

King's Fund response to Health Select Committee inquiry on NHS deficits

Introduction

This paper is a response by the King's Fund to the Health Select Committee NHS deficits inquiry. The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding others. We are a major resource to people working in health and social care, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

1. The size of the deficits and the savings which each trust has to make in 2006–07

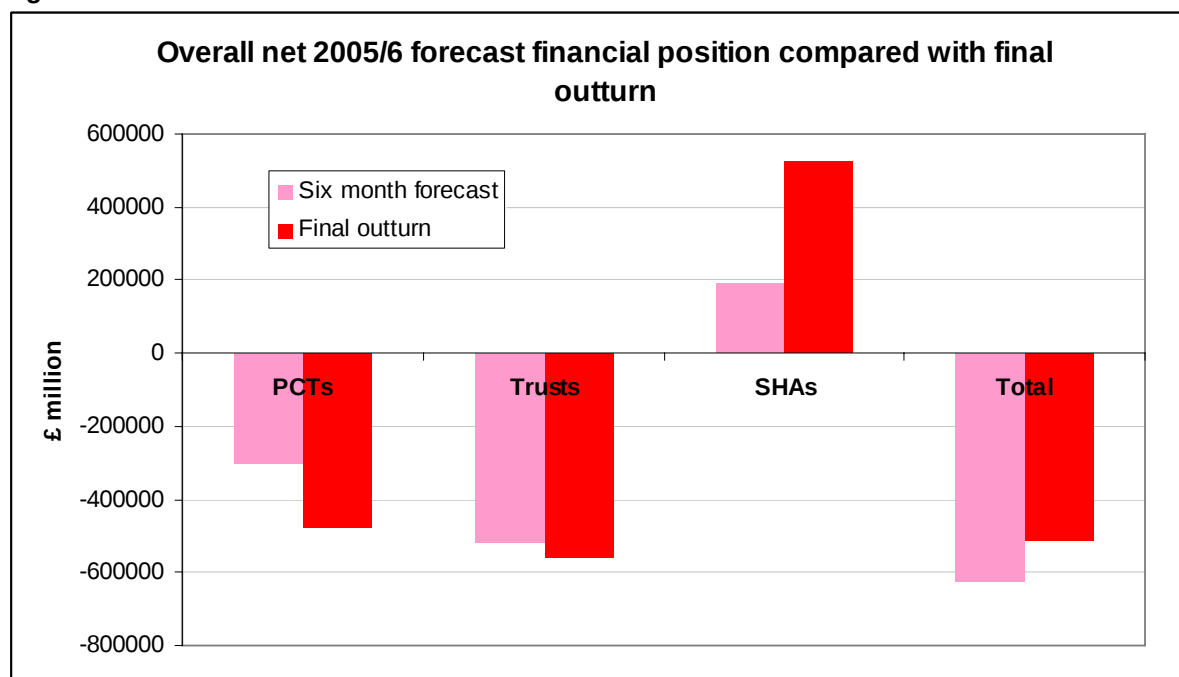
Final (unaudited) accounts 2005/6

The 2005/6 unaudited English NHS accounts (released on June 7th 2006) reveal a gross deficit of £1.277 billion, a gross surplus of £765m and a resultant net deficit of £512m. These figures exclude Foundation Trusts which recently reported equivalent figures of £53.8 million, £29.8 million and a net deficit of £24 million.

Overall, these figures represent not only a deterioration on the outturn position for 2004/5, but a worsening of the gross deficit position compared with the six month end of year forecast by NHS organisations.

Although the net deficit of £512 million is an improvement on the month six forecast of £623 million, this is almost entirely due to much larger *underspends* than forecast by Strategic Health Authorities - primarily on the NHS staff training budget (workforce development confederation) and not the result of improvements in trust and primary care trust finances (see figure 1).

Figure1



Further, while 133 NHS organisations forecast a deficit end of year position, the outturn indicates that this has increased to 174.

A more detailed organisation-by-organisation analysis of the accounts released on June 7th is required, but a first cut, comparing the six month forecast end of year position with the final outturn suggests the following:

Primary care trusts:

- Of the 70 (out of 303) PCTs forecasting at month six an end of year deficit, 38 finally reported a worsening of their deficit and 32 an improvement. Of the improving group, half reported surpluses and half remained in deficit.
- Of the 198 PCTs originally forecasting balanced books, 49 finally reported deficits (totalling £195.5 million), 139, surpluses (totalling £65 million) and 10 remained in balance.
- Overall, the gross PCT deficit rose from £348 million to £391 million, and PCTs forecasting a surplus (of £47 million) finally reported a total deficit of £84.5 million.

Trusts:

- Of the 61 (out of 235) trusts forecasting at month six an end of year deficit, 25 finally reported a worsening of their deficit and 36 an improvement. Of the latter, 20 finally reported a surplus (or balanced books) and 16 remained in deficit.
- Of the 145 trusts originally forecasting balanced books, 27 reported a deficit (totalling £148.2 million), 110 reported a surplus (totalling £69.6 million) and 11 remained in balance.
- Overall, the gross trust deficit fell by £35.8 million, but trusts forecasting a surplus of £34.5 million finally reported a deficit totalling £46.4 million.

Strategic Health Authorities:

- Of the 3 (out of 28) SHAs forecasting a deficit, all finally reported a surplus.
- Of the 7 SHAs forecasting balanced books, all, again, finally reported a surplus.
- Overall, the forecast gross SHA deficit of £50.6 million was finally reported as a surplus of £19.8 million. And the forecast net surplus of £193.2 million rose to £524 million in the final accounts.

Despite the intense pressure on the NHS since the publication of the month six forecast end of year position in December 2005, the overall picture revealed by the final (unaudited) accounts is not overly encouraging. While there have been improvements in many

organisations financial situation, half of those forecasting a deficit in December saw their position worsen. And the overall improvement in the net deficit was largely achieved by the large increase in surpluses reported by SHAs in the final accounts, while the net deficit position of trusts and PCTs worsened overall.

Savings required by NHS organisations in 2006/7 as a result of 2005/6 net deficit

It is difficult to be precise the level of savings that the NHS will make in 2006/7 as a result of the carry forward of the 2005/6 deficit as this hinges on the application of the resource accounting and budgeting (RAB) framework principles and decisions about the period over which recovery plans are agreed.

In principle, NHS Trusts ending 2005/6 with a deficit are wholly responsible for recovering their financial position. Again in principle, the period over which they do this can extend exceptionally to four years, under a recovery plan agreed with their SHA. Under RAB, organisations in deficit in 2005/6 will have their allocations in 2006/7 reduced by the amount of the deficit in order that the Department of Health remains within its Departmental Expenditure Limit (DEL). This is because the Department of Health allows organisations to retain surpluses and the whole system must be in balance. In effect, through this application of RAB, one year's deficit is immediately recovered in the next year, leaving deficit organisations in the position of fulfilling their contractual duties with reduced income.

However, RAB also requires that a deficit incurred in 2005/6 is posted on a Trusts' balance sheet as a cumulative deficit which also needs to be recovered over the following two years. As the NAO have noted however¹, in effect this application of RAB by the Department of Health (that is, cascading down the basic RAB principle to SHAs and then to trusts) means that once financial balance has been lost the effect of this 'double deficit' (reduced income plus a cumulative deficit which needs to be recovered) makes it doubly difficult for an organisation to recover financial balance in subsequent years.

However, as the NAO also point out, how RAB has *actually* been applied within the NHS is unclear, although there appear to be inconsistencies between SHAs.

It is also the case that while the RAB income-reducing principle is also applied to PCTs with a deficit, unlike trusts the deficit does not have to appear on their balance sheet as well. In effect, a deficit PCT 'pays back' its deficit immediately through the simple expedient of having its allocation reduced the following year.

The actual strategies adopted by SHAs to deal with the 2005/6 deficit in 2006/7 appear to adopt a more system-wide approach to fulfilling the RAB principle with, for example, requirements for organisations with surpluses to give these up to their SHAs in order to help deficit organisations with their financial recovery - a sort of up-front brokerage. Deficit organisations can then draw on this money over three years - but are required to pay it back. Some SHAs have gone further, topslicing all organisations regardless of their financial position in order to create such a cash buffer.

2. The reasons for the deficits, including:

¹ National Audit Office Financial Management in the NHS NHS (England) Summarised Accounts 2003-4

- **whether the causes are systemic or local (eg. the role of poor local management and poor central management, the effect of pay awards and Government policy decisions);**

There is no single cause of deficits, nor one cause that stands out as more important than others. Based on our scrutiny of board papers and Public Interest Reports issued by the Audit Commission we have identified three types of cause: local management problems; local health economy problems and the impact of national policies and decisions

Local management problems: These include failings unique to individual institutions, such as (rarely) impropriety in accounting techniques or understaffed finance departments. There are also more generic management failings that are common to many organisations that have experienced financial problems: poor quality financial data and reporting techniques, a failure by senior management to assign the same importance to financial competence as to clinical matters, and (most importantly) a long standing assumption that overspends (and cash shortages) could be sorted out at the end of the financial year through short term fixes, either using capital to revenue transfers (now no longer allowed); brokerage from other NHS institutions and savings from “non-recurrent” sources of money (eg underspent IT projects)

Local health economy problems: these causes include historical deficits (a minority of PCTs appear to have inherited old Health Authority deficits) but also patterns of neighbouring PCTs and Hospital trusts all experiencing deficits. This appears to have led to disputes about payment over work done and unsigned service level agreements. In addition, some areas do appear to experience difficulties because services need to be reconfigured- either there is duplication across several sites or an excess of provision.

National policies : All trusts have been subject to central government targets. In some cases, meeting these targets has led Trusts to spend in excess of their income, which appears to have been justified on the grounds that ensuring patient access is a higher priority than the duty to achieve financial balance. Although this practice has been criticised by the current government, official documents from the Department of Health in the past have struck a similar note, for instance guidance issued in 1999 made it clear that a trust’s breakeven period might be extended beyond three years if the actions needed to cut a deficit “might seriously threaten the achievement of national performance targets” or lead to “unacceptable service consequences”²

All trusts have also been subject to known cost pressures, including higher pay for GPs, consultants and the costs of implementing Agenda for Change, implementing NICE guidance, clinical negligence and so on. Some Trusts do identify the cost of meeting higher deals as a contributory factor but it is not clear why some trusts would feel the impact on a bigger scale than others

Similarly, all trusts are subject to the same accounting regime, namely the Resource and Accounting Budget regime (RAB), which, in theory, automatically adjusts a Trust’s income up or down according to the previous year’s over or underspend. However, some Hospital Trusts have complained that RAB has created a ‘double deficit’(see above) as their income is reduced at the same time as a deficit is posted on their balance sheet. Only a minority of

² Department of Health Health Service Circular HSC 1999/146

deficit-hit trusts mention RAB as a problem, however, which might be explained by SHA's interpreting the regime in different ways, according to the NAO.

What does seem clear is that the big system reforms of patient choice and payment by results are unlikely to be a contributing cause of the deficits, as choice has only been rolled out since January 2006 and Payment by Results has only applied to the bulk of hospital activity since April 2006.

While not a direct cause, system reform could be thought of as an indirect cause: the Government has predicted (and indeed deliberately engineered) a much more risky and potentially turbulent financial environment for trusts in order to generate more responsive and efficient services. This has led to an important change of message from the centre: financial competence has now become the top priority for the NHS and surpluses should be generated routinely in the future, in order to facilitate the new system reforms.

However commendable this new attitude to the stewardship of public money, it is clear that the current deficits have been accruing over several years (and, it must be assumed, with some cognisance by the centre) and are unlikely to be amenable to instant remedy.

• the findings of the 'turn-around' teams, whether these findings are right and whether the turn-around teams have provided value for money; and

The latest government document reports that 98 organisations are receiving "turnaround" support, coordinated by a National Programme Office³. There is no information in the public domain about its current findings, or a full list of the organisations involved. There is no information about the cost of the support.

An initial assessment of financial turnaround was published in January 2006, based on an analysis carried out in late 2005 by KPMG of 62 PCTs and Trusts forecasting significant deficits⁴. According to that assessment, KPMG identified poor management and poor information as key factors, however the full KPMG report has not been published, so it is difficult to comment on their findings.

On 25th January the Department of Health announced that "teams of financial specialists" would be sent into 18 organisations deemed to require urgent intervention. The full effects of these teams have yet to be assessed, however comparing the month six forecast financial situation with the final outturn, of the 18 trusts in question: 8 saw their deficit increase and 10 improved. Of the latter, 6 still have deficits, and 4 are now in surplus.

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

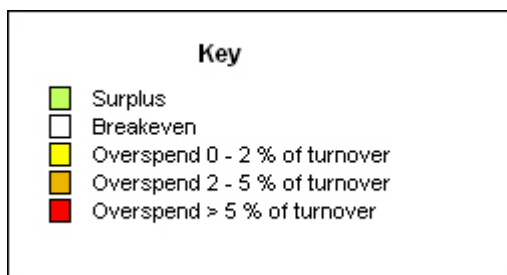
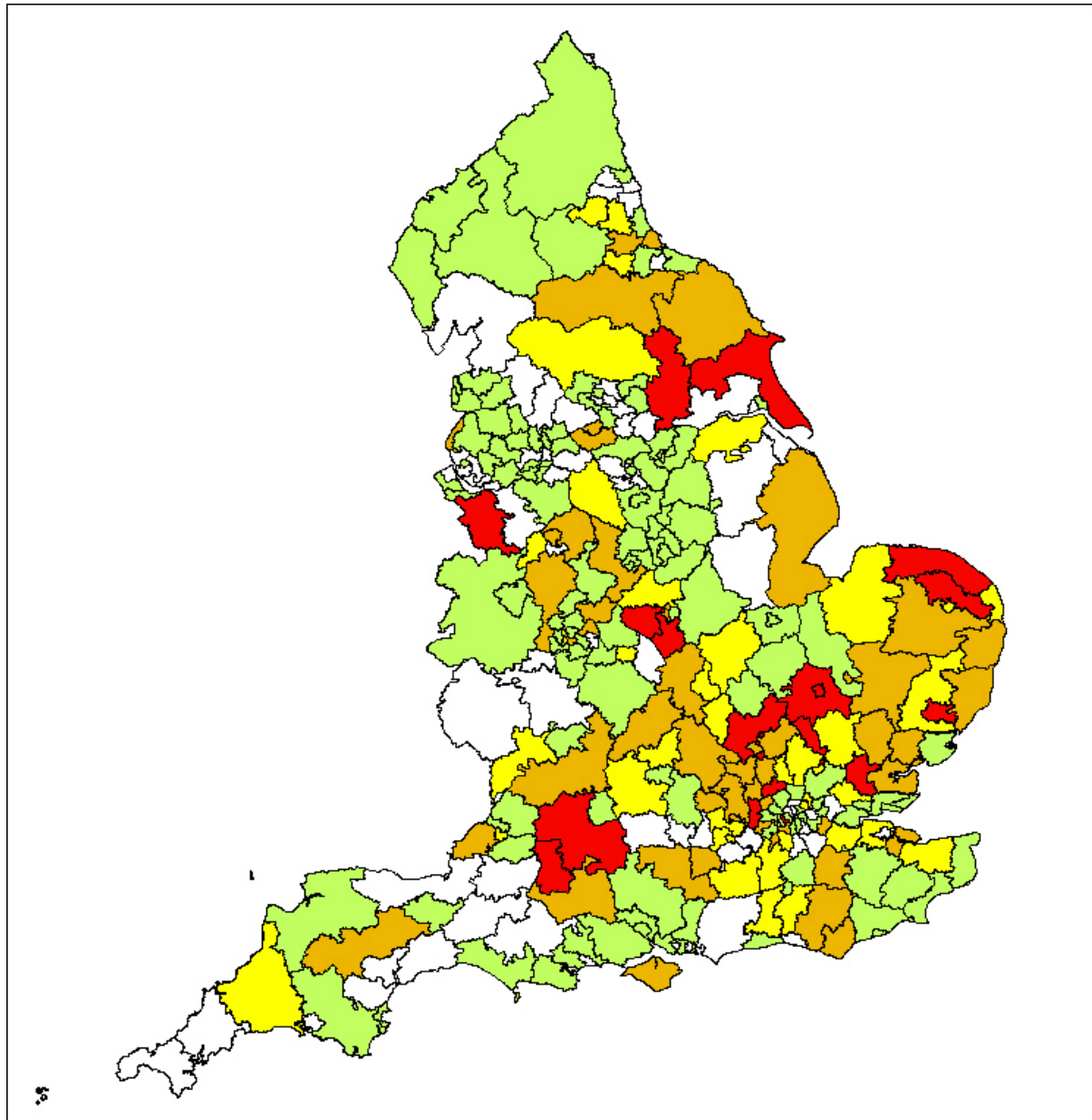
As mentioned above, there are no simple patterns behind the deficits. Although some have suggested that there is a geographical pattern to deficits which is in turn linked to the NHS allocation formulae, the Department of Health² have found no relationship between the size of deficits and spending per head, or the distance from target (for PCTs) or the growth in allocations.

³ Department of Health, NHS Financial Performance 2005-06 June 2006

⁴ Department of Health, Financial Turnaround in the NHS A report from Richard Douglas to the Secretary of State for Health 25 January 2006

The map below similarly suggests that for PCT deficits there is little obvious geographical pattern.

Distribution of PCT 2005/6 surpluses/deficits



Conclusions

The deficit incurred by the NHS in England last year was serious, but not catastrophic; similar overspending has been dealt with in the past. However, the current financial environment now leaves NHS organisations with less room for financial manoeuvre and the demands placed on the NHS, for example, to meet centrally-set targets, are much tougher. While system reforms such as patient choice and payment by results have, in the view of the King's Fund, contributed little so far to the 2005/6 financial position, there is no doubt that these reforms make the current and future financial environment more uncertain for NHS organisations and will demand much tighter financial control than previously.

As the King's Fund and others have already noted, the causes of the deficit problem are multiple and vary from organisation to organisation, in part a result of national decisions and policies, and in part the particularly financial and management history of local organisations.

The solution to future financial stability must lie in much greater transparency in accounting procedures (in particular, a consistent application of RAB and clarity about planned financial support); system-wide support and technical help to head off potentially serious financial problems; and a balanced approach to the incentives on organisations to balance their books.

Importantly, looking to the future, the NHS needs to prepare itself for changes in the financial environment heralded by system reforms such as payment by results and patient choice so that it does not fight the next war as if it were the same as the last.

King's Fund
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