts towards achieving financial recovery. Recovery plans and turnaround plans are instrumental to this activity.

34. Moving forward, the Department of Health published a consultation document on 27 November 2006 proposing a new regulatory framework for health and adult social care. It confirmed the Government's commitment to merge the Healthcare Commission, Commission for Social Care Inspection and Mental Health Act Commission into a single regulator for health and adult social care.

35. The document drew on an evidence base from the Wider Regulatory Review, the Third Sector Commissioning Task Force and independent research into regulatory models in other sectors and other countries. It describes seven regulatory functions and seeks to achieve a balance between system management and independent, national regulation.

36. The seven regulatory functions are safety and quality assurance, promoting choice and competition, commissioner assurance, information provision and performance assessment of providers, price setting and allocation of resources, stewardship of publicly owned assets and distress/failure interventions.

37. This consultation initiates the implementation of a formal failure strategy, incorporating the course of actions required where organisations have, or are likely to, fail financially.

The Funding Formula

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

There is concern about the fairness of the funding formula. We recommend that the formula be reviewed. Consideration should be given to basing the formula on actual need rather than proxies of need.

38. Revenue allocations to Primary Care Trusts (PCTs) are based on a fair shares funding formula that directs funding to those areas of greatest need.

39. The funding formula is continually overseen by Advisory Committee on Resource Allocation (ACRA), which is an independent body made up of NHS management representatives, GPs and academics. Its broad objective is to ensure equity in NHS resource allocation. The Committee makes recommendations to Ministers on proposed changes to the funding formula, based upon primary research and the best available evidence and data.

40. ACRA is currently undertaking a review of the funding formula. The review of the need element of the formula will start with an assessment of the current formulae, leading to the development of alternative formulae for future PCT allocations. It will also investigate the applicability of the formulae (or variants) for resource allocation at practice level in support of Practice-based Commissioning. The research specification for the review specifically asks researchers to consider more direct approaches to measuring need, and to compare with utilisation-based approaches.

41. Research is also about to be commissioned to look at the feasibility of an alternative approach, developing formulae at practice level consistent with Practice-based Commissioning (PBC), and basing resource allocation to practices on the characteristics of individuals. The first (feasibility) stage of this research is expected to be completed by autumn 2007, but will need further work before it could be used for allocations. This research will also consider alternative measures of need.

42. The review of the funding formula also includes looking again at the Market Forces Factor (MFF) and the issues faced by rural areas. The review is expected to be completed by autumn 2007, when ACRA will make recommendations to Ministers. These will inform revenue allocations to PCTs post 2007-08.

43. The allocation formula introduced in 2003/04 provides the best available measure of health need in all areas. In calculating health need in rural areas, it takes account of the effects of access, transport and poverty.

44. The need for the MFF was first recognised in 1976 – it is clear that some parts of the country face higher costs than others. Even where national pay rates limit local pay flexibilities, some parts of the country face higher costs in the form of higher staff turnover, higher recruitment costs and higher agency costs. The MFF is based on research carried out by the University of Warwick, and its development is overseen by the ACRA.

Poor Central Management

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

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

45. We recognise that elements of the Government reform programmes, such as aspects of pay reform, cost more than we initially envisaged. However, as we set out in our evidence to the Committee, other parts of the programmes, such as the price of drugs prescribed in primary care, have cost less. Reforms such as PFI and ISTCs are making a substantial contribution to improving the quality of patient care and reducing waiting times. The NHS has received the highest sustained rate of funding growth in its history, and the record funding increases received in all areas of the country should have been sufficient to deliver the Government's programme of service improvements.

46. Most of the service improvement requirements set for NHS organisations were known well in advance, and we introduced three year PCT allocations to give certainty of funding several years ahead. The Department of Health accepts that some information important for financial planning for 2006-07 was issued later than it should have been, including the national tariff which then had to be withdrawn due to errors in its calculation. This has been improved for 2007-08, with a road-tested national tariff published alongside the NHS Operating Framework in December 2006. The Department's aim is to agree financial and delivery plans with individual NHS organisations by the end of March.

47. The Government accepts that Payment by Results has created some tension in the NHS system, which the Committee has characterised as an "additional hurdle". However, we believe that the discipline of a fixed price, national tariff, is entirely appropriate and is helping to introduce a degree of financial rigour which may not always have been evident in the past. Commissioners and providers are directly incentivised to have a serious dialogue about what activity is actually being provided, about the true costs of provision, and about the management of demand. As a result of PbR, the choices that patients and their GPs make about their care will ensure that good quality providers who attract patients are properly rewarded for the extra work they do. Providers are investing more time and effort in accurate coding and good data quality; this is of itself no bad thing, though our PbR Code of Conduct makes clear our expectations about providers giving advance notice of changes in coding practice. The PbR assurance framework we are rolling out in 2007-08 will use national benchmarking to underpin a programme of external audit, thereby improving the accuracy of data which supports the whole Payment by Results programme.

48. The Department accepts that there were problems with the initial publication of the national tariff for 2006-07, and has made significant changes for 2007-08, as a direct result of the recommendations of the independent report we commissioned. Amongst other things, we have increased the number of people dedicated to tariff work, we have overhauled our governance arrangements, and we published the 2007-08 tariff in October 2006, for NHS "road testing", five full months before it is required. The same principles of openness, certainty and accountability are informing our preparations for 2008-09. We will shortly publish a consultation document on the Future of PbR, setting out our medium term plans and our longer-term aspirations. This document will highlight the steps we are taking to strengthen the "building blocks" of PbR, for example through improved costing of NHS work to better inform tariff calculations.

49. We have always recognised that a national tariff, based on average costs and average case-mix, may not adequately differentiate between routine and complex work. Every country in the world operating a prospective payment system faces similar problems, and PbR is no exception. For this reason, we have worked closely with organisations representing providers of specialised services to agree that some highly specialised work should be excluded from the tariff altogether. For other services a "top up" payment is payable in addition to tariff. The range and percentage value of this top up has been informed by advice from the specialist providers themselves. In the longer term, our aim is to introduce improved currencies, which better reflect case-mix complexity than the current arrangements. We do not under-estimate the importance of case-mix in establishing a fair and credible tariff, and in particular ensuring that specialised services are fairly rewarded. We will therefore continue to work closely with the specialist service providers. Under the new PbR governance arrangements, our expert Clinical Advisory Panel has agreed that this topic will be considered as part of its first year's work programme.

Turnaround Support

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

50. We accept that around £22 million will have been spent on the turnaround programme between January 2006 and March 2007. Out of this total, approximately £19 million relates to consultants appointed by individual organisations to assist them in the development and implementation of cost improvement plans.

51. Following the PCT reconfigurations in October 2006, 104 organisations are currently part of the turnaround programme.

52. The Turnaround programme was established to provide expert and independent assistance in the development of robust and credible financial recovery plans for those organisations in particular financial difficulties. The programme also provides specific methodologies to support the delivery of the plans, and to assist in the delivery and monitoring of progress against the plans.

53. The cost of the turnaround teams is a small fraction of 1% of the turnover of those organisations in the turnaround programme. The Department believes that these organisations will make cost savings significantly in excess of this cost.

54. The value of the turnaround programme, coupled with all other measures introduced by the Department in 2006-07 to improve financial management throughout the NHS, is evident in the significant improvement in the overall financial position reported at Quarter 3. The net deficit of the NHS, excluding Foundation Trusts, reported in final accounts for 2005-06 was £547 million. At Quarter 3, the NHS is forecasting a surplus of £13 million with an expectation that at least financial balance will be achieved by the end of the year. The aggregate deficits of organisations in the turnaround programme have been reducing significantly during 2006-07. The rigour inherent in the turnaround programme is assisting in achieving the improved overall position in 2006-07.

55. The Department is ensuring that issues, strategies, learning points and knowledge are shared across the Turnaround organisations and, additionally, the whole of the NHS.

Staff costs

A few deficits relate to intractable historic problems, many are associated with the extraordinary growth in staff costs arsing from pay rises and the large increase in staff numbers. The pay rises have far exceeded the Department's estimates and the numbers of new staff are far higher even than the figures proposed in the NHS Plan. The growth in staff costs points to serious underlying failures in the financial management of the NHS, which have occurred at all levels of the organisation, from the Department of Health to PCTs.

56. We agree that the initial costs of pay reform have exceeded the Department's estimates by a relatively small margin in relation to the pay bill concerned. We also agree that recruitment and retention have been stronger than expected, that these two factors have produced higher growth in the NHS pay bill than we had planned, and that this has contributed to short-run financial pressures in the NHS.

57. We do not agree, however, that these factors are the main reasons for deficits, or that they point to serious underlying failures in the financial management of the NHS. Each of the pay reforms addressed fundamental weaknesses in the previous pay contracts, including recruitment and retention problems, poor control over outputs provided by doctors and other staff, poor control over earnings growth, low productivity growth and significant exposure to equal pay risks. The fact that the contracts address these inherent weaknesses is evidence of good long-run financial management.

58. The estimated overruns on these contracts should also be seen in the context of the total pay bill for the groups in question. The estimated overrun on the consultant contract in 2005-06 represented around 2.3% of the total consultant pay bill in 2005-06, and the estimated excess cost in the first 12 months of the Agenda for Change contract represented between 0.8% and 1.5% of the Agenda for Change pay bill in 2005-06.

59. Since the contracts were entered into, pay settlements have fallen relative to inflation. Unplanned earnings drift has fallen, and vacancies in all sectors have reduced to historically low levels. The additional staff recruited and retained have in turn led to a significant reduction in patient waiting times. It remains to be seen whether the initial excess costs will be offset by the improved overall control established by the new contracts, improved productivity growth and the reduced risk of successful equal pay claims against NHS employers.

60. We accept, however, that there are lessons to be learned from the excess initial cost estimates for all these contracts, and from the higher than planned recruitment in some individual NHS organisations. The Department is planning its own internal evaluation of the lessons to be learned, and the further steps that may be needed to ensure that the new contracts are used to improve overall financial control, increase productivity, and improve the quality of services for patients and working conditions for staff.

Reduction in Workforce

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

61. These headline figures reflect reductions in the number of posts, not the number of redundancies. As Trusts become more efficient, they can continue to provide high quality care with fewer staff. We know from individual Trusts and SHAs that the reductions in posts are being managed in ways that minimise the need for redundancies – for instance through recruitment freezes, natural wastage, and redeployment.

62. The actual number of compulsory redundancies reported in 2006-07 in Trusts, is low out of an organisation that employs over a million staff. Far from hitting nurses, the vast majority of these redundancies have been focussed on managers and administrative staff, and away from frontline staff and patient care. This is further evidence that the reductions are being managed in such a way as to minimise their impact on front-line services.

63. Nationally 64% of nursing, 71% of midwifery, and 64% of Allied Health Professional (AHP) graduates are estimated to have found work. This picture varies around the country – for nurses from 51% to 86%, for midwives from 34% to 100%, and for AHPs from 44% to 89%. Again we have evidence from Trusts and SHAs of a range of good practice around graduate recruitment in three main areas – changes to the use of preceptorship and Health Care Assistants (HCA) posts for newly qualified staff on the nursing bank, more flexible working and recruitment arrangements, and the development of new roles for newly qualified staff. The position is most difficult for physiotherapy graduates where nationally 58% are estimated not to have found work. We are working with SHAs to ensure that steps are taken within each region to provide practical support for newly qualified graduates and maximise their chance of securing employment.

Cuts in Education and Training budgets

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

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

64. Funding for developing the healthcare workforce through the Multi Professional Education and Training levy (MPET) was allocated to SHAs in 2006-07 as part of a bundle of central budgets. This was done to allow SHAs greater flexibility to use resources to address local priorities including financial deficits. The result of this has been that expenditure on workforce development has been cut, leading to reductions in numbers of commissioned training places and support for NHS organisations providing training places for students and trainees.

65. For 2007-08 allocations for MPET have again been included in the bundle of central budgets. The MPET share of the bundle has been increased to reflect the costs of an increasing number of trainees especially medical students and training grade doctors. Although MPET funding will not be ring fenced, there will be a more robust service level agreement which will seek to ensure that SHA decisions on what training to fund and the level of commissions of training places requires are made on the basis of long term workforce need. SHAs will be held to account on the basis of key outputs and not on the basis of spending a particular amount of money on workforce development.

Recovery Time to Pay Debts

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

66. Returning the entire NHS to a financially sound position has been a key priority in 2006-07. Sustaining this good financial health throughout the NHS will be a key objective in 2007-08. The Department continues to work closely with Strategic Health Authorities to help those NHS organisations forecasting deficits. Action plans have been agreed with SHAs to ensure that financial performance continues to improve. Those appointed to manage and lead SHAs and PCTs, supported where appropriate by turnaround teams, fully understand the importance of both improving the quality of care for patients and achieving better value for money for tax payers in the context of financial balance.

67. We recognise that some NHS organisations are facing very challenging financial agendas. However, NHS organisations must live within their means. Any deficits in NHS Trusts (or indeed any other NHS organisation) must be matched by surpluses or underspends elsewhere in the NHS. In the year after it has recorded a deficit, an NHS Trust should strive to make a surplus, to ensure that other bodies can utilise underspends from the previous year.

68. In circumstances where a surplus cannot be generated in the following year, for example in the case of the small number of organisations with particularly large deficits, SHAs can agree to a recovery plan which phases the recovery of those deficits over a number of years. This would require other NHS organisations within the health economy to underspend over the same period. Any such arrangements would have to be subject to the agreement of local providers, commissioners and the managing SHA.

69. NHS trusts have a statutory duty to break-even over a three (exceptionally five) year period. Over the period, all deficits must be matched by equivalent surpluses. All NHS organisations should continue to comply with current statutory and financial duties. Indeed, in 2007-08, we will expect the NHS overall to plan to deliver a net surplus of at least £250 million, over and above the surpluses required by trusts to make loan repayments to the Department.

70. Significant changes have been made to the way historic cash problems are managed and reported from 2006-07. Under the new financial regime, cash to finance deficits is no longer a free good – trusts that overspend will need to borrow cash, pay interest and repay loans, all of which will be clearly visible in individual organisations' accounts. This has not been the case in the past where cash was moved between organisations by the informal brokerage system.

71. From this financial year, deficits remain where they occur. By abolishing the opaque system of brokerage and planned support, we have stopped the movement of money round the system that might otherwise have masked deficits. We have allowed Strategic Health Authorities to top-slice their PCTs, and build up a reserve for their overall economy. These reserves are designed to allow an SHA to deliver an overall balanced financial position for their area, but not by moving money about. Money would certainly not be moved from an organisation which is performing well to a poorly performing one.

72. It is an important part of an SHA's management of its economy that as many of its organisations as possible are in balance or better. Shifting deficits would be contrary to this performance management principle.

Cuts to vulnerable services

Although there have been few redundancies the posts lost by retirement and natural turnover have affected patient services. Soft targets such as mental health and public health services have also suffered as has funding for voluntary organisations. We believe this to be unacceptable.

73. All areas of the country have seen significant improvements in services, and continue to deliver improvements to access and the quality of patient care, despite a minority of NHS organisations being in deficit. Indeed, waiting times remain at record low levels, cancer patients are being treated faster, and although A&E attendances are increasing patients are still being seen within targets.

74. We accept that some difficult decisions have to be made by a number of those NHS organisations currently in deficit. However, all NHS organisations need to continue to look at the way they provide services to patients to ensure they are delivering the best possible value for money.

75. For example, the Government has always made it clear that mental health services remain one of the top priorities for the NHS. The Department's mental health objectives on the delivery of the targets on Assertive Outreach, Crisis Resolution/Home Treatment and Early Intervention teams have been endorsed by the 2007-08 Operating Framework. We are committed to improving mental health services and our record demonstrates this. Over the last four years, there has been an unprecedented increase in investment in mental health services of around £1billion in real terms. Thanks to the strong emphasis we have put on improving mental health services since publishing the mental health National Service Framework and the NHS Plan, very significant progress has been made. For example, the move to treat some mentally ill patients in the community has reduced the number of acute mental health beds. As at January 2006, there were 343 crisis resolution teams, 118 early intervention teams and 252 assertive resolution teams in place.

76. We recognise that many NHS organisations have had to make tough financial decisions this year, and it is right that they look at how they deliver services to patients in the most efficient way possible. However, improving financial management does not mean compromising services for patients. To ensure that these services are not compromised the Department of Health has asked SHAs to ensure that local changes to spending plans are equitable across the local health economy, and that NHS organisations providing mental health and learning disability services should not be asked to contribute more in savings or cost improvement plans than any other service, unless the mental health or learning disability services contributed to the deficit.

77. Any cases raised with the Department of Health will be investigated and SHAs will be asked to demonstrate that local financial recovery plans do not require a greater proportion of a mental health provider's turnover in savings, than would be expected from local acute providers.

Planned support

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

78. From 2006-07, we have introduced greater transparency into the NHS financial system, not least by ending the practice of moving money around the NHS. We have abolished brokerage and planned support, both of which may, in the past, have masked deficits in individual organisations. Whilst in the short term this will have exposed some financial problems in the health care system, our action also means that organisations now have to address these problems and take steps to ensure that they live within their means. Deficits will remain where they occur, and will be transparent in the final accounts of individual organisations at the year-end.

79. In 2006-07, we have allowed Strategic Health Authorities to top-slice their PCTs and build up a reserve for their overall economy. Such reserves will allow an SHA to deliver an overall balanced financial position for their area, but not by giving support to any of its organisations in deficit. It is an important part of an SHA's management of its economy that as many of its organisations as possible are in balance or better.

Delay in recognising deficits

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

80. In recent years, the primary financial focus has been on organisations achieving financial balance or break-even (which, in the short-term may drive organisations towards incurring deficits). We have changed this financial focus, and, in the context of greater transparency, now encourage the NHS to plan towards achieving surpluses. We recognise that this change requires both a cultural and policy shift, as the Department has been criticised in the past for ending a financial year with an overall underspend.

81. The first part of the NHS Plan was concerned with building capacity to deliver real service improvements for patients. The next few years will be focused on consolidation of these improvements, and building sustainable financial health based on the NHS achieving financial balance in 2006-07.

82. Neither the NHS nor the Department have hidden deficits in the past – neither have they just appeared. Instead, our tighter grip on NHS financial management, our policy of holding firm to the numbers and not allowing money to move around the system, coupled with the outcomes of our reform agenda and an increased emphasis on data quality and performance management, have led to greater transparency in financial reporting and the exposure of underlying financial problems.

Failure of financial management

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

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

83. The Department accepts that within the highly complex NHS system, day-to-day financial management practice has not always been of a consistently high standard. With this in mind, we have critically evaluated our whole approach to financial and performance management, and have implemented a number of changes which are designed to improve both accuracy and financial control.

84. The Department has appointed a Financial Controller for the NHS. He and his team work directly with SHA Chief Executives and Finance Directors to challenge financial performance in individual organisations, and to improve the accuracy and quality of financial information, not least by the sharing of best practice, and more frequent and prescriptive data monitoring. Improved feedback mechanisms are now in place to ensure that issues of data quality, and the results of analysis, are played back to the NHS, so that corrective action can be taken as appropriate.

85. The publication of quarterly financial information supports our commitment to be more open and transparent about NHS accounts than ever before and has led to an improvement in data quality.

86. By publishing the 2007-08 NHS Operating Framework in December 2006, and the PbR national tariff in October 2006, the Department believes it has given the NHS the clarity it needs to plan more effectively for the next financial year. We intend to agree 2007-08 financial plans for all NHS organisations by the end of March, and in finalising the financial monitoring arrangements for 2007-08, will consider the extent to which accounting guidance needs to be restated.

87. There has been a huge improvement in the financial position of the NHS since the end of last year. We can see this by considering the movement in the net deficit. At the end of 2004-05, this stood at £221 million, and increased to £547 million by the time of the 2005-06 final accounts. If this trend had continued on a straight-line basis, we might have expected a deficit of around £750 million by the end of the current year. However, the forecast net surplus of £13 million at Quarter 3, and our expectation to at last achieve financial balance by the end of the year, shows just what a significant improvement there has been.

Poor Local Management

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

88. The Department agrees that, in some cases, local management is one of the factors contributing to NHS deficits, not least because all financial positions are to some extent the consequence of the management decision-making process.

89. Financial Management is one of the areas that will be assessed by the Auditors Local Evaluation scores. Each SHA is to set improvement targets in this area for 2006-07. The Finance and Staff Development (FSD) Board has developed twelve standards of good practice aimed at Finance Directors and their staff to promote improvements in financial governance, and will cover the whole finance function.

90. By publishing the 2007-08 NHS Operating Framework in December 2006, and the PbR national tariff in October 2006, the Department believes it has given the NHS the clarity it needs to plan more effectively for the next financial year. We intend to agree 2007-08 financial plans for all NHS organisations by the end of March, and in finalising the financial monitoring arrangements for 2007-08, will consider the extent to which accounting guidance needs to be restated.

Strengthen role and position of Finance Director

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

91. A national training programme for Strategic Financial Leadership is in the process of being set up and every organisation will be expected to support their Finance Director in attending this programme.

92. It has been a requirement for many years that all Finance Directors in the NHS are qualified accountants, affiliated to one of the Consultative Committee of Accounting Bodies (CCAB) professional bodies. The recent restructuring of SHAs and PCTs has provided the opportunity for Finance Directors with the appropriate professional attributes and levels of experience to be appointed. All Finance Directors will be assessed in respect of their suitability and competence as part of the wider Foundation Trust assessment and PCT Fitness for Purpose programmes. All CCAB organisations require their members to undertake a minimum level of continuing professional development training in each year, which ensures continued professional competence.

93. As noted above, the Department, in conjunction with Monitor, has set up a development programme for NHS Finance Directors. Two pilot courses will operate in the current financial year, and, subject to evaluation, all PCT and aspirant FT Finance Directors will then be expected to attend in the future.

94. The Finance Staff Development (FSD) Board has issued a publication entitled: "Role of the Finance Director", which highlights the responsibilities of Boards in respect of the finance function, and in particular the requirement that Board should take ownership of financial management.

95. The ten SHA Finance Directors have a key responsibility for the professional and other development of all finance staff within their overall SHA area.

Non-Executive members

Boards should include non-executive members with relevant financial expertise.

96. As part of the Foundation Trust Diagnostic programme and the PCT Fitness for Purpose programme the competencies of the non executives are assessed. This assessment includes financial competencies and where there are insufficient non-executives with the appropriate financial background this is addressed in the organisation's Action Plan.

97. The Appointments Commission is now working to a revised set of competencies when assessing the suitability of non-executive directors for appointment to NHS boards. These competences give a greater emphasis to financial management capability and the level of experience and expertise in running large, complex organisations. In addition, the revised fees for this category of director recognise the additional responsibility placed on the non-executive member in being the Chair of the organisation's Audit Committee. The restructuring of SHAs and PCTs has provided the opportunity for all non-executive directors to be appointed under these new criteria.

98. The Appointments Commission and Department expect that at least one non-executive director in each organisation will be financially qualified.

Organisations Collective responsibility

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

99. This area of Governance has been assessed through the Foundation Trust Diagnostic programme and the PCT Fitness for Purpose programme. Where there is lack of clinical engagement this will be strengthened as part of the organisations action plan.

100. The Finance Staff Development (FSD) Board has issued a publication entitled: "Role of the Finance Director", which highlights the responsibilities of Boards in respect of the finance function, and in particular the requirement that Board should take ownership of financial management.

Value for money

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

101. Since publication of the NHS Plan in 2000, the NHS has been expected to continue improving patient care, in particular by transforming A&E and cutting waiting times. As patient surveys show, the NHS has responded for the most part well to a challenging agenda designed to improve access and choice for patients.

102. The emphasis on costing policies properly is not about elevating financial considerations above those of either quality or care based on sound evidence; rather it is about making sure that evidence and the assumptions that flow from it are translated properly into financial terms.

103. We agree that proper financial management should not jeopardise the quality and effectiveness of NHS care and welcome the Committee's encouragement of our efforts to reduce spend on inappropriate interventions.

104. In October 2006 the NHS Institute published a suite of "Better care, better value" indicators to help the NHS identify and share best practice and improve efficiency and productivity. In total, the areas covered by the indicators identified a productivity opportunity in excess of £2 billion based on NHS organisations improving their performance to that of the top 25%. We plan to publish further indicators in 2007-08.

105. In addition, the National Institute for Health and Clinical Excellence (NICE) has embarked on a new programme of work in 2006-07 which is aimed at identifying ineffective practice. This was announced jointly by NICE and Department of Health Ministers in September 2006.

106. The Institute has already issued the first products from this new programme (guidance to commissioners to support decisions on potential service reconfiguration) and will be issuing recommendation reminders (based on existing published NICE guidance and aimed at identifying cost savings). The institute will also be publishing ineffective treatment guidance in cases where evidence suggests that current practice is no longer appropriate or effective and does not improve patient care. NICE will develop this programme further in 2007-08.

Policy costing and piloting

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

107. We welcome the Committee's support in this area. The Department is committed to improved policy costing. All large-scale business cases have been subject to robust financial challenge by a dedicated central unit, Revenue Investment Branch (RIB), since May 2006. The overriding objective is to ensure that the (cost) impact of policies on the NHS is understood better prior to their implementation.

108. We are at the start of a process to embed costing at the heart of policy development so that the emphasis shifts from challenge (which, whilst highly effective, is still reactive) in favour of getting costing right from the outset. A key element in this guidance and support package is the implementation of a costing handbook for use by all policy makers. Roll out will take place by the end of 2006-07. Further reinforcement will be provided during 2008-09.

109. There is already evidence that the Department is consulting with stakeholders to test the robustness of its policy proposals and is prepared to pilot projects where policies are novel and where little empirical data are available on which to base reliable costings. Examples of this approach include current work to extend choice in maternity services.

110. Besides specific pilots, work is under way to draw together expert panels from key specialisms in the NHS (such as Human Resource and Finance). These panels will be used by RIB as part of its independent challenge role and will comment on the reliability of costings and, more importantly, the assumptions on which they are based.

111. The assumptions on which costs are based can, for the most part be shared as part of this process or through effective consultation and piloting, subject to the constraints of commercial confidentiality.

112. Policy Costing will not of itself, eliminate the uncertainty involved in developing policy in new areas. However, it will provide a structured approach to recognising uncertainty and adapting as better data become available or circumstances change.

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