House of Commons

Committee of Public Accounts

# Financial Management in the NHS

## Seventeenth Report of Session 2006–07

*Report, together with formal minutes, oral and written evidence*

*Ordered by The House of Commons to be printed 27 February 2007*

**HC 361**
**[incorporating HC 1662-i of Session 2005–06]**
Published on 20 March 2007
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

## The Committee of Public Accounts

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

### Current membership

Mr Richard Bacon MP (*Conservative, South Norfolk*)
Annette Brooke MP (*Liberal Democrat, Mid Dorset and Poole North*)
Greg Clark MP (*Conservative, Tunbridge Wells*)
Rt Hon David Curry MP (*Conservative, Skipton and Ripon*)
Mr Ian Davidson MP (*Labour, Glasgow South West*)
Mr Philip Dunne MP (*Conservative, Ludlow)*
Helen Goodman MP (*Labour, Bishop Auckland*)
Mr John Healey MP (*Labour, Wentworth*)
Mr Sadiq Khan MP (*Labour, Tooting*)
Mr Edward Leigh MP (*Conservative, Gainsborough*) (Chairman)
Sarah McCarthy-Fry MP (*Labour, Portsmouth North*)
Mr Austin Mitchell MP (*Labour, Great Grimsby*)
Dr John Pugh MP (*Liberal Democrat, Southport*)
Don Touhig MP (*Labour, Islwyn*)
Rt Hon Alan Williams MP (*Labour, Swansea West*)
Iain Wright MP (*Labour, Hartlepool*)

The following were also Members of the Committee during the period of the inquiry:

Kitty Ussher MP (*Labour, Burnley*)

### Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the Internet via www.parliament.uk.

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at http://www.parliament.uk/pac. A list of Reports of the Committee in the present Session is at the back of this volume.

### Committee staff

The current staff of the Committee is Mark Etherton (Clerk), Philip Jones (Committee Assistant), Emma Sawyer (Committee Assistant), Anna Browning (Secretary), and Luke Robinson (Media Officer).

### Contacts

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

# Contents

## Report

| | | Page |
|---|---|---|
| | Summary | 3 |
| | Conclusions and Recommendations | 5 |
| 1 | Financial Standing of the NHS | 7 |
| 2 | What are the factors leading to organisations being in financial deficit? | 11 |
| 3 | What are the implications for organisations as a result of being in financial deficit? | 14 |
| 4 | How are organisations in deficit returning to financial balance? | 16 |

| | |
|---|---|
| Formal minutes | 18 |
| Witnesses | 19 |
| List of written evidence | 19 |
| List of Reports from the Committee of Public Accounts Session 2006–07 | 20 |

# Summary

Spending on the National Health Service is the fastest growing area of public expenditure. The NHS budget for 2004–05 was £69.7 billion, rising to £76.4 billion in 2005–06 and will be £92.6 billion in 2007–08. Despite the increased resources, the NHS reported an overall deficit of £251 million (including Foundation Trusts) in 2004–05, the first time since 1999–2000 that the NHS as a whole had overspent. In 2005–06, the overall deficit increased to £570 million (£547 million excluding Foundation Trusts). There was an increase in both the number of NHS organisations—Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts—reporting a deficit (up from 168 to 190) and the proportion of those bodies reporting a deficit (up from 28% to 32%).

On the basis of a Report by the Comptroller and Auditor General,[1] jointly prepared by the National Audit Office and the Audit Commission, the Committee took evidence from the Department on three main issues: what factors had led to the deficits, what the impact was on organisations in deficits, and what steps were being taken to recover deficits.

We found that there is no single reason why NHS bodies are in deficit, but that a number of factors are at work. Those reporting a deficit tended to have had a deficit the previous year. Excluding foundation trusts, of the 159 bodies reporting a deficit in 2004–05, 117 (74%) also recorded a deficit in 2005–06. The NHS has also been under significant financial pressure to meet the costs of national pay initiatives which the Department had not fully costed. Some NHS bodies have coped better than others in managing these cost pressures, indicating that the standard of financial management expertise varies across the NHS, as does the level of clinical engagement in financial matters. Bodies already in deficit looking to turn their financial position around can also be disadvantaged as they are expected to recover that deficit in the next financial period.

NHS bodies in deficit face the challenge of maintaining and improving the level of healthcare services whilst managing and recovering their deficit, during a period of significant reform and rationalisation within the NHS. To manage their deficits, NHS bodies have needed to cut the size of the workforce, with 903 compulsory redundancies in the six months to 30 September 2006; reduce the number of open hospital wards; and defer significant capital projects. It has also become much more difficult for recently qualified clinical staff to find work in the NHS.

The NHS is aiming to return to financial balance in 2006–07 and to produce a £250 million surplus in the subsequent financial year. In order to achieve balance in 2006–07, the Department has top-sliced the budgets to create a strategic reserve of £450 million as at the end of September 2006. Bodies with large deficits are required to produce financial recovery plans which are reviewed by the Department. Whilst some plans have been successfully designed and delivered, others have been based on unrealistic assumptions or short-term measures. A key feature of the strategy to return to financial balance has been the formalisation of the turnaround process and the creation of the National Programme

1 C&AG's Report, *Financial Management in the NHS—NHS (England) Summarised Accounts 2004–05*, HC (2005–06) 1092-I

Office to oversee it. It is too early to judge whether the turnaround process will deliver financial balance and offer good value for money. However, there are instances of organisations successfully implementing turnaround plans, whether internally or with the aid of external consultants, and it is important that the lessons learned in these cases are shared with the wider NHS.

# Conclusions and Recommendations

1. **The in-year financial information produced by some NHS bodies for management and reporting purposes does not allow the Department to manage the national finances of the NHS in the most effective manner.** The Department should require NHS bodies, at regular intervals during the year, to produce and interpret balance sheet information as well as robust income and expenditure and cash flow figures. All figures should show the year to date as well as the forecast position. Local NHS bodies would then be able to identify and address emerging problems promptly and Strategic Health Authorities and the Department could manage the national picture better.

2. **The Department does not have an overall picture of the impact of deficits on the NHS's capacity to deliver services, and was only able to provide us with information about the number of redundancies, closures and abandoned capital programmes after our hearing.** Decisions on structuring and staffing in individual organisations are taken at a local level, but the Department should collect this information as part of its wider performance management arrangements so that decisions affecting the capacity of the NHS to deliver its objectives are properly informed.

3. **There is a lack of financial management expertise in the NHS, and a need to strengthen communication between those responsible for the finances and for the delivery of local health services.** Measures to bring about financial balance need to stem from a partnership between financial managers and clinicians to enhance both the efficiency and the effectiveness of healthcare. The Department should identify models of successful joint working between financial and clinical management, and promote them across the NHS.

4. **Errors in the costing of the Agenda for Change pay initiative, General Practitioner and consultants contracts meant that in 2005–06 individual NHS bodies were required to fund a £560 million shortfall in resources to pay for these central initiatives.** The Department of Health should analyse the original costings to determine where lessons can be learnt so that local NHS organisations are not required to meet the ongoing cost of these schemes without sufficient funding.

5. **Decisions by Strategic Health Authorities on whether deficits incurred by NHS bodies should be repaid in the next financial year, and on the amount of financial support for NHS bodies in deficit, are not being applied consistently across the NHS.** And while Strategic Authorities need some flexibility to take account of local circumstances, the Department should give a lead in determining the tolerable range of variation in financial regime. The accounts of NHS bodies should be enhanced to clarify the various sources of income, including financial support, which those bodies receive, to give a more transparent picture of their financial performance.

6. **The arrangements for disseminating best practice arising from the work of turnaround teams are not sufficiently robust to maximise the impact such findings can have.** The Department should set up a formal process for sharing turnaround reports both internally and publicly, allowing all NHS bodies to consider

whether they too could achieve efficiency savings by adopting the actions identified. The Department should also establish a failure regime setting out the consequences of falling into significant deficit and formalising the required recovery procedures.

# 1 Financial Standing of the NHS

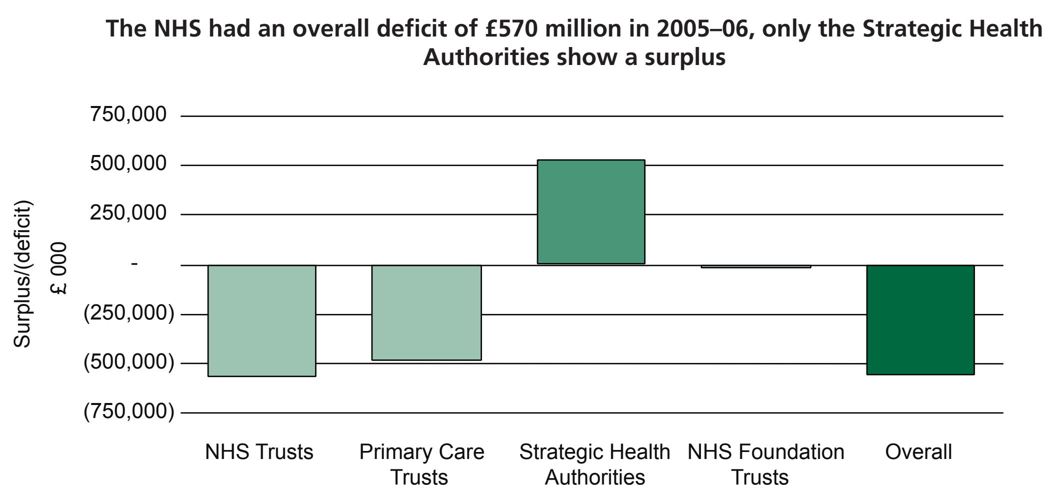
1. In 2004–05, the NHS in England received funding of £69.7 billion, rising to £76.4 billion in 2005–06 and to £92.6 billion in 2007–08. Over this period, spending on health is the fastest growing area of public expenditure.[2]

2. The financial duties of NHS organisations require Strategic Health Authorities and Primary Care Trusts to contain expenditure within approved revenue resource limits and NHS Trusts to break even.[3]

3. The key financial target for the Department in all financial years is to deliver financial balance across all NHS bodies. In 2004–05 the Department did not meet this target and, for the first time since 1999–2000 the NHS failed to break even overall. The aggregate deficit, including NHS Foundation Trusts, was of £251.2 million, representing 0.38% of the total revenue expenditure of £66.3 billion. 168 NHS bodies (including Foundation Trusts) out of 615 (27%) recorded a deficit or overspend. There was an increase in the number of bodies with a deficit or overspend compared to 2003–04 (when 17% of bodies reported a deficit), and more of these deficits were significant in size.[4]

4. Audited year-end figures for 2005-06 show that the aggregate overspend for all NHS bodies, including NHS Foundation Trusts, increased to £570 million representing 0.74% of total expenditure.

**The NHS had an overall deficit of £570 million in 2005–06, only the Strategic Health Authorities show a surplus**




*Source: National Audit Office*

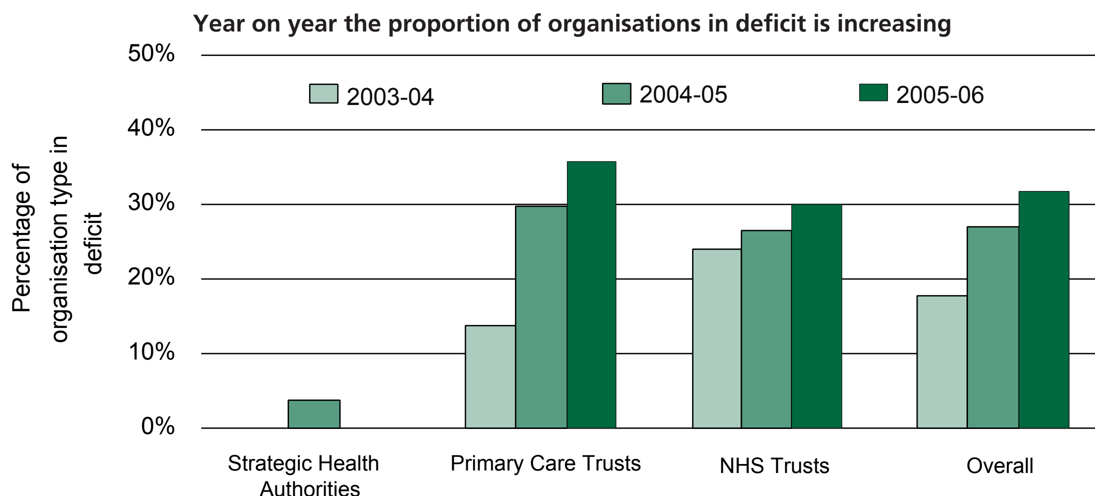
190 NHS bodies (including Foundations Trusts) out of 599 (32%) recorded a deficit or overspend, up by 4 percentage points from 2004–05. The number of significant deficits also increased.[5]

2 C&AG's Report, Summary, para 2

3 C&AG's Report, Appendix Two

4 C&AG's Report, Summary, paras 4–5; paras 2.8–2.15

5 Department of Health, *NHS organisations audited final accounts surplus, deficits or breakeven position, 2005–06*




*Source: National Audit Office*

5. In addition to in-year deficits, NHS Trusts can have cumulative deficits from the past. Trusts have a statutory duty to recover such deficits and break even within three to five years. As at 31 March 2006, the aggregate total of these cumulative deficits across NHS Trusts was over £1.1 billion, up from £598 million at 31 March 2005. In addition, the number of NHS Trusts failing in the break even duty had risen from 1 to 12 as at the end of the 2005–06 financial year.[6]

6. In 2006–07, the Department aims to achieve financial balance across the NHS, excluding Foundation Trusts. The plan is that there will be a reduction in the number of individual bodies reporting a deficit or overspend, and fewer of the deficits and overspends will be significant in size. Strategic reserves have also been created to provide financial flexibility at a regional level. The Department is dependent on the Strategic Health Authorities to negotiate the level of contribution to these reserves from each Primary Care Trust, and to ensure that the financial solvency of successful Trusts is not put in jeopardy by support for organisations in financial difficulty. The contributions would be repaid on return to financial balance. The repayment period would vary depending on the organisation but would be unlikely to stretch beyond five years.

7. The Department is expecting a surplus in the region of £250 million for 2007–08 with an increased surplus expected for 2008–09. Forecast financial data for 2006–07, released at the end of June 2006, indicated a surplus of £18 million for the NHS, excluding Foundation Trusts, and after applying the £350 million reserve held by the Strategic Health Authorities. A reduction in the number of bodies reporting a deficit and the value of those deficits was also forecast.[7]

8. Updated forecast information released at the end of quarter two suggests that financial performance is deteriorating. At the end of September 2006, the Department was forecasting an overall deficit of £94 million after the application of the £350 million reserve. The Department plans to offset this deficit by adding a further £100 million, released from

6 C&AG's Report, Summary, paras 5, 2.12; paras 3.9–3.12; Department of Health, *Annual Report to the NHS Summarised Accounts 2005–06*, para 44(b)

7 Qq 43–46, 93, 104–109, 17–175, 200–201; Department of Health, *NHS financial performance Quarter 2, 2006–07*

NHS bodies delivering a surplus in 2006–07, to the reserves held by Strategic Health Authorities.[8]

9. In 2004–05, auditors appointed by the Audit Commission qualified the accounts of one Strategic Health Authority and 92 Primary Care Trusts as these bodies had incurred expenditure in excess of their resource limits. In 2005–06, the number of qualifications relating to excess expenditure increased, with the accounts of one Strategic Health Authority and 110 Primary Care Trusts being qualified in this manner. In 2005–06, the auditors reported that they had concerns about financial standing at 348 NHS bodies (excluding Foundation Trusts), representing 59% of organisations.[9]

10. There was an unusually large shift between bodies' unaudited and audited financial position in 2004–05. The overall deficit for the NHS, including Foundation Trusts, moved from £133.9 million to £251.2 million, an increase of £117.3 million. The three most significant causes for movements between the two sets of accounts were errors in the recorded liabilities for prescribing expenditure and adjustments to liabilities to be incurred as a result of the Agenda for Change pay initiative, and adjustments to service level agreements.

11. There is also a perverse incentive for NHS bodies (other than Foundation Trusts) in deficit to underestimate its size in their unaudited accounts since the deduction to resources in the following financial year is based on the unaudited deficit. Any significant difference between the unaudited and audited position is adjusted in the year after. Until 2005–06, there was a further incentive for bodies to underestimate deficits in their unaudited accounts since the Healthcare Commission's "star rating" assessment of financial balance was based on unaudited figures. There is no such incentive under the annual health check introduced from 2005–06.[10]

12. Auditors reported evidence of inappropriate adjustments and/or omissions in 125 NHS bodies' accounts (21%) in 2004–05. In the case of Scarborough and North Yorkshire NHS Trust, management had disregarded the auditor's advice and had employed inappropriate accounting adjustments in order to achieve financial balance. The Department are to instigate disciplinary action against the Chief Executive and Director of Finance of the Trust. The Department did not believe that other NHS bodies had deliberately manipulated or falsified their accounts. They maintained that the shifts between the unaudited and audited accounts were due to differences of judgement between management and the auditors, which were to be expected as a result of the audit process. The movement between unaudited and audited accounts in 2005–06 has been much lower, at £34.3 million.[11]

13. The differences between unaudited and audited accounts raises more general concerns about the quality of financial information used by some NHS bodies for management and financial reporting. At an individual body level, not recognising the true financial position

8 Department of Health, *NHS financial performance Quarter 2, 2006–07*

9 C&AG's Report, Summary, paras 21–23, 28; paras 4.2–4.7, 5.2

10 C&AG's Report, Summary, paras 24–25; paras 4.25–4.28; Oq 24, 176

11 C&AG's Report, Summary, para 25, 4.26; Qq 25, 99–103, 110–116; Ev 24

may mean that necessary corrective action is not identified and taken. At Strategic Health Authority and national level, it makes the monitoring and management of the position more difficult. Auditors have highlighted concerns over financial standing at a number of NHS bodies with common themes including poor financial and strategic planning, inadequate monitoring at Board and operational level and weak governance arrangements. Strategic Health Authorities and the Department monitor the financial performance of Health bodies, excluding Foundation Trusts, based on monthly returns. Although there is currently no requirement for these bodies to provide periodic in-year balance sheets and income and expenditure accounts, which is good practice elsewhere, the Department acknowledged that this requirement may need to be introduced in order to meet the timetable for "faster closure" of the Department's accounts and to improve cash management.[12]

14. The Department stated that the record levels of NHS funding of recent years had resulted in benefits in terms of reduced waiting times and action against coronary heart disease and cancer for example, and that most if not all the NHS major performance objectives had been delivered. Work by the Office for National Statistics using measures adjusted for issues such as increases in the quality of care showed that NHS productivity had increased by 1.6% on average per year over the last five years. The Department conceded that this increase needed to be improved upon.[13]

12 C&AG's Report, Summary, para 25; paras 4.10, 4.27; Qq 70–72

13 Qq 1, 47–48, 199

# 2 What are the factors leading to organisations being in financial deficit?

15. There is no single cause of deficits. Although poor financial management can be a contributory factor, it is not the sole cause. NHS organisations are subject to a number of financial pressures which are complex, and not always within the control of individual bodies. All organisations have faced costs pressures, but some have been able to manage these better than others.[14]

16. A number of NHS bodies reported that they experienced cost pressures arising from the need to meet performance targets and to implement national initiatives. In particular, the costs associated with the Agenda for Change pay initiative, the consultant contract and the new General Medical Services (GMS) contract had caused the NHS to be stretched financially. The Department accepted that some policies, such as those on pay reform, had not been properly costed and as a result had been under-funded. Unanticipated issues resulted in the consultant's contracts costing £90 million more than anticipated in 2004–5. The costs associated with the GP contracts exceeded the Department of Health forecasts by a further £250 million in that year. The cost of implementing Agenda for Change was £220 million more than expected in 2005–06. Taken together, these three national pay initiatives cost the NHS £560 million more than expected in 2005–06, which was inevitably a significant factor in the increase in the overall deficit.[15]

17. Fourteen Trusts have asked for contributions to costs incurred as a result of delays in the implementation of the National Programme for IT. The Department reports that information on how much has been claimed by each trust is not available as the requests include a mixture of one-off costs, ongoing costs, alternative interim solutions and unspecified amounts. The Department has not to date made any such payments.[16]

18. In some circumstances, spending by NHS bodies on planning capital projects that failed to go ahead have contributed to financial difficulties. For example, £15 million was spent on planning the Paddington Health campus scheme which was subsequently abandoned. The Department confirmed that it does not keep records on capital projects below a capital value of £25 million. Schemes below this threshold are managed locally and any write-offs should be declared in the accounts of the body concerned. The Department told us that a total of £20.2 million has been written off as abortive development costs in such schemes.[17]

19. Deficits are more prevalent in the south of England than in the north. The Department did not think that hospitals based in rural areas or operating from a number of sites had greater problems than others, arguing that other organisations managed adequately in the same circumstances. The Department also rejected claims that the allocation formula

14 C&AG's Report, Summary, para 8; paras 3.30–3.31; Q 1

15 C&AG's Report, Summary, para 8; para 3.30; Qq 1–3, 84–92, 129, 137–143

16 Qq 132–133

17 Q 134

disadvantaged certain areas. One possibility was that it was more difficult for organisations in the south to find suitable management and finance staff. The Department had considered various factors but could find nothing that explained the geographical pattern of deficits. The most significant indicator of deficit in a year is a deficit in the previous year. In some cases where organisations with financial difficulties have received support in the past, the underlying problems have not been resolved.[18]

20. Previous NAO Reports have made detailed recommendations about the role of NHS Boards in delivering effective financial management, taking collective ownership of financial issues. Given the challenges which they are currently facing, NHS bodies need to take an organisation-wide approach to financial management. Delivering financial balance must not be seen as a task for the finance department alone but should also involve senior clinicians and managers.[19]

21. Auditors reported concerns about the level of resources available or the capabilities of finance staff at 28% of organisations. They also had concerns about the financial management capabilities of general management at 30% of organisations, and about non-executive directors at 25% of organisations. Such concerns raise questions about whether there are sufficient financial management skills at local level to cope with the impact of recent reforms. Most organisations managed their financial affairs adequately, but the Department conceded that some areas needed improvement.[20]

22. The Department believes that recent changes in the transparency of the NHS financial regime, including better accounting disclosures and reduced access to financial support, have made the extent of local deficits more apparent. The regime has been tightened so that, for example, the transfer from capital to revenue is no longer allowed.[21] However, in both 2004–05 and 2005–06 there was still inconsistency over how the regime was applied, with some deductions being passed down to individual Trusts with others being held at Strategic Health Authority level. The regime needs to be applied consistently and correctly to ensure a level playing field and for the effects of such support to be transparent.

23. Current funding arrangements for the NHS mean that a body's income in a given year is increased or reduced based on its prior year surplus or deficit. In the case of NHS Trusts, any deficit incurred also remains on the Trust's books as historic debt. Trusts have a statutory duty to recover such deficits and break even within three to five years. The combination of the carried forward cumulative deficit and a reduction of income in the following year is known as a "double deficit", and Trusts have expressed concerns that once financial balance is lost, the cut in income makes recovery doubly difficult.[22]

24. Strategic Health Authorities have the power to apply the regime flexibly in order to meet local circumstances. Foundation Trusts are not subject to income adjustments based on their prior year surplus or deficit, nor do they have a statutory break even duty. To this

18 C&AG's Report, Summary, Figure 4; paras 40, 44; Qq 20–21, 32, 127–128, 159–160

19 C&AG's Report, paras 3.40–3.51

20 C&AG's Report, para 5.36; Q 4

21 C&AG's Report, Summary, paras 40–41; para 2.16–2.18; Qq 1, 29, 191

22 C&AG's Report, Summary, paras 10–14; paras 3.5–3.10; Qq 32, 159–162

extent, Foundation Trusts in deficit are at an advantage to non-Foundation Trusts in deficit, though they are also subject to a stricter cash borrowing regime and have no access to financial support.[23]

25. The Audit Commission reviewed the NHS financial regime and reported their findings in July 2006. They found that the current approach to funding NHS Trusts was incompatible with their financial regime, as reducing income to recover past deficits was inconsistent with the concept of earning income from patient treatments under Payment by Results. The Audit Commission recommended that the Department should instead establish a national buffer to allow NHS Trusts to operate in a more sustainable way. In the Department of Health publication *The NHS in England: the Operating Framework for 2007–08,* the Department conceded that the "double deficit" regime applied to NHS Trusts will become increasingly unsustainable as the reforms continue. They stopped short of accepting the recommendation, however, stating that reversal of the past income deductions with the associated creation of a central buffer to absorb the impact would require additional resources from the Government. The Department made clear that no additional resources are available for this purpose.[24]

23 C&AG's Report, Summary, para 12; para 3.7; Qq 12–16

24 C&AG's Report, Summary, para 39, para 5.37; Qq 118–121; Audit Commission, *Review of the NHS Financial Management and Accounting Regime—A Report to the Secretary of State for Health,* July 2006; Department of Health Report, *The NHS in England: the Operating Framework for 2007-08,* December 2006

# 3 What are the implications for organisations as a result of being in financial deficit?

26. NHS organisations are required to meet a large number of targets relating to healthcare services. Those bodies in deficit face the significant challenge of maintaining these services whilst managing and recovering these deficits. This challenge increases as the NHS continues to implement the reform programme, both in terms of restructuring and with the introduction of major initiatives. Dealing with financial pressures diverts resources away from normal strategic and operational priorities. If a body's management are concerned chiefly with recovering a deficit and managing its side effects, they may be unable to give sufficient attention to issues such as clinical performance or current NHS re-structuring.[25]

27. Some measures taken to return to financial balance have resulted in a rationalisation in the capacity of the NHS. The Department confirmed to us that 903 compulsory redundancies had been made in the six month period to 30 September 2006. Decisions on service reconfiguration are a matter for local NHS bodies, but the Department were satisfied that essential services were being protected, if not improved in the current year.[26]

28. Large cuts have been made in the workforce and training budgets. Some graduates currently could not get jobs, but there could be a shortage in future and unless staff planning is considered alongside financial planning in order to avoid this situation. The Department conceded that it needed to review workforce planning arrangements in the NHS to avoid a boom-and bust position.[27]

29. Organisations that have significant deficits are also likely to be short of cash, which will affect their ability to meet their financial commitments. In 2004–05, a small number of NHS bodies considered deferring payment of tax and social security to HM Revenue and Customs, with a handful even struggling to pay staff wages. On average, NHS Trusts with a deficit of over £5 million in 2004–05 paid only 75% of invoices to non-NHS bodies within 30 days, some 8% below the national NHS average. The Better Payment Practice Code requires them to pay all such invoices within a 30-day period.[28]

30. The NHS funding regime has traditionally allowed the movement of funds from one body to another, often in the form of financial support and adjustments to service level agreements. This movement of cash around the system was used in some cases in 2004–05 to ensure that the financial commitments of NHS bodies in financial difficulties could be met. There were concerns within the NHS that the principles of the system are not applied

25 C&AG's Report, Summary, paras 32–34; paras 3.19–3.27, 5.8–5.16, 5.24–5.29, 5.35

26 Department of Health, *NHS Redundancy Figures,* 30 October 2006; Qq 6–7, 76–77, 131–132

27 Qq 27–28

28 C&AG's Report, Summary, para 9; paras 3.22–3.24; Qq 144

consistently to local bodies however, and its effect on their financial performance is not sufficiently transparent. From 2006–07, the Department is to replace these practices with a more transparent system of loans and deposits. Under the new arrangements it is likely that bodies in deficit incurring loans will not be required to repay them the following year, with appropriate terms and conditions being negotiated with the Strategic Health Authority. The Department acknowledged, however, that more changes were needed to further improve cash management.[29]

29 C&AG's Report, Summary, paras 5, 16; paras 2.16–2.27, 3.7–3.8; Qq 19, 73–75, 145

# 4 How are organisations in deficit returning to financial balance?

31. The NHS is going through a transitional period in terms of the way in which healthcare is delivered and the systems used. A number of key policy initiatives are currently being implemented across the NHS. These include Payment by Results, Practice-based Commissioning, NHS Foundation Trusts, and the rationalisation of the Primary Care Trusts and Strategic Health Authorities. These policies have been introduced to improve efficiency and financial performance, but they carry significant financial risk. This risk is reflected by the appointed auditors of local NHS bodies, who reported concerns about financial standing at 348 NHS bodies (excluding Foundation Trusts), or 59%.[30]

32. Although organisations in financial difficulty are expected to return to financial balance within a realistic timetable, the Department aims to be supportive and flexible in working with them. For those organisations with major problems the Department would not insist that the books balanced in 2006–07, giving them more time to recover. As mentioned in paragraph 6, Strategic Health Authorities have also been allowed to build strategic reserves for 2006–07. In 2006-07, most of the funds will be used to assist those with deficits but in future such funds could be put to different uses. The original size of the planned reserves was £350 million, but the Department confirmed that it was looking to create an additional £100 million of reserves to cover the forecast 2006–07 deficit of £94 million.[31]

33. This top-slicing of budgets, which includes all bodies whether in deficit or not, is designed to create a national buffer whereby bodies in deficit can be supported. It is difficult to envisage a situation where all NHS bodies are able to deliver balance or a surplus, and the aim of the reserve is to fund overspending in one location with underspending in another. It does however have the impact of effectively penalising those well-managed bodies that are able to deliver financial balance or a surplus. The Department has given a commitment that Trusts will regain their top sliced funds, but Trusts who are net contributors to the reserves will need to delay spending programmes.[32]

34. For 2004–05, while most bodies with large deficits had a recovery plan, a significant number had not been delivering all elements in practice. Some bodies' financial recovery plans had been successfully designed and delivered, but others had been based on unrealistic assumptions or short-term measures. The Department stated that it had taken action to improve the situation ensuring that it has better oversight of the plans.[33]

35. A key feature of the drive to return to financial balance across the NHS has been the introduction of the turnaround programme. Following a competitive process, the Department contracted external consultants to perform a preliminary assessment of 98 NHS bodies identified as facing particular financial difficulties. In December 2005, these

30 C&AG's Report, Summary, paras 32–34; paras 5.2, 5.8–5.17, 5.24–5.29; Qq 163–173

31 Qq 22, 56, 63, 180, 182–184; Department of Health, *NHS financial performance Quarter 2, 2006-07*

32 Qq 22, 33, 56, 58

33 C&AG's Report, paras 3.34–3.35; Q 26

turnaround teams produced preliminary reports on what action could be taken to assist recovery. Since then the organisations have been required to produce recovery plans, assisted by turnaround expertise. The Department's National Programme Office was set up in February 2006 to oversee the turnaround process. The National Programme Office is responsible for ensuring robust plans are developed that are deliverable and for then monitoring their implementation in the organisations concerned. Support is provided from a Turnaround Director appointed for each Strategic Health Authority, who also acts as the interface with the National Programme Office. To date much of the work has been aided by external turnaround expertise. The 98 original turnaround organisations were due to submit their recovery plans to the National Programme Office by mid-June 2006; as at mid-October 2006, 60 such plans had been submitted and approved.[34]

36. The introduction of turnaround support had been particularly effective in improving the standard of financial recovery plans. For example, for the first part of 2006–07, NHS organisations in turnaround were delivering 95% of their cash-releasing cost improvement programmes, compared to a delivery rate of 50-60% eighteen months ago.[35]

37. If turnaround is to be a success, the Department needs to make sure that the lessons identified from turnaround teams are shared with the rest of the NHS in an effective manner. The NPO issue a quarterly newsletter, Strategic Health Authorities facilitate the sharing of information between Finance Directors, and there are arrangements for local organisations to get together to share good practice.[36]

38. The Department agreed that in order to meet the current challenges it was necessary for everyone in an organisation to understand the importance of financial management. Delivering financial balance must not be seen as a task for the finance department alone. There was a need to improve the quality and financial leadership provided by the Board and senior management. The Department are working with the NHS Appointments Commission to improve the financial training given to board members.

39. Clinical engagement in financial matters is key to delivery of financial balance and there is a need to bring more clinicians into senior management positions. Decisions need to take into account both the clinical need and the financial implication, if high quality healthcare is to be delivered most effectively and efficiently. To take such informed decisions, senior management needs to be an effective mix of financial and clinical experience. The introduction of Payment by Results is expected to help increase the financial awareness of clinical and other staff.[37]

34 C&AG’s Report, Summary, paras 35–37; paras 3.52–3.54; Qq 5, 124–126, 194

35 Q 193

36 C&AG’s Report, Summary, para 38; para 3.55; Qq 23, 52

37 C&AG’s Report, para 3.40–3.51; Qq 54–55, 176, 190, 192, 196

# Formal minutes

## TUESDAY 27 FEBRUARY 2007

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Annette Brooke
Mr David Curry
Mr Philip Dunne
Helen Goodman
Mr Sadiq Khan
Mr Austin Mitchell
Dr John Pugh
Mr Don Touhig
Mr Alan Williams

**Draft Report**

A draft Report (Financial Management in the NHS), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 39 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the seventeenth Report of the Committee to the House.

*Ordered*, That the Chairman 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 until Wednesday 28 February at 3.30 pm.

# Witnesses

## Monday 16 October 2006

**Mr David Nicholson CBE**, Chief Executive, National Health Service, and **Mr Richard Douglas**, Director General, Finance and Investment, Department of Health Ev 1

# List of written evidence

1 Department of Health Ev 24

# List of Reports from the Committee of Public Accounts Session 2006–07

| | | |
|---|---|---|
| First Report | Tsunami: Provision of support for humanitarian assistance | HC 25 |
| Second Report | Improving literacy and numeracy in schools (Northern Ireland) | HC 108 |
| Third Report | Collections Management in the National Museums and Galleries of Northern Ireland | HC 109 |
| Fourth Report | Gas distribution networks: Ofgem's role in their sale, restructuring and future regulation | HC 110 |
| Fifth Report | Postcomm and the quality of mail services | HC 111 |
| Sixth Report | Gaining and retaining a job: the Department for Work and Pensions support for disabled people | HC 112 |
| Seventh Report | Department for Work and Pensions: Using leaflets to communicate with the public about services and entitlements | HC 133 |
| Eighth Report | Tackling Child Obesity—First Steps | HC 157 |
| Ninth Report | The Paddington Health Campus Scheme | HC 244 |
| Tenth Report | Fines Collection | HC 245 |
| Eleventh Report | Supporting Small Business | HC 262 |
| Twelfth Report | Excess Votes 2005–06 | HC 346 |
| Thirteenth Report | Smarter Food Procurement in the Public Sector | HC 357 |
| Fourteenth Report | Ministry of Defence: Delivering digital tactical communications through the Bowman CIP Programme | HC 358 |
| Fifteenth Report | The termination of the PFI contract for the National Physical Laboratory | HC 359 |
| Sixteenth Report | The Provision of Out-of-Hours Care in England | HC 360 |
| Seventeenth Report | Financial Management of the NHS | HC 361 |

# Oral evidence

## Taken before the Committee of Public Accounts

## on Monday 16 October 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Annette Brooke
Mr Greg Clark
Mr David Curry
Mr Ian Davidson
Mr Philip Dunne
Helen Goodman
Mr Sadiq Khan
Sarah McCarthy-Fry
Mr Austin Mitchell
Dr John Pugh
Mr Don Touhig
Mr Alan Williams

---

**Sir John Bourn KCB,** Comptroller and Auditor General gave evidence.

**Ms Paula Diggle,** Treasury Officer of Accounts and **Ms Susan Mathewson,** HM Treasury, were in attendance.

**Report by the Comptroller and Auditor General**

**Financial Management in the NHS**

**NHS (England) Summarised Accounts 2004–05 (HC 1092-I)**

---

*Witnesses:* **Mr David Nicholson CBE,** Chief Executive, National Health Service, and **Mr Richard Douglas,** Director General, Finance and Investment, Department of Health, gave evidence.

**Q1 Chairman:** Good afternoon and welcome to the Public Accounts Committee. Today we are considering the C & AG's Report on *Financial Management in the NHS.* We welcome Mr David Nicholson, who is the Chief Executive of the NHS, and Mr Richard Douglas, who is the Director General for Finance and Investment at the Department of Health. So, Mr Nicholson, as the politicians have ensured that NHS spending has been at record levels in recent years in real terms, why are we still seeing deficits, redundancies and service cuts across the country? Is it down to weak management on your part or on the part of the trusts?

***Mr Nicholson:*** The first thing that I would say is that we have had significant growth but we have done a significant amount with that. I know that you will have heard from a number of witnesses in the past about the benefits in terms of waiting times, coronary heart disease, cancer and the rest of it, as well as the increase in the number of staff by a third over the past few years.

**Chairman:** We can take it as read for the purposes of the Committee that we congratulate you most warmly on the progress that you have been making. However, I was not asking you about waiting times and such indices, which are all very welcome. I was asking why, with spending at such record levels, we are still seeing deficits, redundancies and service cuts in some areas.

***Mr Nicholson:*** I obviously wanted to say that to begin with. The second issue that I would identify, in line with the National Audit Office Report, is that there is no single cause of deficits in the NHS. There are a multiplicity of causes, which we will no doubt talk about. One thing I can say about NHS finances over the past period is that our performance has become increasingly transparent. One of the problems with the financial regime under which we have operated over the past few years is that the implications of management and clinical decisions in the financial sphere have not always been clear, and now they are. We have also considerably tightened the regime. It was not long ago that we had the opportunity in the National Health Service to transfer capital to revenue. Indeed, some £250 million was transferred during the last year of that happening. Almost all such issues have now disappeared, so it is clear which organisations are responsible for the deficits. Thirdly, there is no doubt that we could be better at costing some of our policies. There are examples of some policies, when we have costed them, that have in practice for various reasons cost more, the obvious one being the reforms to the pay system. Finally, undoubtedly there have been some examples of poor management and financial practice.

**Q2 Chairman:** That is a full and honest answer. Let us consider local NHS management of deficits. You mentioned it in your penultimate point. Paragraph 3.30 states that: "auditors reported that the issues which caused financial pressures and left some NHS bodies unable to manage within their current

resources included . . . implementation of workforce contracts" and "additional activity". People are saying locally that you are underfunding your own initiatives. It seems from the answer that you gave a moment ago that you were accepting that criticism. Perhaps you could do better in future. Some initiatives have been underfunded by hundreds of millions of pounds, have they not?
***Mr Nicholson:*** Yeah, but on the other side of course—
**Chairman:** So "yeah" is yes, is it? The answer is yes to that point.
***Mr Nicholson:*** I said that some of the policies that we have implemented had not been properly costed. That is absolutely true. But others have operated in the other direction. For example, the pharmaceutical price regulation scheme changes in the costing of drugs enabled us to reduce the costs by 7% throughout the NHS. It has cost both ways.

**Q3 Chairman:** But you accept the criticism under paragraph 3.30 to which I have just referred.
***Mr Nicholson:*** Yeah.

**Q4 Chairman:** Thank you very much. We have heard a lot of criticism about local management and deficiencies. You will see stated at paragraph 5.36 on page 71 of the Report that the auditors had "concerns about the financial management capabilities of general management at 30% of organisations, and about non-executive directors at 25% of organisations." Is that a real problem and do you believe that there are sufficient financial management skills within the trust to cope with the reforms and the extra work that you have had to undertake in recent years?
***Mr Nicholson:*** It is worth pointing out that most organisations balance their books and that most organisations manage their financial affairs adequately, but undoubtedly some areas need improvement. There is a whole series of things that we and the NHS—

**Q5 Chairman:** What is going wrong at local level?
***Mr Nicholson:*** In terms of?
**Chairman:** Financial management.
***Mr Nicholson:*** One of the things that we have been doing over the past six months or so is going through a whole series of diagnostic work with NHS trusts and primary care trusts to look at issues in respect of the financial management of organisations. For each one, we have identified the issues within the individual organisation, whether it be putting in turnaround people for help and support, strengthening financial management on the board, working with the Appointments Commission to enable the chairs of audit committees to get up to speed and house training and supervision for finance staff. We are putting into place all those sorts of things.

**Q6 Chairman:** We have read a lot recently about deficits causing redundancies and ward closures throughout the country. How will you ensure that essential services in the NHS are maintained, if not improved?
***Mr Nicholson:*** That essentially is a local matter. All those issues play slightly differently in each local circumstance. We are dependent on local PCTs and NHS trusts reaching arrangements that suit them overall. Obviously each organisation has put its plans to the strategic health authorities, and we have looked at them overall. We are satisfied that the development in health services in the NHS over the next 12 months will deliver the things that we want to deliver in respect of the six priorities identified by the Department. Each organisation goes through its planning process. They have to identify that they must deliver their waiting times and so on, and we are satisfied that that is what they are currently doing.

**Q7 Chairman:** Let us be clear about this. Despite the deficits and the publicity that we are reading about redundancies and ward closures, are you giving an assurance to the Committee that you can from the centre ensure that vital services are maintained, or are you saying that that is not within your power or gift because of local management?
***Mr Nicholson:*** No, I think we are satisfied that vital services are being protected and indeed developed—
**Chairman:** If not improved?
***Mr Nicholson:*** If not improved, because do not forget that even the smallest amount of growth in any health community this year is, I think, about 8.2%. We would expect in those circumstances both to protect and to enhance those services.

**Q8 Chairman:** My last question relates to annex two of the Report on page 74, headed "Financial Duties of NHS Organisations". Would it be a fair criticism of you to say that you have perhaps not taken financial targets in the past as seriously as other, hotter issues, such as waiting times and performance measures? Would that be a valid criticism, reading this annex?
***Mr Nicholson:*** I do not think it is a valid criticism of the NHS as a whole. As I said, most NHS organisations manage to deliver financial balance and the improvements that I have identified, but there are small number, for a variety of reasons, that have had difficulty doing so. The strategic health authorities and the Department are there to help and support these organisations to improve their financial management, but also to deliver improved services.

**Q9 Chairman:** Because there are statutory duties and the regulatory duties, are there not? Under "Departmental/Regulatory" it says: "Achieve financial balance without the need for unplanned financial support." At first sight it may seem that

that does not have the top priority that it should. Perhaps not everything can have top priority. If that is the case, just say so.
***Mr Nicholson:*** I think it is equal to all the other priorities. We are seeing the consequences of not getting financial balance in those organisations and areas of the country.

**Q10 Dr Pugh:** In the old days, the national health service more or less balanced, but individual cost centres did not. There was a lot of brokerage around in the system. Now a lot of hospitals with newer buildings affected by resource-based accountancy and so on are suffering rather more than some older hospitals. Do you not see that as an anomaly and a problem that needs addressing?
***Mr Nicholson***: I do not think there is any evidence to suggest that those organisations that have major capital expenditure are having undue financial problems compared with those that are not, so I do not actually see the issue.

**Q11 Dr Pugh:** Well, they are certainly saying that, are they not? A number of hospital have complained precisely along these lines, suggesting that they are being penalised for having PFI buildings, for having new buildings or for having major capital investment and making it more costly for them to deliver the same service than an older hospital down the road.
***Mr Nicholson:*** Well, they may say it—
**Dr Pugh:** You do not recognise their problem?
***Mr Nicholson:*** I do not recognise that problem.
**Dr Pugh:** Even though Ministers have been sympathetic to that problem hitherto, or have made appropriate noises, if I may put it like that?
***Mr Nicholson:*** We have got to help organisations to deal with the problems as they see them, but a blanket "it is because they have got new buildings" seems to me not supportable.
**Dr Pugh:** So that is not an issue?
***Mr Nicholson:*** Not as far as I am concerned.

**Q12 Dr Pugh:** Foundation trusts do not have the same regime as other hospitals and other trusts at the moment; in fact, they need to budget and reach a balance over a cycle rather than an individual year. Do you not think that that makes it a lot worse for hospitals that perhaps are trying to come to terms with their financial problems but which are not yet ready for foundation trust status?
***Mr Nicholson:*** It is a freedom that NHS trusts get when they have shown that they can manage their affairs appropriately. It seems to me a good incentive for an organisation to get its finances in order.

**Q13 Dr Pugh:** But if the weaker hospitals are subjected to a stiffer regime that means they are on a vortex of decline, does it not?
***Mr Nicholson:*** It does not necessarily—lots of them are not—and if you look at the number of organisations that are coming forward for foundation trust status, that would not be supported by those numbers.

**Q14 Dr Pugh:** Right. What is the case for treating foundation hospitals and foundation trusts differently from the others, in terms of where and how they must balance and how they must treat their revenue?
***Mr Douglas:*** The whole issue with foundation trusts is that the entire regime is different. It is not just breaking even one year with another that is different; they have a stricter regime around cash borrowing—

**Q15 Dr Pugh:** But whether they are judged to have balanced their accounts is judged differently, is it not? I want the rationale for that, please.
***Mr Douglas:*** How they judge whether they have balanced their accounts is the same. The accounting regime is broadly the same; there is one minor difference, but it is broadly the same. They do not have a statutory duty to break even taking one year with another, like trusts do, and they do not have an administrative duty to break even each and every year, like trusts do. Now, those differences in the foundation trust regime were given to organisations that had demonstrated that they were financially strong and could manage within that new environment. We want to start moving other NHS trusts on to a very similar regime, even in advance of becoming foundation trusts. We want to take people through the trust regime they have now, through a quasi-foundation trust regime into the full one.

**Q16 Dr Pugh:** I understand that. You want to put it on the record that those trusts are basically treated in the same way with regard to adjudicating whether they are in balance.
***Mr Douglas:*** Not in terms of the break-even duty. The break-even duty is different. Those trusts do not have the annual duty that normal trusts have, but they have also not had access to the support that other trusts have had. The Chairman raised issues about planned support—they have not had access to that support which other trusts have had.

**Q17 Dr Pugh:** If a hospital is overdrawn, it receives brokerage in one particular year, which is currently taken up as revenue for the following year, is it not? To an ordinary person, that would seem to be deliberately making life more difficult for that hospital to pull out of a decline. How would you respond to that?
***Mr Douglas:*** The issue we have with the way we resource account the budget is that in relation to the fixed pot of resource, if an organisation underspends, we give it the benefit of that underspend in the following year. To fund that, where organisations overspend, they must have the resource taken off them in the following year. You cannot have one side of the system without the other. The system is not universally applied, as the NAO Report says, to each and every trust in the country. Strategic health authorities have a capacity locally to determine whether individual hospitals can manage that resource reduction.

**Q18 Dr Pugh:** But it compounds their problem, does it not?
***Mr Douglas:*** In the same way that if I overspend on my bank account and I get an overdraft, I do not have that overdraft—
**Dr Pugh:** Yes, but when you overspend on your bank account, your boss does not take money off your salary, does he?
***Mr Douglas:*** But I cannot use that money, which is the same principle entirely.

**Q19 Dr Pugh:** In the figures that you have given, there are elements of brokerage in some of the cost centres, are there not? Why are some hospitals getting brokerage and are perceived to be in credit and to be balanced, and some are not?
***Mr Douglas:*** This is the planned support that we have had under the system. We distinguish between unplanned support, which is money given to people late on in the year to balance their books, and planned support, which is money that was agreed at the start of the year or early in the year with the health authority as part of the recovery plan for the organisation. Up until last year, we did not allow unplanned support, but we allowed planned support. From this year, we have stopped both forms of support, so organisations have to break even on the basis of their normal income.

**Q20 Dr Pugh:** Would you accept that some hospitals have a greater problem than others and that that is reflected in the outline figures? For example, some hospitals are on a number of sites; some hospitals are in rural areas; and some hospitals have intermediate treatment centres near them. All those factors will compound those hospitals' ability to deliver a good service. Would you accept that those are factors that should come into an assessment of their financial performance?
***Mr Nicholson:*** But I could point to hospitals that quite adequately manage their affairs, even though they have all those issues. We try to be flexible and supportive to organisations that have major problems. That is why we have not insisted that every organisation balances its books this year and that not every organisation will be in run-rate balance this year. Some special organisations have particular problems, and we will allow them a bit more time to get their position right.

**Q21 Dr Pugh:** So no extra allowance will be given for rurality or for hospitals that are on a number of sites for good clinical reasons?
***Mr Nicholson:*** No; there are good examples of organisations that have for many years managed their books adequately in rural areas and on split sites.

**Q22 Dr Pugh:** With regard to co-operation between health service institutions, if everyone has to reach a black line every year and there is no brokerage and no acceptance that the system as a whole has to be treated as a system and that each institution needs to be treated as a separate cost centre, will that not discourage the development of desirable clinical networks between various elements of the health service? People will be careful to get what business they can, perhaps regardless of the interests of the patient.
***Mr Nicholson:*** There is a balance to be struck. This year, we have allowed the development of strategic reserves, where PCTs have put money into a pool, which we have been able to use flexibly across the patch to help and support organisations that are going through significant change. Most, if not all, of that money this year has been used to deal with deficits, but as we develop in the future, we should be able to develop strategic reserves to enable us to do the sorts of things that you describe. There are issues around clinical networks that need further development. One of the jobs of the new strategic health authorities is to help and support the development of clinical networks, and I am sure that they will start to do that in a significant way. The unbundling of the PBR tariff—I am sure that we will come on to this and that you have discussed it before—will, to an extent, help us to look more flexibly at the way in which networks are moved. To be frank, clinical networks are the way in which major services will be delivered in the NHS over the next 10 years or so.

**Q23 Dr Pugh:** One last and very quick question: should turnaround teams' reports be public documents?
***Mr Nicholson:*** I thought they were.[1]

**Q24 Annette Brooke:** I would just like to return to John's point about the knock-on effect of this year's deficit on the subsequent year. These large deficits across the NHS have escalated as we have moved from predicting them to reporting them and then to the actual out-turn. The report identifies perverse incentives, which is where it ties in with my point, because there has been a tendency to underestimate the size of the deficit in the unaudited accounts. What progress has been made to address that particular perverse incentive? What further perverse incentives have you identified in terms of transparent and efficient financial accounting?
***Mr Douglas:*** The issue there is that the resource reduction that we make is based on the unaudited accounts, so if things deteriorate between the unaudited and the audited accounts, someone could, in effect, get a one-year benefit. People have not responded to that, as far as I can see, as an incentive, so I do not think that we have had a situation in which people have deliberately manipulated their month 12 forecast numbers to get a one-year gain. It is a potential disincentive, and, for next year, we are looking at whether we should base the resource reduction on the final audited accounts, not the month 12 figure, so, if something moved adversely after month 12, we could make a further resource reduction to compensate for that. The year 2004–05 was the first

[1] *Note by witness:* These are publicly available and are also often to be found on the websites of the organisations concerned.

year in which we had a big adverse movement in the accounts between month 12 and the audited figures. We had not seen anything on that scale before, despite the fact that we had operated the same system for a number of years.

**Q25 Annette Brooke:** If you do not put it down to that particular perverse incentive—the predictions of the size of the deficit this financial year have, of course, been going up and up—why do you think that there is such a big gap between the early prediction and the actual out-turn?
***Mr Douglas:*** The movement this year between month 12 and the final audited numbers was about £35 million, which is still too big a number for me, but it is not an enormous movement on the scale of numbers that we are talking about across the system. If you looked at the draft unaudited accounts and the final audited accounts of lots of organisations, you would find movements of that fraction of a per cent. In the year to which the report referred, there were three big issues that caused that movement: one was how people calculated creditors' prescribing costs; one was how we introduced and then scored the cost of the "Agenda for Change" pay contracts; and one was the capitalisation of assets. Those were the main things. We went through each of those with the finance directors of the strategic health authorities and made changes to our manual of accounts and our guidance to the NHS, where we needed to, and, as a result, we have not seen a recurrence of that sort of movement. I think that there were just three very particular issues in that year.

**Q26 Annette Brooke:** We shall see. Can I just ask you to reflect on figure 20 on page 36 of the Report? It shows that a very high proportion of primary care trusts and NHS trusts do not have a comprehensive plan in place that will be delivered in practice, if I interpret it from a negative point of view—according to the charts, it is rather a negative fact. So what are you doing about that situation?
***Mr Nicholson:*** This became a significant issue for us in the NHS about 18 months ago, when we started to work with organisations that were approaching foundation status. One of the things that we found at that time was that, on average, organisations were delivering about 50% or 60% of their cash-releasing cost-improvement programmes, and that they were balancing the rest off by non-recurring means. We saw that develop over the period, and we started to take action, particularly on getting people to organise their plans better, sharing them and giving us oversight over them to ensure that they were in place. One big change that has occurred over the past year has been the development of turnaround support to organisations that are in particular financial trouble, which has been particularly effective at getting those plans in place. So, for example, for the first part of this year, NHS organisations in turnaround were, in overall terms, producing 95% of their cash-releasing cost-improvement programmes on time and in the way that they had planned. That is the kind of action that will bring things into balance much better.

**Q27 Annette Brooke:** Finally, although I appreciate that things are being brought into balance, the costs of getting back into balance must be quite considerable. An example came my way recently, when I met the professor of health studies at the local university, who is very concerned at the cutbacks in the commissioning of places at the university for the future training of doctors, nurses and everybody else, right across the board. I am concerned that we have a boom-and-bust situation, which will have a worrying knock-on effect in the education system in three years' time, in terms of having our own trained professionals. Is that fully taken on board in your strong financial approach?
***Mr Nicholson:*** I would be absolutely straightforward that we need to deliver balance. We will have to take some difficult decisions in the short term to enable us to do that. If we had taken the same action last year, we would have had less pain this year—that is absolutely true, and I am determined to achieve it. In terms of training places, I have no evidence on that. In fact, the situation is the opposite—training places have increased over the past few years. As you are aware, we are now training more doctors and nurses than ever before.

**Q28 Annette Brooke:** May I just interrupt? My point is that right now we have graduate physiotherapists, midwives, nurses—you name them—who cannot get jobs, but the next fear is that in three years we shall have a surplus. Have we got proper planning for health staff running alongside the financial planning?
***Mr Nicholson:*** Clearly the NHS cannot guarantee a job to all the people coming out of the schools and colleges now. That is not what we do—we are there to deliver health care. However, we can do quite a lot to help and support people who find themselves in difficulty at the moment, and we are doing that. There are lots of examples from different parts of the country of how we are taking people on part-time or supporting them through training, retraining or whatever, to enable them to take employment at the end of that process. However, there is no doubt that we now have to take a long, hard look at the numbers and our work force planning arrangements in the NHS to ensure that we do not get ourselves into a boom-and-bust position.

**Q29 Helen Goodman:** Chart 1 and chart 2 at the front of the Report show that the deficits have been increasing over the past five years. This gives the impression that the financial situation and the financial management are worsening. Do you think that they are getting worse and, if so, why?
***Mr Nicholson:*** No; I do not think that financial management is getting worse, but the pressure on the system to improve its performance, on the one

hand, and the transparent way in which we are dealing with finance, on the other, make such things much clearer than they were in the past.

**Q30 Helen Goodman:** You have chosen 0.5% of income as the cut-off point for starting to measure your deficit, which seems quite small, really. Why did you choose such a small percentage?
***Mr Douglas***: Well, we have classed deficits of more than 0.5% as significant; but we count all deficits. The numbers here would count as a deficit if the figure was £100,000. The process will count everything. We did that quite deliberately because, within the fixed resource pot that we have, one person's deficit has to be someone else's surplus and it is important that we always keep that perspective in the system. Every deficit is important to us.

**Q31 Helen Goodman:** In answering the earlier questions you made it clear that the majority of the trusts—three quarters, I think—are in surplus and hitting their targets and only 25% are problematic. Chart 14 on page 23 and chart 15 on page 25 show deficits of more than £5 million. It looks as if two thirds of the deficits are accounted for by about 30 trusts, so the major part of the problem is concentrated in a small number of trusts. Is my understanding of the situation correct?
***Mr Nicholson:*** Yes.
***Mr Douglas:*** Yes.

**Q32 Helen Goodman:** Why do you think that more problems seem to be emerging in the south of England than in the north of England? The maps in figure 4 on page 5 show that South-West Peninsula, Avon, Gloucester and Wiltshire, Hampshire and the Isle of Wight, Surrey and Sussex and Kent and Medway have been persistent offenders over the last three years. Why should there be a geographical difference in the performance of the trusts in the NHS?
***Mr Douglas:*** We have tried to look at a whole range of reasons for what causes the variations in deficits. We have looked at the allocation formula, the level of activity, the level of general practitioners. You can look at almost any of these indicators. We cannot get anything that correlates dramatically to the variation in deficits. The one thing that comes through strongly and links back to other Members' comments earlier is that the biggest indicator of deficit in a year is a deficit in the previous year. In some parts of the country there have been financial difficulties and they have, to some extent, been helped through a period with support either from the NHS bank or from other parts of the NHS system. Problems have not been resolved and they have built up in the system. That seems to me to be the only explanation. I do not know whether David has other views.
***Mr Nicholson:*** No.

**Q33 Helen Goodman:** May I ask you some questions about the duties and accountabilities, following from some of the questions asked by Dr Pugh? Looking at annex 2, which sets out all the duties, you can see that different duties are placed on the different bits of the organisation. Given that that is so, is it possible for all parts of the organisation to be breaking even, or are their objectives competing to such an extent that you are bound to have problems somewhere, just because of the way in which the system works?
***Mr Nicholson:*** Twenty years ago, when I was working in the NHS, it was all relatively straightforward, in the sense that the money was allocated from the centre to various organisations that spent it and you got a little bit more the year after. In those circumstances it is relatively straightforward to be able to do the sorts of things that you describe. However, what we are running now is not an organisation but a system that has some 600 organisations in it—all with different objectives, and working together. The resources move between them as a part of clinical activity contracts, and all the rest of it. It would be surprising for every organisation to be completely in balance all at the same time; it would show a lack of dynamism in the system that would, frankly, be unbelievable. This is one of the issues that we—as an NHS—have to face in future. If you try consistently to deliver a nought in the bottom right-hand corner of all the clinical activity and all the activity of the NHS, the chances are, more often that not, you will get it wrong—sometimes a little bit more, sometimes a little bit less. What we need to do in the NHS—this is quite a difficult cultural thing for the NHS to deal with—is look towards delivering surpluses in the future. It seems to me that that is the only way in which we will get the financial flexibility to be able to let the system work in an appropriate way. That, I think, will be quite difficult, because most organisations, as you know, are on the one hand full of clinical staff who are desperately keen and ambitious to take their services forward and to do more, and on the other hand you have the boards who feel, often, that it is their moral responsibility to spend every single penny that they have on delivering health care.

**Q34 Helen Goodman:** Well, that is interesting, and it relates to the next thing I was going to ask you about, which is the complication that we have now in the system. On pages 14 and 15 we have two charts, about the structure of the NHS in England and the audit arrangements, which are not absolutely straightforward. I think that even a fan of the reforms would say that. In particular, I want to ask you about the accountability of NHS foundation trusts. One of their accountability lines is to Parliament. How are they accountable to Parliament?
***Mr Douglas:*** They present their accounts directly through the NAO to Parliament. The NAO audits their accounts. They are not absorbed with our accounts. The regulator for foundation trusts,

Monitor, can be called before any of the House Committees, to answer about the foundation trust system.[2]

**Q35 Helen Goodman:** But, for example, there is a chart somewhere that shows that some of the foundation trusts that were supposed to be very well performing—four of them, it says on page 25—are in deficit. What can we as parliamentarians do about the trust in Bradford, for example? What powers do we have? What I am asking you is this: is this accountability meaningful or does it just operate on paper?
***Mr Nicholson:*** My assumption is that it is meaningful and that you can call foundation trusts or the foundation trust regulator to account in the way that you would me or Richard.

**Q36 Helen Goodman:** But we would not have any powers to sack the chief executive, would we?
***Mr Nicholson:*** Of a foundation trust?
**Helen Goodman:** Yes.
***Mr Nicholson:*** Monitor can do that—the regulatory body.[3]

**Q37 Helen Goodman:** I see; but if you look at the chart you can see that they get money from one place and their accountability is to other places, so the accountability pressures are not the same as the budget pressures, and, indeed, the local elections will be from communities of people who will want to maintain their local hospital services, and that will be their priority, rather than financial responsibility, will it not?
***Mr Nicholson:*** No, they have a statutory responsibility, like any other organisation, to deliver their financial duties, but they are slightly different; that is true.

**Q38 Chairman:** Sir John, can you explain? Are NHS trusts accountable to the Audit Commission and therefore not to Parliament, or to you, and therefore to us?
***Sir John Bourn:*** No. The foundation trusts may choose their own auditor. They could choose the Audit Commission; they could choose a private sector auditor. We are the auditors of the consolidated accounts of foundation trusts. Their finances are covered in the Report that the Committee has before it, but when the Committee comes to discuss the Report that we shall produce on the 2005–06 accounts, you may wish to have the head of Monitor, who is the man responsible for the finance for the foundation trusts, before you, so that you can put questions to him as well.
**Chairman:** Thank you.

**Q39 Mr Khan:** The Chairman, in his introduction, commented on the generous moneys invested in the NHS and gave credit to all politicians—I think he meant the Labour Government, but that is by the bye; I am not sure whether it was an insult or a compliment. The question that I have is this: you will know from the figures the huge increase in funding, but the deficits in percentage terms, when you compare the amount of money invested, are for last year 0.74%, and for the year before 0.38%. I am sure that to trusts like my own that suffer the deficits they are huge in micro terms, but in macro terms they are not huge deficits when compared with the amount of money that you spend. My question is—I assume that you will say "0%", but forget that answer for a second, and let me ask the question—what percentage of overall deficit is acceptable to you? We will not accept zero as an answer, as I said.
***Mr Nicholson:*** I am struggling now.
**Mr Khan:** My point is this: bearing in mind your answer to Helen about the bottom right-hand corner, is it not inevitable that there will be some variation?
***Mr Nicholson:*** For the NHS as a whole, there should be a surplus, not a deficit. That is the only way that we will be able to manage all the organisations operating in the system.

**Q40 Mr Khan:** What surplus would you look for—0.3%, 1%?
***Mr Nicholson:*** It must be realistic. There would be nothing worse than just plucking a figure out of the air.

**Q41 Mr Khan:** Let us look four years forward. No, let us look three years forward—if the Conservatives win, there will be £19 billion of cuts four years forward. What would be a realistic figure for a healthy surplus three years forward?
***Mr Nicholson:*** It is not something that I have considered.

**Q42 Mr Khan:** I am sorry, but, flippancy aside, do you not think that you should be considering it?
***Mr Nicholson:*** I agree.

**Q43 Mr Khan:** You are saying that we should be looking for a surplus, that it is hoped to break even within 18 months. Is that fair?
***Mr Nicholson:*** We expect to break even this year and have a surplus next year.

**Q44 Mr Khan:** What surplus do you expect next year?
***Mr Nicholson:*** Something in the order of £250 million.

**Q45 Mr Khan:** What is that in terms of percentage of overall spend?

[2] *Note by witness:* An NHS foundation trust presents its accounts directly to Parliament. An NHS foundation trust appoints its own auditor. The regulator for NHS foundation trusts, Monitor, is required to produce consolidated accounts which provide an overall summary of the accounts of NHS foundation trusts. The NAO audits the consolidated accounts.

[3] *Note by witness:* Where the regulator (Monitor) determines a NHS Foundation trust is failing he may remove any or all of the directors including the chief executive or members of the board of govenors and appoint interim directors or members of the board.

***Mr Nicholson:*** It is just over 0.3%.

**Q46 Mr Khan:** What about the year after?
***Mr Nicholson:*** Depending on how we do next year, I would expect that 0.5% might be appropriate.

**Q47 Mr Khan:** Thank you for that. One of the criticisms is that there has been huge monetary investment, and one cannot argue about the investment. You started listing the performance improvements—your list was much longer but you were cut short by the Chairman. I accept that there have been huge increases, but the argument and challenge that are made is that the improvements have not been proportionate to the investment. I am sure that you have heard that criticism. How does one assess whether the improvement is proportionate to the money invested?
***Mr Nicholson:*** One way to measure that is in relation to whether you are delivering your objectives. Most if not all the major objectives that we identified for ourselves over the past few years have been delivered.
**Mr Khan:** May I stop you there? This is on the same issue. I assume that you allude to targets. Some people call them national strategies, but we call them targets.
***Mr Nicholson:*** There are issues around cancer, coronary heart disease, mortality, the number of hospitals built and waiting times.

**Q48 Mr Khan:** So if you can tick all those things, there is value for money.
***Mr Nicholson:*** That is one aspect. The second is productivity: whether we are getting more from every pound that we spend than we have in the past. On some crude measures, the story did not look so good, but you will be aware that the Office for National Statistics took into account quality and the shift to primary care and decided that the NHS improved its productivity overall by about 1.6% over the past five years. We need to increase that—I think that we can do better—but that is the position.

**Q49 Mr Khan:** Following that through, my trust has a budget deficit of £21 million. On the criteria that you mentioned, it has saved thousands of lives through treatments for cancer and other illnesses. More patients are going through the hospitals than ever before and more lives are being saved, but it has a huge deficit. My trust tells me that it has a better financial regime and can see funding problems—there is more transparency—but that it can no longer do what it did previously, which was simply to lift from capital to revenue. Nor can it use next year's money to subsidise this year's problems. Are you suggesting that once my trust gets down to zero and then goes forward, it will be giving value for money and the proportionate improvement will be commensurate with the money invested?
***Mr Nicholson:*** I am not saying they are not giving us value for money now, because I suspect they are. We are not saying to St George's, which is in deep difficulties, as are a number of other organisations, "You have to balance straight away." We are saying, "We need to work with you to ensure that the plans for cash release in cost improvements is on a deliverable timetable."

**Q50 Mr Khan:** One of their criticisms is that they originally agreed to meet their nil deficit in three years, but they were then told by the SHA one year into a three year programme that the target was two rather than three years. Their three year plan was brought forward by a year, which meant that savings could turn into cuts. Instead of the previous position in which they could guarantee that there would be no adverse clinical consequences, there is now the potential for adverse clinical consequences. What was the reason for bringing forward the time scale?
***Mr Nicholson:*** We will always try to push organisations as far as we can. As you know, the NHS has a long history of setting out reasons why issues cannot be dealt with, and we were keen to drive that forward. There was a negotiation about it.

**Q51 Mr Khan:** What happens if they are not in nil deficit and still have a deficit next year?
***Mr Nicholson:*** I am confident that they will do it.
**Mr Khan:** So am I. What happens if they do not?
***Mr Nicholson:*** Well, we will have to talk to them about it.
**Mr Khan:** Right. That sounds ominous.
***Mr Nicholson:*** Sorry; I did not mean to sound ominous. Either the planning was not right, there is something that they have not done that they should have done or circumstances changed in such a way to make it difficult for them.

**Q52 Mr Khan:** How do you disperse the information that you receive from your turnaround teams to other trusts that could benefit from it?
***Mr Nicholson:*** In a whole series of ways. The finance directors, through the SHA, share that information; a quarterly newsletter comes out from the national turnaround office; and, in different parts of the country, there are what are euphemistically described as "recovery clubs" for organisations that get together to share good practice.

**Q53 Mr Khan:** Do you think St. George's will be in a position to apply for foundation status by 2008?
***Mr Nicholson:*** Yes.

**Q54 Mr Khan:** Okay. This is my final question. In the report you talk about everyone in the business understanding the importance of financial management. Is that a fair summary?
***Mr Nicholson:*** Yes.

**Q55 Mr Khan:** How are you going to do that? How are the cleaners in the wards, the nurses and the junior doctors going to understand the importance of financial management?

***Mr Nicholson:*** There are two ways in which it works. First, it starts at the top with management teams and the boards of organisations—all boards, medical directors, nursing directors and all the rest of it—understanding the consequences of what they are doing. We are doing a lot of work on that. Secondly, the transparency helps a lot—it is clear now for organisations. One thing that I have noticed over the last six months going around NHS hospitals is that there is a lot of understanding from clinical and other staff about the implications of payment by results. I am sure you will not be amazed at the number of experts there are in hospitals now on how it all works. The level of understanding is growing significantly. The other issue is at the micro level, where people ask, "What are the financial consequences of decisions that I, as an individual, take?" There is evidence that people are picking that up, too. That is an important part of the message.

**Mr Khan:** Thank you. My time is up, but thank you very much.

**Q56 Sarah McCarthy-Fry:** Portsmouth Hospitals NHS Trust, which is in my constituency, is in financial balance, but the strategic health authority requires it to come up with another £7.35 million in order to bail out other trusts in the county which have problems. Are there any safeguards to ensure that the financial solvency of successful trusts, such as mine, is not put in jeopardy by that requirement to bail out poorly performing trusts?

***Mr Nicholson:*** That is one of the most difficult questions in relation to all of this, because in lots of ways, some of our most successful and well-managed organisations are having to take action to deliver money and to support other organisations. If nothing else, it reinforces the importance of what we are doing. In the circumstances of Portsmouth, I am dependent on the strategic health authority making a sensible assessment of what is possible. No doubt Sir Ian Carruthers and his team will work with Mike Waterland and the team at Portsmouth to ensure that. It would be false to put another organisation into financial difficulty to support another one.

**Q57 Sarah McCarthy-Fry:** The NAO Report says that it is concerned that strategic health authorities have applied the regime differently across the country. Do you agree that that is a concern?

***Mr Nicholson:*** Yes; it is. It certainly makes it extraordinarily difficult from a national perspective to see where financial performance is improving and not improving when different SHAs operate these sorts of things differently. One of the things I have done in the past three or four weeks is to ask Richard and the finance directors to make sure that it is applied universally in exactly the same way across the whole country.

**Q58 Sarah McCarthy-Fry:** You talk about organisations creating surpluses in the future—in other words, holding a reserve. In some ways, that is something that the SHA in Hampshire is doing now—it is clawing money in, which it is actually using to prop up other organisations, but it could do that to create the reserve that you want. Do you think that that is the role of the SHA, or should the trust create its own operating reserve?

***Mr Nicholson:*** It is up to each organisation to create its own ability to have financial flexibility. The SHAs do not create the reserves—the primary care trusts do. Virtually the whole of the reserve is currently being used to offset deficits. We want to get away from that and use the reserve to give us the financial flexibility to do the management of change and the transformation that we need.

**Q59 Sarah McCarthy-Fry:** What is the role of the SHA, if it is not creating the reserve?

***Mr Nicholson:*** The SHA is responsible for setting the direction of the health service in its part of the world and for ensuring that the organisations within it—the PCTs and the NHS trusts—deliver.

**Q60 Sarah McCarthy-Fry:** So, it is not the SHA that has required this money coming in from the trust?

***Mr Nicholson:*** I am sure that the SHAs have played a significant role in pulling all of this together—that is their job. However, it is not their money; it is the PCTs' money.

**Q61 Sarah McCarthy-Fry:** Do the SHAs have any funding of their own?

***Mr Nicholson:*** They have a base funding for their running costs, and a series of national budgets are in place, mainly around the work force.

**Q62 Sarah McCarthy-Fry:** Could they use that money to bail people out?

***Mr Nicholson:*** I hope that they do not use any of that money to bail people out. At the moment, if we allocate money to an organisation, it is done on the basis of a repayable loan.

**Q63 Sarah McCarthy-Fry:** I am trying to get back to the role of the SHA, because presumably in that case my hospital trust can turn to the SHA and say, "No; you are not having it." Can it do that or not?

***Mr Nicholson:*** Yes; I suppose it could, but trusts are accountable to the SHA. Having been an SHA chief executive for three and a half years, I know that you have to persuade the organisations of the requirements and the benefits of using this money across the patch as a whole. In my experience, I have never found an organisation that has refused after being given that set of arguments.

**Q64 Sarah McCarthy-Fry:** Let us move on to a different point. On 11 October, *The Guardian* had an article about hospitals being declared weak. The Healthcare Commission apparently felt the need to use "'lie-detection software' to analyse the trusts' own assessments of performance and found 42% embroidered the truth and gave misleading accounts." Do you recognise that?

*Mr Nicholson:* This was the self-assessment that was done. The survey that the Healthcare Commission did was not random, and it did not pick out a random group. It picked out those whose self-assessment looked rather odd when set against some of the other figures that it had, and it found that among that very small group there were some problems.

**Q65 Sarah McCarthy-Fry:** Is it a requirement for trusts' finance directors to be qualified accountants?
*Mr Nicholson:* Yes.

**Q66 Sarah McCarthy-Fry:** And are they all qualified accountants?
*Mr Douglas:* I think that there may be one in the countryside who is not. I will have to check that, but it is a requirement for them to be qualified accountants. That has been the case since the early 1990s. I think that a dispensation was made for one person, who had been in office since before that time. I could check that for the Committee. It is definitely no more than one.[4]

**Q67 Sarah McCarthy-Fry:** I was interested in the point you were making about the difference between audited and unaudited accounts. Is there a culture of internal audit within trusts?
*Mr Nicholson:* Yes.

**Q68 Sarah McCarthy-Fry:** Do you monitor that internal audit?
*Mr Douglas:* We do not monitor the internal audit from the centre. We do not have any performance management across internal audit regimes. We know that they have internal audit teams in place, and if there were real problems with weaknesses in internal audit, the Audit Commission would draw it to our attention and we would intervene at that point. We do not directly performance manage that.

**Q69 Sarah McCarthy-Fry:** Has the Audit Commission drawn your attention to any weaknesses in the internal audit?
*Mr Douglas:* In a few places, it has. We would then have discussions with the strategic health authority's finance directors.[5]

**Q70 Sarah McCarthy-Fry:** You gave three reasons for possible differences in 2004–05—the calculation of creditors and the capitalisation of assets were two. Are the trusts required to do what one might call "a hard close" at the end of each month, and is that what is causing the problem? If so, would there be a requirement for them to do a six monthly hard close, as if they were producing a set of audited accounts, and would that help you to see the problem earlier?

*Mr Douglas:* At the moment, no, they are not required to do that. We need to move pretty quickly to closes that are at least quarterly for NHS organisations, partly to meet the timetable to deliver early resource accounts and also, more importantly, to ensure that organisations are on top of their money. Some do close in such a way, but there is not a requirement across the system.

**Q71 Sarah McCarthy-Fry:** Would it be your role to ensure that that was done or the Audit Commission's?
*Mr Douglas:* It should be our role. We should stipulate that requirement.

**Q72 Sarah McCarthy-Fry:** What sort of processes do you have in place to get this sort of financial health check information from the trusts to you at the centre?
*Mr Douglas:* We get monthly monitoring information from every trust and PCT in the country. Although it is not based on a hard close from accounts, we broadly get their income and expenditure account sent to us every month. That is quality assured by the strategic health authority finance directors on our behalf. We can then carry out analysis around that data, raise questions and follow that up with performance management conversations, if we need to.

**Q73 Sarah McCarthy-Fry:** I want to move on to the cash balances that were referred to in the NAO Report. There were some dangers that trusts were not holding enough cash to meet their short-term requirements. Do you put a requirement on trusts that they must keep a certain percentage of their cash available, and how do you calculate what that percentage should be?
*Mr Douglas:* We do not place a requirement on trusts to keep a certain percentage. It would be quite difficult to say for each organisation what that percentage should be. We monitor what is happening with the cash so that if organisations are getting into cash difficulties, we can arrange for short-term movements of funds to help to deal with those difficulties.

**Q74 Sarah McCarthy-Fry:** Do you not think that given the problems with deficits and cash counting, it might be a good idea—just in the short term—to put some of those disciplines in place, so that that culture becomes part of everyday thinking in the national health service?
*Mr Douglas:* I think there is a need for some changes in cash management in the organisation. We have moved from a system that was almost purely cash-based six or seven years ago to one that focuses a lot more on expenditure overall rather than just cash. I think that some people have lost their way a little on cash. From this year, we will start to provide a system of formal cash loans across the system, which formalises a lot of what were just gentlemen's agreements. That places cash discipline on people. Some of the targets impose a degree of cash discipline. We have targets around

---

[4] *Note by witness*: Yes. All Trust finance directors are appropriately qualified accountants.

[5] *Note by witness:* In 2004–05, auditors reported that at 95% of NHS bodies, Internal Audit meet all relevant internal audit standards.

creditor payment periods, so that you can identify pretty quickly if an organisation is getting into cash difficulties through any slippage in the creditor payment periods.

**Q75 Sarah McCarthy-Fry:** That was what I was going to come on to. You would not want them to go down the route of preserving their cash by not paying their suppliers, because presumably a lot of suppliers are also in the public sector.
***Mr Douglas:*** Absolutely not. Some of this would switch the problem to elsewhere in the sector, and some would switch it to elsewhere in the public sector. Even if it was not the public sector, we do not want people to push their problems on to external suppliers.

**Q76 Greg Clark:** Mr Nicholson, can we clear one thing up? We know that some of these deficits have resulted in ward and sometimes hospital closures. There is a report in *The Times* today that says that the chances of a community hospital being closed in a Conservative constituency are seven times higher than in a Labour constituency. Is that true?
***Mr Nicholson:*** I have absolutely no idea whether that is true or not. I certainly do not look at the service in those sorts of terms. There are 150 new PCTs in existence, all working with their trusts, looking at the way in which their services are configured. I would get to see them only if they got to a position where they were about to implement some arrangements or whatever that were in some way contested by the system as a whole. We are certainly improving our management of that kind of knowledge and information, so that we are better in touch with it, but I genuinely have no idea whether that figure is true.

**Q77 Greg Clark:** So the PCTs come to you at the final stage?
***Mr Nicholson:*** Yes.

**Q78 Greg Clark:** Have you ever discussed hospital closures with the Department's special advisors?
***Mr Nicholson:*** No.

**Q79 Greg Clark:** Have you been in any meetings in which other Ministers from outside the Department were involved?
***Mr Nicholson:*** No. I have been in post for five weeks.[6]

**Q80 Greg Clark:** Can you speak for your predecessor on that?
***Mr Nicholson:*** Yes. I am sure that he would not have been involved in any of that either.

**Q81 Greg Clark:** Can we check and clarify that for the record?
***Mr Nicholson:*** Yes.

[6] *Note by witness*: Neither Sir Ian Carruthers not I have been in discussions about hospital closures with Ministers from outside the Department.

**Q82 Greg Clark:** Moving on to more substantial points, can we turn to table 9, on page 19 of the report? We see there that in 2004–05—the most recent financial year reported on—the number of PCTs in deficit, to take an example, almost doubled in a year, rising from 41 to 90. Did you expect this deterioration in finances or was it a surprise?
***Mr Nicholson:*** It was not planned.
**Greg Clark:** It was a surprise?
***Mr Nicholson:*** It became clear during the year that a number of PCTs were not going to hit their targets, so in that sense it was not a surprise, but it was certainly not planned.

**Q83 Greg Clark:** So you just realised during the year, rather than before the beginning of year?
***Mr Nicholson:*** Yes.

**Q84 Greg Clark:** Page 4, paragraph 8 of the Report says: "The reasons for the financial difficulties . . . cannot be attributed solely to poor financial management". In other words, there were other reasons. Can you outline some of the other reasons for these deficits?
***Mr Nicholson:*** I mentioned earlier the GPs' contract, "Agenda for Change" and the consultants' contract, all of which cost more than we had identified in the original costings.

**Q85 Greg Clark:** Yes, these contracts had been negotiated, yet the deficits that they produced were a surprise to you. If they were negotiated, surely you knew what they would cost the organisations.
***Mr Nicholson:*** Absolutely—they were negotiated nationally, but they were all implemented locally. For instance, the consultant contract negotiations were essentially local discussions between the management of the organisation and an individual consultant or a group of consultants, to deal with, for example, the number of PAs or the number of sessions that they were doing.

**Q86 Greg Clark:** Why was it not possible to foresee the impact of that and to fund it?
***Mr Nicholson:*** On the other side, I would say that most organisations managed to live within the money that they had or found alternative ways of funding the cost.

**Q87 Greg Clark:** You say that, Mr Nicholson, but 90 out of 130 PCTs were in deficit in 2004–05.
***Mr Nicholson:*** Yes.

**Q88 Greg Clark:** So, most PCTs did not manage to cope with those pressures.
***Mr Nicholson:*** No, there are 303 PCTs.
**Greg Clark:** Sorry. Almost a third did not manage.
***Mr Nicholson:*** Yes.

**Q89 Greg Clark:** That is not a trivial proportion. A lot of PCTs struggled to cope with something that should have been predictable—the costs of new contracts.

*Mr Nicholson:* If you take on PCTs, a major issue in relation to those contracts was the quality outcomes framework. Nationally, we took the best advice that we had, and our conclusion was that the average score for a GP would be about 750 points. In fact, it was more than 1,000 points in practice.[7]

**Q90 Greg Clark:** Whose fault is this? You are the chief executive and we have the finance director here. The cost of the GMS contract was £300 million more than anticipated and the consequences are being visited on our constituencies, in ward and bed closures. Who is responsible for that underestimate?
*Mr Nicholson:* The consequences for most organisations—two thirds of organisations—were good in the sense that they managed to deliver within the amount of money that they had. The quality and outcomes framework is a measure of quality of primary care, so—

**Q91 Greg Clark:** Do you not care about the ones that could not deliver? You got it wrong to the tune of £300 million. You did not fund them enough. Do you write them off? Do you have no sympathy for them?
*Mr Nicholson:* It is their job to live within the amount of resources—

**Q92 Greg Clark:** Even when you get your sums wrong to the tune of £300 million?
*Mr Nicholson:* We also got some other sums right—for example, on the benefits of changing the amount that we spent on drugs.
**Greg Clark:** But you got them wrong to the tune of £300 million, did you not? You gave organisations £300 million less than they needed and told them to get on with living with that.
*Mr Nicholson:* Yes, but that was in the context of them getting between 8.2 and 10% worth of growth. It seems perfectly reasonable for an organisation to manage its affairs against that scale of growth.

**Q93 Greg Clark:** But £300 million—a third of a billion pounds—seems quite a big mistake. None the less, let us look to the future. Some of your answers indicated that things are getting better. Is that right?
*Mr Nicholson:* I think that things are getting better, yes. There is the potential that we can balance the position across the NHS as a whole this year.

**Q94 Greg Clark:** Why, at paragraph 5.2 on page 63, do the auditors of 59% of NHS bodies report concern about the financial standing of their organisation for the year just ended? The figure has gone up.
*Mr Nicholson:* Because the environment in which people are working is more difficult than it was last year.

**Q95 Greg Clark:** You said that things are getting better, but more auditors this year are concerned about the financial standing of their organisations than they were last year or the year before.
*Mr Nicholson:* That is to say that the management challenges are greater; it is not to say—
**Greg Clark:** But you say things are getting better.
*Mr Nicholson:* Of course, because the management of the NHS are rising to that particular challenge.

**Q96 Greg Clark:** If an auditor expresses concern about the financial standing of an organisation, is that concern not a negative thing, which it is difficult to reconcile with something getting better?
*Mr Nicholson:* I do not think that at all. The bottom line in all this is whether we will deliver our financial targets, and we are on plan to be able to do that. It is going to be very tough for the NHS to live within its money this year, but I am confident that it can, because people will rise to the challenges that you have identified.

**Q97 Greg Clark:** But 59% of auditors have their doubts. My concern is this, Mr Nicholson: this year, we have had real-terms increases of 7.3% for the NHS—as the report makes clear, it is the best-funded public service—but deficits are impacting on service standards and auditors are expressing concern. We cannot expect those funding increases to continue, so if we are having difficulties now, how will your organisation cope with the more stringent circumstances that we all expect?
*Mr Nicholson:* That is why it is so critical to make those very tough and difficult decisions this year, while we have the growth to enable us to do so.

**Q98 Greg Clark:** You find it difficult to live within a 7.3% real-terms increase. If that figure fell to match the rate of growth of the economy, could you reasonably expect the NHS to cope without experiencing the problems that we are currently seeing, or worse?
*Mr Nicholson:* I think that we are going through a transitional period in terms of the way in which health care is delivered and of the system that we use. In those circumstances, there will undoubtedly be difficulties. For most of my career, however, I have lived with significantly less growth in the NHS than we have now, and it is possible for the NHS to do what you say.

**Q99 Greg Clark:** Why are some bodies resorting to fraud? Page 51 of the Report says that the appointed auditors reported "evidence of inappropriate adjustments and/or omissions" in 21% of NHS bodies' accounts. One in five NHS bodies are fiddling the figures. Why is that?
*Mr Douglas*: I think that it would be stretching it quite a lot to refer to that as fraud.

**Q100 Greg Clark:** Fiddling the figures, making inappropriate adjustments—how would you describe it? What is another word for that?

[7] *Note by witness*: The average score per practice was 959 points.

***Mr Douglas:*** What the auditors referred to was changes between draft accounts and final audited statements. Auditors will make judgments about a set of financial statements, in the same way that management will make judgments about a set of financial statements. Sometimes those judgments will differ. I could not say in the case of all the 125 bodies that the organisation had deliberately manipulated or falsified. They had made a different judgment from the auditor. That happens in the audit process.

**Q101 Greg Clark:** They made a different judgment from the auditor?
***Mr Douglas:*** Yes.

**Q102 Greg Clark:** Mostly when the auditor expresses a judgment on a company's set of accounts one tends to go with that judgment. One does not say, "Well he says one thing and he says the other." The fact that you can say that about the NHS's accounts when one in five—
***Mr Douglas:*** I disagree. When someone produces a set of draft accounts there may be issues where the board has a different judgment from the auditor. That will happen in commercial company accounts in the same way as it will happen in these accounts. I am sure that the NAO would have a number of cases where, during the process of audit, accounts change. That is not an unusual circumstance in any sector.

**Q103 Greg Clark:** We are not talking about movements of sums, but of specific inappropriate adjustments that have been made. The financial management here is rather perplexing. It concerns me that these practices are going on in the current buoyant times. The level of grip and detailed competence makes me worried about the future.
**Chairman:** Can we for the sake of this debate set the parameters of the argument? We are having this discussion today about 2004–05, where we are talking about 615 bodies, with 27% in deficit. Do you accept that? A briefing from the NAO tells me that the figures for 2005–06—the current financial year—are worse: there are 599 bodies of which 32% are in deficit. Do you recognise that?
***Mr Nicholson:*** Yes, I recognise that.

**Q104 Chairman:** So of the bodies we are talking about today, 27%. are in deficit and that figure is rising to 32%? What will be the position for this year? Can you give me a guarantee that things will get better?
***Mr Nicholson:*** Yes, we expect organisations that currently have a deficit either to be in balance or to have a smaller deficit than they had last year, and that the number of organisations with deficits should go down and that we should be in balance.

**Q105 Chairman:** The number should go down?
***Mr Nicholson:*** Yes.

**Q106 Chairman:** Could the NAO help me on this? There seems to be a slight difference.
***Sir John Bourn:*** We shall audit the current financial year—2006–07—during the course of 2007 and we will be able to see the extent to which Mr Nicholson's claims that fewer bodies—

**Q107 Chairman:** You are not able to comment on that yet?
***Sir John Bourn:*** No, because we are only part way through the financial year.

**Q108 Chairman:** But we assume that we can accept in general terms his argument that although the situation was deteriorating in 2004–05 to 2005–06, we hope that in 2006–07 it will be better?
***Sir John Bourn:*** That is the challenge for Mr Nicholson.
***Mr Nicholson:*** That is what we are trying to do at the moment.

**Q109 Chairman:** And you are confident that you can meet that challenge?
***Mr Nicholson:*** Yes.
**Mr Bacon:** Mr Douglas, I think that your answers to Mr Clark just now were misleading and deliberately so. Would you turn to page 52? You will see that case study 6 on Scarborough North-East Yorkshire NHS Trust states: "In November 2004, the Director of Finance reported to the Board that whilst the forecast year-end position was break-even, divisional overspends were expected to total £6.8 million by the end of the year. These overspends were expected to be partly offset by additional income, but during 2004–05 the Trust also considered a number of further measures to break even. These included a number of accounting adjustments. Before the accounts were prepared, the appointed auditor provided guidance that the proposed adjustments would not comply with accounting standards as set out in the NHS Trust Manual for Accounts. The Director of Finance chose to disregard the auditor's view and prepared a balanced set of accounts . . . Despite the existence of clear rules on large adjustments related to purchases made in previous years, the Trust hoped it could reduce in-year spending by reclassifying previously purchased medical instruments as stock and fixed assets. The accounts also contained examples of incorrect accounting treatment and inadequate checking procedures leading to significant errors. In the Public Interest Report, the auditor reported that a number of adjustments employed by the Trust were a device to achieve financial balance, rather than improve the accuracy of the accounts, and did not comply with accounting standards." That is correct, is it not?
***Mr Douglas:*** In that case, that was fundamentally wrong. The Director of Finance should not choose to disregard the auditors.

**Q110 Mr Bacon:** What happened to the director of finance in that case?
***Mr Douglas:*** I would have to check. I do not know.

**Q111 Mr Bacon:** Mr Nicholson, do you know?
***Mr Nicholson:*** I think I know.

**Q112 Mr Bacon:** Was he disciplined?
***Mr Nicholson:*** Both the Chief Executive and the Director of Finance were suspended subject to an investigation, which is just about to report.

**Q113 Mr Bacon:** Can we have a note on that? We once took a report from Sir John on the suspensions of clinical staff, and sometimes suspensions in the NHS go on for several years. But you think this is nearly over, do you?
***Mr Nicholson:*** Not in my experience of finance directors and chief executives. They seldom go on long.

**Q114 Mr Bacon:** Is he still suspended?
***Mr Nicholson:*** Yes.

**Q115 Mr Bacon:** And when will he not be suspended?
***Mr Nicholson:*** I have not seen the report, and I do not know what has happened. I just know that it is about—

**Q116 Mr Bacon:** I would like to know the result of it, and include it in our evidence, because that case study is an example of a more widespread tendency—the 125 bodies to which Mr Clark referred. Basically, it is people manipulating the figures to get the desired result, is it not?[8]
***Mr Douglas:*** I do not believe that that was the case in those 125 organisations. In this case, that was wrong. Someone should take the auditor's advice; they should not disregard it.

**Q117 Mr Bacon:** Do you think that the NHS accounting manual and standards should be complied with.
***Mr Douglas:*** Yes, absolutely.

**Q118 Mr Bacon:** Paragraph 5.37 refers to the review that the Secretary of State has asked the Audit Commission to undertake of the NHS financial and accounting regime. One of the things that the Audit Commission concluded was that "resource accounting and budgeting . . . is incompatible with the NHS trusts' financial regime and should not be applied to those organisations." Do you accept that finding?
***Mr Nicholson:*** We are considering the report, and we have not finalised those deliberations.

**Q119 Mr Bacon:** What is your view? They are saying that resource accounting and budgeting are incompatible. It is a strong statement.
***Mr Nicholson:*** I can perfectly understand from a trust's perspective why that might be the case. If you have the size of deficit that some organisations have, it makes running a trust extraordinarily difficult. However, there is no such thing as a free lunch: if we allow the flexibility to be moved away from individual trusts, the NHS as a whole somewhere else will have to pick up the responsibility for it. There is no technical answer for the NHS as a whole; of course, there may very well be one for individual trusts.

**Q120 Mr Bacon:** The Audit Commission provided another suggestion of having a national buffer to allow NHS trusts to operate more sustainably. Will you implement that buffer?[9]
***Mr Nicholson:*** It will mean that we will have to take money from somewhere else in the system to create it.
**Mr Bacon:** With respect, I did not ask what implementing the buffer would mean; I asked you whether you would implement it. If the answer is yes, please say yes; if it is no, please say no.
***Mr Nicholson:*** We have not come to a final conclusion.
**Mr Bacon:** About whether you will or not?
***Mr Nicholson:*** That is right.

**Q121 Mr Bacon:** When do you think you will come to a conclusion?
***Mr Nicholson:*** In the next few weeks.
**Mr Bacon:** Okay.
***Mr Nicholson:*** We certainly need to do it, because soon we need to put out the new tariff for next year and the operating statements about the way in which the NHS will be financially managed next year.
**Mr Bacon:** You will come to a conclusion in time for us to issue our report?
***Mr Nicholson:*** Yes.
**Mr Bacon:** So, could you write to us about it?
***Mr Nicholson:*** Yes.

**Q122 Mr Bacon:** Thank you. That is very kind. The Audit Commission also suggests: "The NHS Manuals for Accounts should be reviewed, made less prescriptive and more principle based and brought more closely in line with UK Generally Accepted Accounting Principles (GAAP)." Is that a recommendation you accept?
***Mr Douglas:*** Yes.

**Q123 Mr Bacon:** The Report goes on: "This would also have the benefit of making NHS finance staff less reliant on specific Department of Health instructions and more reliant on their own professionalism." Would you accept that, too?
***Mr Douglas:*** Yes.

---

[8] *Note by witness:* The Chief Executive and Director of Finance of Scarborough and North East Yorkshire NHS Trust are currently suspended. A report looking into the Trust's governance arrangements has now been concluded and, as a result of the report, it has been decided to take disciplinary action.

[9] *Note by witness:* Earlier this year, the Secretary of State asked Sir Michael Lyons and the Audit Commission to undertake a review of the NHS financial regime. The final report was published in the summer. The Secretary of State is now considering options in respect of each of the report's recommendations. The Department will respond formally, in due course, and will then notify the Committee.

**Q124 Mr Bacon:** Excellent. Paragraph 3.45 on page 43 talks about the organisations that were required to send in a recovery plan that would be reviewed by the SHAs and by the turnaround directors, and eventually released—the word used in the report—to the national programme office. As at 23 May, the national programme office had formally received 11 plans from organisations within the turnaround cohort. How many plans have now been received?
***Mr Nicholson:*** Sixty.[10]
**Mr Bacon:** Sixty? So, 60 out of the 98?
***Mr Nicholson:*** Yes.

**Q125 Mr Bacon:** And how many have been assessed and accepted?
***Mr Nicholson:*** The 60 have been accepted.

**Q126 Mr Bacon:** Oh. So, how many have been rejected?
***Mr Nicholson:*** Well, I do not know whether we actually reject plans, but we send them back. The balance will have been sent back for more work to be done on them.

**Q127 Mr Bacon:** Right. May I ask you about my own area, Norfolk? The new PCT in Norfolk—the combined PCT—starts with a very large deficit. I have got a document here from it. It says that it starts with a debt of £50 million from the former five PCTs. Work has been undertaken to identify the robustness of the projected position. The current year-end forecast is a projected deficit of £40 million. This sounds a lot compared with the national total. Norfolk only has 800,000 people. Are there special problems associated with the east of England and with Norfolk?
***Mr Nicholson:*** The east of England seems to have a lot of debt in it. That is absolutely true.

**Q128 Mr Bacon:** Why is it so much more? It is pretty much more than everywhere including London, according to the SHA summaries that I have seen.
***Mr Nicholson:*** Yes.
**Mr Bacon:** Why is that? It is significantly more. Most of them seem to be in the 30s, 40s or 50s of millions, and the east of England combined is at well over £200 million. Why is that?
***Mr Nicholson:*** There are a variety of reasons, depending on where in the east of England you want to talk about. Some of it is historic debt, and problems that have not been dealt with in the past, which have rolled on. Some of it is related to the kinds of things we talked about earlier in relation to contracts. There is a whole range. I do not think there is one particular issue that will identify the east of England as being special.

**Q129 Mr Bacon:** You talked about the extra money going on salaries. Is it possible you could send us a note showing the increased spending—because everyone knows there has been a lot of extra money going into the NHS—since *Agenda for Change*, the GP contract and the consultant contract were implemented? Can you write to us with a table showing the amount of increased spending, the total of spending and in each year the total on salaries, so that we can see how much has gone on salaries out of the increase, and how much was left for other things?[11]
***Mr Nicholson:*** Yes.
**Mr Bacon:** I will leave it to your artists to come up with a bar chart that shows it clearly, but to have it with numbers as well would be helpful.
***Mr Nicholson:*** Yes.

**Q130 Mr Bacon:** How many hospitals have closed one or more wards?
***Mr Nicholson:*** I have not got that information.
**Mr Bacon:** It must be accessible information.
***Mr Nicholson:*** We have a yearly census on the number of beds, but it is not something we would collect routinely, regularly.
**Mr Bacon:** You could find out.
***Mr Nicholson:*** I do not know whether there is a mechanism.
**Mr Bacon:** A quick e-mail, Mr Nicholson, would do it.
***Mr Nicholson:*** I do not know how practical it is.

**Q131 Mr Bacon:** How many hospitals have actually reduced the number of nurses that they employ, recently? You do not collect figures on that either?
***Mr Nicholson:*** We collect total figures.
**Mr Bacon:** It must be possible to work it out, surely, or just ask them. Each hospital must know how many nurses it employs, must it not? We often hear members of the Government standing up and saying how many nurses are employed. That can only be possible because information is taken and then aggregated.
***Mr Nicholson:*** Yes, we have got total figures.

**Q132 Mr Bacon:** Well, if you could send us figures on how many hospitals have reduced the number of nurses they employ I would be interested to see that.[12] Could you say what are the total costs to trusts of delays in the national programme for IT in the health service, whether or not they are recoverable from "Connecting for Health"? A lot of trusts have complained both about the costs incurred from the sudden decision to cut "Information for Health" and about delays in the national programme causing them to incur costs on things like training, and various other things, that they cannot recover from CFH or anyone else. What is your figure for how much?
***Mr Nicholson:*** I hear all this; I have seen no evidence to support that assertion.

---

[10] *Note by witness:* 60 is the number of category 1 & 2 received (those in most urgent need) out of 63. 31 out of 35 category 3 & 4 had also been received, making a total of 91 out of 98 received.

[11] Ev 24

[12] Ev 24–33

**Q133 Mr Bacon:** You do not think that the trusts have incurred any costs that they cannot recover?
***Mr Nicholson:*** I have not seen any evidence that will support what you have just said. I have heard lots of talk about it—lots of chat—but I have not seen any numbers that would lead me to believe that was occurring.
**Mr Bacon:** If you find any, would you send the Committee a note about it?
***Mr Nicholson:*** I will if I find any.

**Q134 Mr Bacon:** How much was spent on planning new hospitals and extensions that were not built? We know about the £15 million for the Paddington health campus, but how much in total?
***Mr Nicholson:*** I am sorry; I have not got that.
**Mr Bacon:** Is it possible you could send us a note on that as well?[13]
***Mr Nicholson:*** I am sure we could do that.

**Q135 Chairman:** We have had problems with these notes in the last year. There can be no vagueness on the part of accounting officers in their answers on provision or otherwise of notes to this Committee, so you must read the transcript. You were asked some specific questions and you must tell us whether you can provide these notes or not.
***Mr Nicholson:*** Yes.
**Chairman:** And you must bear personal responsibility for delivering these notes on time to this Committee and for their accuracy.
***Mr Nicholson:*** I understand.

**Q136 Mr Touhig:** The NAO and Audit Commission Report, right at the beginning on page 1, tells us that next year spending will reach almost £93 billion and that "healthcare . . . remains the fastest growing area of public expenditure." Is our money safe in your hands?
***Mr Nicholson:*** Absolutely. Even though we have a deficit, which clearly we in the NHS are not proud of, it is a relatively small deficit and there is little evidence to support an idea that we are not spending the money on what it is meant to be spent on, which is improving services, more staff, buildings, treatments, drugs and all the rest of it. But there is lots of good evidence to show that it is being used to good effect so, yes, I think it is safe.

**Q137 Mr Touhig:** I accept your point. The Chairman made the point at the beginning about improvements in the health service as a result of the investment. However, Mr Clark made a point about the number of PCTs that have problems; one third have financial problems. Is it not a fact that you negotiated nationally the pay increases for the consultants and GPs and you got it wrong?
***Mr Nicholson:*** We got it wrong.
**Mr Touhig:** You got it wrong by about £300 million.
***Mr Nicholson:*** But we also got other things right, which improved that.

[13] Ev 33

**Q138 Mr Touhig:** I accept that. But the consultants and others believed you had your own mint. They thought you were going to print the money and just give it to them and, frankly, you did, did you not? You just caved in.
***Mr Nicholson:*** No, I do not think we did. If you take the GMS contract, there have been some significant improvements in primary care services which are demonstrable though the quality of outcomes.

**Q139 Mr Touhig:** So consultants are working harder and doing more as a result of the extra money you have given them.
***Mr Nicholson:*** Overall, productivity has increased.

**Q140 Mr Touhig:** You are about £300 million overspent on that one particular contract. Were Ministers involved in the negotiations on the contract?
***Mr Nicholson:*** I have to say that I do not know.
**Mr Touhig:** Can you find out?
***Mr Nicholson:*** I can. Yes, they would have been.
***Mr Douglas:*** An agreement or contract of that nature must involve Ministers.

**Q141 Mr Touhig:** Yes, right. So what was said when Ministers realised that you were going to be £300 million short? The Ministers had you in, I suppose, and interrogated you and asked, "Why are we in this position?"
***Mr Douglas:*** The issue around the GMS contract has been primarily but not entirely about over-achievement against the targets that were built into the contract. Advice was taken on what level of achievement we could have expected from GPs. We worked with the NHS Confederation, with NHS Employers, and took the best evidence we could about how people would respond to the incentives. They responded better to the incentives than we had anticipated.

**Q142 Mr Touhig:** Anecdotally, I pick up that consultants are laughing all the way to the bank as a result of your settlement with them.
***Mr Nicholson:*** In terms of the consultants, the two issues that caused the problem in relation to the amount of money it was going to cost were, first, the on-call arrangements for consultants, when the assumption was that the vast majority of consultants could be on call by telephone and have lower payments. In fact, in the vast majority of the arrangements they come into the hospital, which seems to me a reasonable thing to do. Secondly, there is the number of PAs that they have and the number of sessions that they work. There is some evidence that this year, through negotiation, there has been a reduction in the number of PAs overall for consultants, as we have appointed more.

**Q143 Mr Touhig:** You are going to provide us with figures on the amount you have spent on extra salaries and so forth, but would you accept—I think the Report indicates this—that one reason

why you have the difficulties is that the way you handled the contract negotiations has cost you much more?
***Mr Nicholson:*** Most of the money that we spend in the NHS is on pay, so inevitably when we have deficits pay is an element of it.

**Q144 Mr Touhig:** Page 4.9 of the Report tells us that "a small number of NHS bodies considered deferring payment of tax and social security costs to HM Revenue & Customs, with a handful even struggling to pay staff wages." Did you not get them into a hell of a mess if they could not pay their own staff?
***Mr Nicholson:*** But they did, and the NHS as a whole worked with those organisations and enabled them to do that.

**Q145 Mr Touhig:** How did they overcome that problem?
***Mr Douglas:*** By moving money round the system in the way we have just described.
**Mr Touhig:** Something went; something had to give. Something was not funded in order to—
***Mr Douglas:*** Surpluses and cash had to be moved in order to do it, that is true. But that only reinforces our need to ensure that we get ourselves into balance so that we do not get into that position again.

**Q146 Mr Touhig:** I think that is important; it is right. On sharing good practice, you indicated earlier that you have all sorts of initiatives for sending out information. Do you have a must-do approach to sharing good practice? Do you have a lessons-learned approach, and do you ensure that it goes right through the whole health service? Do the two thirds of PCTs that you said are doing okay in respect of their financial balances share good practice with those that are having difficulties?
***Mr Nicholson:*** Yes, and the Audit Commission helpfully put together some useful stuff that we have used in the NHS. Overall, that is true.

**Q147 Mr Touhig:** Yes, but is it a must-do, or is it, "Oh, I think that I will tell old Bob about this"? Is that how it goes?
***Mr Nicholson:*** No.

**Q148 Mr Touhig:** Do trust chairmen bump into each other and say, "We did rather well," and, "How did you do that?" over a cup of tea or a gin and tonic?
***Mr Nicholson:*** No. Richard works with each strategic health authority finance director, and they work with all the finance directors in their patch to ensure that lessons are absolutely learned.

**Q149 Mr Touhig:** To what extent are Ministers advised of the trusts that are having difficulties?
***Mr Nicholson:*** Ministers see the financial information that I see in the submissions that are made. They are well aware of the organisations that have financial difficulties.

**Q150 Mr Touhig:** Yes, and what happens then?
***Mr Nicholson:*** We tell them what we are doing about it, and that is it.
**Mr Touhig:** That is it?
***Mr Nicholson:*** They ask for further information and test us as to whether we are taking appropriate action or whatever, but that is what happens.

**Q151 Mr Touhig:** Health in Wales is devolved, as you know, Chairman. When I was a Wales Minister and spoke to a Health Minister in Wales about a trust chairman whom I had some concerns about, the shoulders were shrugged, but trust chairmen are appointed by Ministers.
***Mr Nicholson:*** They are appointed by the Appointments Commission.
**Mr Touhig:** By the Appointments Commission?
***Mr Nicholson:*** Yes, it is an independent organisation.

**Q152 Mr Touhig:** What do Ministers do if a trust fails and concerns are expressed about the management, control, direction and leadership given by a chairman? Do Ministers get involved at all?
***Mr Nicholson:*** Not in my experience. The chairman of the strategic health authority would deal with the situation in conjunction with the Appointments Commission.

**Q153 Mr Touhig:** So nobody gets blamed or sorts out the problem?
***Mr Nicholson:*** Yes, of course they do. In my experience, chairmen have been dealt with in that way. A statement by the strategic health authority chairman setting out its assessment of the performance of the chairman goes to the Appointments Commission, and it makes a judgment as to whether to remove the chairman or ask for their resignation. That happens.

**Q154 Mr Touhig:** Do you think that that is the best way of doing it?
***Mr Nicholson:*** It is the most effective way of doing it.

**Q155 Mr Touhig:** You think that it is effective. You do not think that Ministers have a role to play.
***Mr Nicholson:*** I do not think that Ministers have a role to play.

**Q156 Mr Touhig:** Not in putting on pressure?
***Mr Nicholson:*** No, it is up to the Appointments Commission, which is an independent organisation.

**Q157 Mr Touhig:** My right hon Friend Mr Williams and I have certain views about devolution, but I remember that in pre-devolution days the Health Minister in Wales would ring up a trust chairman on the weekend if there was something wrong.

I shall leave my questioning there, Chairman.
***Mr Douglas:*** I should add that at the end of the last financial year, the Secretary of State personally wrote to all chairmen of organisations with large deficits. At the same time that the chief executive wrote and expressed concerns, the Secretary of State did so as well.

**Q158 Mr Touhig:** And how many chairmen were removed as a result? Were any removed for failing? We have all sorts of failing things—failing schools, failing this, failing that—but we let the chairmen of failing trusts carry on, do we? They pick up £15,000 a year or more—nice work if you can get it.
***Mr Nicholson:*** I know of examples where chairmen were removed as part of the process.

**Q159 Mr Mitchell:** Mr Douglas, why is the deficit problem worse in the south than in the north? You said that you had considered all the possible correlations but the only one that you could find was that if there was a deficit one year, there would be a deficit the next year. That says that once you are in a hole, you do not get out of it.
***Mr Douglas:*** It says that once you are in a hole, it is very difficult to get out of it.

**Q160 Mr Mitchell:** Why would southern trusts get into more holes than northern trusts?
***Mr Douglas:*** There is not really anything that correlates with deficits in certain parts of the country. As I said before, people have raised all sorts of issues about allocations and so on, but none of them work. I do not know whether there are different management issues in the south, whether it is more difficult to get and keep people at the appropriate level in management and finance jobs, but there is nothing that jumps out automatically.

**Q161 Mr Mitchell:** Once you are in a hole, it is difficult to get out of it. Why are you now proposing to reduce the income the following year for those in deficit? Paragraph 3.10 of the Report states that "a number of Trusts have expressed concerns to us that once financial balance has been lost, the resultant cut in income under the RAB regime makes recovery doubly difficult." That seems barmy.
***Mr Douglas:*** The only way in which that you can allow additional income and repayment for those who have underspent is for it to come off those who have overspent or you create a central buffer—a central reserve—to handle it. It is the only way in which it can be done.

**Q162 Mr Mitchell:** So if they are down, you will hit them? That is the system.
***Mr Douglas:*** If people have got into deficit, they have to recover that deficit. The double deficit issue, as the Audit Commission report makes clear, is an important timing issue so that, in the end, people are not hit twice. We allow strategic health authorities to operate the RAB adjustment differentially at a local level to give them a cushion.

**Q163 Mr Mitchell:** It seems an odd way in which to carry on. You are trying to impose a framework of financial discipline in nice boxes, but at the same time the trusts are being deluged with policy initiatives and changes that make it difficult to predict the situation and make it really difficult to do it. A number of key policy changes are being implemented, such as payment by results, practice-based commissioning, NHS foundation trusts and whether they will happen or not, and the rationalisation of primary care trusts and strategic health authorities. You cannot have one thing or the other, can you? You cannot have balance in the system and an endless series of initiatives thrown down from the top.
***Mr Nicholson:*** There is no doubt at the moment that we are in a period of maximum risk for NHS financial management in the sense that a major set of re-organisations is going on in PCTs and SHAs. It is our job to manage that, but most of the things that you have described should in the medium term help the position, not hinder it. As someone who has spent 15 years of his career running hospitals, the most obvious is being paid for what you do. It is something that people who have run hospitals have said that they have wanted for a long time. That is essentially what payment by result is. It is being paid for what you do, and it seems a helpful way of being able to plan and develop services in the future. Practice-based commissioning gives GPs control over resources and the ability to move patients through the system and to organise services around them.

**Q164 Mr Mitchell:** But it takes us back to 1997—
***Mr Nicholson:*** No. Practice-based commissioning should help that, because it will enable clinicians to be engaged directly in managerial, financial and service decisions at that level. Those sort of things will help the position, not hinder it.

**Q165 Mr Mitchell:** Let us hope that that is true. However, in the medium term many of the patients are dead.
***Mr Nicholson:*** I do not accept that the implementation of what I have just described will result in patients dying.
**Mr Mitchell:** But in the medium term, you are embarked on what amounts to a huge game of bluff. You said, "We have to push them as far as we can."
***Mr Nicholson:*** Yes.

**Q166 Mr Mitchell:** You are bluffing them that there will be a sanction at the end, and they are bluffing you by fiddling the figures—or by creative accounting—that they are actually achieving the targets. It is a huge national game of bluff. It sounds barmy at this particular time.
***Mr Nicholson:*** I do not accept that it is a game. Anyone who has worked in the NHS will know that it is not a game. It is far too serious for that. It has real consequences.

**Q167 Mr Mitchell:** If it were not a game, surely they would have you by the stethoscope because you would not put anyone in a situation in which they fire large numbers of staff, close wards and in which there is a deteriorating service. Members of Parliament would be clamouring around you all the time. It is impossible politically to put a trust into that situation, so it is a game of bluff.
***Mr Nicholson:*** We are trying to transform a system completely both in terms of the way in which we deliver care and in the structure of care. For example, we will increasingly be looking at treating people in the community—in primary care—and at how certain elements of care need to be centralised in regional centres. That will not happen by accident or without significant difficult decisions having to be made. We need to ensure that the financial regime is designed in such a way as to reinforce that to make it happen. That is why payment issues are so important.

**Q168 Mr Mitchell:** These are two separate issues.
***Mr Nicholson:*** No, they are not.
**Mr Mitchell:** It seems daft to combine one set of pressures with another. The restructuring of the service is causing all sorts of alarms about the closure of cottage hospitals—particularly in Conservative constituencies, I see from this morning's *The Times*—and emergency services. You cannot push that through at the same time as you are trying to push through this financial discipline because the two are separate issues, are they not?
***Mr Nicholson:*** No, they are not. They are exactly the same.

**Q169 Mr Mitchell:** Are you saying that those trusts that are in deficit and in the worst financial situation will have such structural changes pushed on them first?
***Mr Nicholson:*** No. I am saying that finance and good management are two sides of the same coin. We need to do both of those things at the same time, and we need to take services forward. The financial regime that we are talking about exposes those issues very clearly, so that if a PCT decides to avoid lots of medical admissions and to treat far more patients in the community, it needs to have the financial discipline to be able to do that. The reforms enable it to make that happen.

**Q170 Mr Mitchell:** That may be so, but my point is different: what confidence will the public have in structural changes, which are causing lots of fears locally about the closure of cottage hospitals and various services, if they are thought to be part of an economy measure—you may say that they are producing greater efficiency—and if they are concentrated on those trusts that are in most financial difficulty?
***Mr Nicholson:*** What I am saying, obviously not very well, is that the need to restructure care is being driven by a whole set of issues—demography, technology and so on.
**Mr Mitchell:** But it is a separate issue from these deficits.
***Mr Nicholson:*** That is what is driving things. We need to ensure that we have a solid financial basis in order to do all this. That is what we are trying to do.

**Q171 Mr Mitchell:** Why do them both at the same time? Why not get a solid financial basis and then go in for the structural changes, which in the long term may or may not be necessary? If the two get muddied, it will produce an impossible situation and an incredible public reaction.
***Mr Nicholson:*** It is obviously necessary to do both at the same time.

**Q172** Mr Mitchell: Why?
***Mr Nicholson:*** Because the expectations of our patients, the expectations in relation to the introduction of new drugs and new evidence about the safety of services all mean that things need to be done as soon as we possibly can do them.

**Q173 Mr Mitchell:** You can have every guarantee that the doctors against closure party will be the largest single party at the next election. In a year in which the financial provision for the health service is better than ever, it seems bad management to produce this atmosphere of crisis, cuts, restructuring and chaos.
**Mr Bacon:** Say what you really think, Austin.
***Mr Nicholson:*** I do not accept that.
**Chairman:** Mr Dunne will attempt to follow that.

**Q174 Mr Dunne:** We have heard a lot of talk of your confidence in the improvement in the current year, Mr Nicholson. A number of Members have touched on that issue. Can you explain how it is that you have such confidence? Let us consider the context of Government initiatives and NICE decisions that are emerging all the time, which impose additional cost obligations on the trusts.
***Mr Nicholson:*** I am sorry, I did not mean to sound overconfident about balancing the position at the moment. We are confident that we have the plans in place to enable us to do that. We cannot exactly foresee the future and the events that might be around the corner, but based on the best evidence that we have, our series of plans and the evidence from the quarter one results indicate that we should be able to live within the total financial envelope available to us.

**Q175 Mr Dunne:** How good is the financial forecasting?
***Mr Nicholson:*** It is getting better.

**Q176 Mr Dunne:** It is clear from page 51, paragraph 4.28, that, until this last year, trust managers had a perverse incentive to understate their deficits because the star-rating system clearly rewarded them on the basis of unaudited accounts, and that system is now behind you. What has been done to improve the financial capacity of trusts and the skills of the finance directors to undertake

forecasting, because in the past they have clearly been motivated to do so in a particular way that no longer applies?

***Mr Douglas:*** One of the issues that you rightly raise is not just that of competence but the question of the incentives in the system. Historically, for a number of organisations, bidding up the deficit early in the year was part of a negotiating strategy. Particularly as a trust, they might forecast a large deficit in the hope that the trust would get some support from the health authority and the PCT to cover that deficit. That would be done to get additional income and was part of the negotiating position in the NHS. The first thing that we are trying to do is to change that culture. By removing the support in the system of the movement of money, we are no longer incentivising people to bid up problems. That is the first thing. The payment-by-results system has the same effect, because people are paid on the basis of what they do. In terms of skills and capabilities, a range of training programmes are run through our strategic health authority finance directives. Along with the foundation trust regulator, we are introducing a new development programme for finance directors to help us to up their game. The most important skills aim, as the report makes clear, is that we get financial skills right across the boards. We are working with the NHS Appointments Commission on the training that we give to whole boards, not just to the finance directors.

**Q177 Mr Dunne:** In the current year, budgets were set based on a tariff that finance directors were told about only after they had submitted their original budget. That is not a particularly good example of best practice coming from the centre. How can you be confident that the current budgets will be remotely in line with what you expect?

***Mr Douglas:*** First, I agree entirely that it was not an example of best practice and it was not our finest hour in the Department. In terms of whether the budgets will be what people actually deliver, from the moment the tariff was issued, we have worked through the strategic health authorities with individual trusts and PCTs to try to verify their plans. We have a continual dialogue with the SHAs, their performance directors and their finance directors to ensure that the plans stack up. Whether each and every organisation will deliver the specific plans that we have agreed remains to be seen as we progress through the year, but the information that we are receiving says that the system as a whole will meet the overall targets that we have set.

***Mr Nicholson:*** The key issues in terms of financial discipline for this year and whether plans are taken out are twofold. First, there is the issue of whether NHS trusts will manage to deliver the cash-releasing savings problems that they have identified. The second issue is whether the numbers of patients referred into secondary care by PCTs are of the kind of numbers that were identified in the plans. Those are the two issues that will make the big difference.

**Q178 Mr Dunne:** Both are very difficult to predict in a period of transition.

***Mr Nicholson:*** Very difficult. The second is easier to predict, and we are monitoring closely the delivery of the cash-releasing cost improvement programmes in trusts. The first issue is more difficult to predict.

**Q179 Mr Dunne:** Mr Touhig touched on the role of the NHS Appointments Commission. Given the change that is going on—the reduction in the number of PCTs and SHAs—what is being done to ensure that the chief executives and the finance directors involved in the 18 failing trusts are assessed for competence and what is the price of failure for those particular trust managements?

***Mr Nicholson:*** As far as the organisations that are in the most difficult category are concerned, you will find that a number of the chairs, and/or chief executives and financial directors have changed. There has been a whole set of management movements in that area already. We are now in the position of supporting the new organisations to deliver those changes through the sorts of things that Richard has been talking about.

**Q180 Mr Dunne:** Can I move on to the double deficit issue that has been talked about, particularly in relation to payments to the NHS bank, in addition to the resource accounting deficit make-up? Those trusts that are in deficit are having to make substantial contributions to the NHS bank, and that is particularly true of the west midlands health authority area, which is where I am. However, there seems to be little provision for repaying that funding out of subsequent years' annual resources. How will it be paid off?

***Mr Nicholson:*** You are referring to the money that PCTs have given up for the reserve across the west midlands and across a number of strategic health authorities. That money is being used to support the deficits in a whole set of organisations in the west midlands. The issue of payback is yet to be finalised, and I am sure that it is subject to significant negotiation, but the real driver is the delivery of financial balance in those organisations that are in deficit. Once they are in financial balance, they will no longer need the resource, so it can be paid back. That is the delicate issue that needs to be negotiated, but we obviously hope that the PCTs get the resources back as fast as we can arrange it.

**Q181 Mr Dunne:** But the tariff makes no provision at all for helping to recover historic deficits. How do you intend to square that circle?

***Mr Douglas:*** The tariff does not make specific provision for any organisation for any individual thing; it is based on the average cost across the NHS and is then uplifted by pay and prices. For organisations to generate surpluses and recover past deficits, they will have to operate at less than the tariff price—they will have to be more efficient than the average organisation.

**Q182 Mr Dunne:** And if they cannot be? They are left with a debt, are they not? Should you not be arguing to the Government that you should be looking for a longer repayment of historic debt? Is that not a way out of the problem?

***Mr Douglas:*** I think that there are two issues. One is the cash issue for organisations. Where organisations have got into a cash problem as a result of running a deficit—it is the cash thing that people usually call the debt—we are creating a system under which we are potentially looking at giving people longer-term loans to repay that cash.

**Q183 Mr Dunne:** Sorry, but can I be clear about that? You are looking potentially at longer repayment terms? Over what period?

***Mr Douglas:*** For the cash payment. At the moment, if someone borrows cash from elsewhere in the system, it is flipped over to the following year and paid back. What we have done is to look at the demands for cash from each NHS organisation, based on their past financial problems, and at those organisations that will potentially have a surplus of cash. We are matching the two and, in most cases, that will lead to short-term loans. However, for some organisations—those with the most intractable problems—those loans may stretch over longer periods.

**Q184 Mr Dunne:** Could you envisage those periods stretching over three years or beyond five years? How do you see that?

***Mr Douglas:*** We have got to look at the final figures for this. I would find it difficult to see any stretching beyond five years.

**Q185 Mr Dunne:** Thank you. My final question relates to paragraph 3.37 on page 37, which states: "Recovery plans may need to include non-recurrent measures such as asset disposals to tackle cumulative deficits", so asset disposals clearly could be one means of paying off historic deficits. The problem for many of the trusts with assets on their books that have not been properly depreciated through the NHS accounting rules is that there is a substantial impairment charge. Under your accounting rules, it has to be written off against revenue in the year in which it is incurred, thereby effectively stymieing any opportunity to use asset sales as a means of solving the problem. Would you like to comment on that?

***Mr Douglas:*** We follow normal accounting practice on the impairment of assets, so organisations have to recognise an impairment in their revenue account.

**Q186 Mr Dunne:** Yet you do not follow normal depreciation rules for fixed assets such as buildings, do you?

***Mr Douglas:*** The system overall is broadly in line with normal accounting practice, and the NAO and the Audit Commission confirm our compliance with UK general accounting procedures. The issue of using land sales to deal with deficits is quite complicated because if you get a capital receipt from a land sale, you have to apply that for capital purposes; you cannot apply it to pay off a historic revenue deficit. The only element of a land sale that allows you to deal with a deficit is the profit on disposal, so this is not an easy way for people, just to dispose of assets.

**Chairman:** Thank you very much. Your last questioner is Mr Williams.

**Q187 Mr Williams:** Is not the ultimate problem that there is an ambivalence right at the heart of the health service as to who is in control? You, for example—we have had a succession of yous, as you will understand—sit there and issue your Caesar's edict, which is carried out to the provinces, but by the time the chariots get back you have already lost control. The information system is not adequate to begin with to enable you at the centre to exercise more hands-on, contemporaneous control. Is that a fact?

***Mr Nicholson:*** We are not running a Ukrainian tractor factory—that is true.

**Mr Williams:** This is not the allusion that I am trying to get at.

***Mr Nicholson:*** No, and I would not want to give the impression in any way that I was, but there are two or three things that we can do. First, we can ensure that we have proper business processes in the system; and secondly, we need to ensure that the organisations have the capacity to respond. Those are quite important things for us to do, but we should not get carried away with the idea that there are certain levers—there is certainly no lever in my office connected to some hapless nurse on ward.

**Q188 Mr Williams:** You are not a Ukrainian factory controller—you are sitting in Moscow pulling levers and expecting things to happen, but the lever is not connected to anything. Let us take this ambivalence to a different level. Is it not also a fact, administratively and operationally, that there is ambivalence in the key units within the health service? Some years ago, we were asking Sir Alan Langlands—who was a very good witness and for whom we had great admiration—about controlling this vast empire and he told us, "Well, I have about 600 accountable officers". I am told by the NAO that the precise figure is now 567 accountable officers, but they are an illusion, are they not? How does their power, as accountable officers, compare with your power as an accounting officer? They have the responsibility, but do they have the power to go with it?

***Mr Nicholson:*** They certainly have the power to manage their own organisations. They are all part of statutory boards that have the kind of statutory responsibilities that we have. They all manage incredibly complex organisations, many of the costs of which are driven by clinicians treating patients.

**Q189 Mr Williams:** But that is a value judgment. I hope that Sir John does not mind my quoting his reply to a note that I passed to him. I asked about

the accountable officers and he said, "Well, they don't cut the ice in the way the accounting officer in other departments does." That is the reality, is it not?
***Mr Nicholson:*** I do not think that I quite understand that point.

**Q190 Mr Williams:** When I probed the issue a bit further, the Comptroller and Auditor General made the point in a second note that the accountable officers do not have the same authority as the permanent secretary and that they lack that status when compared with the clinicians. Is it not a fact that there is a struggle down at the operational level? Those who want the resources actually have more status than the people are trying to control those resources.
***Mr Nicholson:*** What is true is that you get the best results where clinicians and managers work closely together. That is absolutely true and I have seen from my own experience, when I was responsible for Doncaster royal infirmary for 10 years, that that is exactly what happens. That was exactly the position that we were in, working very closely with clinicians. If you are set in opposition to clinicians, things become very difficult and a trial of strength. It was true up to about four or five years ago that the mean reason chief executives were fired was because they fell out with their doctors. That is not the case now, but it was.

**Q191 Mr Williams:** I know of an example of precisely that. The administrator was in the right, as it happened in this particular instance, as I recollect. We have had reference to creative accounting at a local level, but is that not a way of covering up this tension and incompatibility with the wishes of service suppliers and the need for control by the man or woman in charge of the finances?
***Mr Nicholson:*** I cannot accept that there is lots of creative accounting going on in the system. Perhaps I can give you an example of the sort of thing that I think that you are talking about. It could be that a particular hospital has a deficit and that, historically, a deficit was dealt with by the region or the strategic health authority, or whoever it was in those days, shifting resources to it to enable it to cover that up so it could say that it was in balance. That was often done on the basis that it had a year to sort its problems out. Typically, those problems did not get sorted out, because the really tough decisions about the way in which clinical practice is developed, including the number of day cases, the number of beds that a particular clinician would require for his or her work, and the perioperative length of stay—all those things—are difficult to deliver. One thing about the transparency that we have now is that it is impossible to avoid making those big decisions. That is the crux of the matter at the moment. We need to be absolutely resolute to ensure that we make those difficult decisions and deliver them.

**Q192 Mr Williams:** We are told in the report that 70% to 80% of the bodies with a deficit, knowing that they are in deficit, are not implementing their recovery programmes; they are definitely implementing the programme that exists. Are you saying that this is entirely down to the accounting officer, who will therefore be held accountable for failure at the end of the financial year?
***Mr Nicholson:*** They are accountable for delivering their savings programmes. That is their job; that is what they are paid to do.

**Q193 Mr Williams:** But how is it, since their job is on the line, that they cannot ensure that, in 70% to 80% of the cases where a recovery programme has had to be introduced—they must know that their job might be on the line—they get the response that they need from the body that they are working within?
***Mr Nicholson:*** Well, I think they are getting better at it. I have identified that, some years ago, it was 50% for the turnaround organisations and now those are delivering 95%. One of the major lessons from the turnaround teams is clinical engagement. That is what you need in order to deliver.

**Q194 Mr Williams:** That was my next question—and exactly where I was going. Because of the less formal attempts being made to reconcile finance with need in the past, when the turnaround teams go in and draw up their proposals, how binding are they? Are they laid down as commands that shall be obeyed or are they guidelines around which the old ambivalence can recur?
***Mr Nicholson:*** We do not accept a turnaround plan unless the local organisation owns it. So we start from a basis that that is what it needs to do. If it does not think that it can deliver it or it does not own it or, particularly, if its clinical staff do not believe that it is deliverable, we would not accept it. That is why we are taking so much time to get these plans in place.

**Q195 Mr Williams:** I am running out of time. I apologise. Jumping to your aspirations for the future, I am slightly confused. I can see that it is a real problem for you, intellectually. If you aim for break-even, you either make it or you do not; you may be just above or just below. I understood you to say that you are aiming for small surpluses everywhere. When small surpluses occur—if they do—will the hospitals or other organisations be told, "You have been good children. You can carry this forward to next year in addition" or will they be told, "That nasty Treasury is breathing down our necks and since you had a surplus last year, you are having less this year"? Is not that a temptation at the centre: to try to claw to some of it back to put to other uses?
***Mr Nicholson:*** It is certainly not a temptation for me, because I have to put exactly the right incentives in place. If I said to people, "Whatever surplus you get, we are going to whip it off you," I should get the surpluses that I deserve, should I not? My ability to deliver those surpluses to people

is dependent on our ability to deliver balance in those places that have deficits. If they are organisations that continue to rack up deficits, I shall never be able to give them back their surpluses.

**Q196 Mr Williams:** This is my final question. What structural changes have been necessary to ensure that you get that collective view, so that instead of there being a struggle between the head of finance and the clinicians, you now have a consensual approach to the solution?
***Mr Nicholson:*** I do not think there is a structural solution to it; it is about the way in which organisations function. One thing that potential foundation trusts must demonstrate in terms of their ability to manage their finances is that clinicians are brought into the general strategy and direction of that organisation. Those are the processes that are most likely to deliver. The other thing I would say is that we need to improve the quality and leadership of management in the NHS in general. One thing that I need to do is to start to encourage and bring more clinicians into senior chief executive and management positions in the NHS. We are quite unusual in the developed world for having relatively few—particularly doctors—in those positions. One of my jobs is to make that happen over the next period.
**Mr Williams:** I look forward to seeing you in a year's time when you can boast about your 567 surpluses. Thank you.
**Chairman:** Thank you, Mr Williams. Mr Bacon has a final supplementary question based on the evidence.

**Q197 Mr Bacon**: Actually, it is based on Mr Nicholson's CV. Would you clarify whether you were the chief executive of West Midlands South and of Shropshire and Staffordshire strategic health authorities consecutively, or was it one joint appointment? It looks like you have had four jobs since last year.
***Mr Nicholson:*** I have had five jobs since last year actually, including this one. I was the chief executive of Birmingham and the Black Country strategic health authority. In the August or September, I was given the job of running both the Birmingham and the Black Country and the Shropshire and Staffordshire strategic health authorities. About one month later, I took over responsibility for West Midlands South SHA. I was the chief executive of three organisations by October last year.

**Q198 Mr Bacon:** When you stopped being chief executive, you did not get any severance payments from those SHAs, did you?
***Mr Nicholson:*** No. I applied for one of the 10 strategic health authority chief executive jobs, and I got the London strategic health authority job. I was there for two months before I came here.

**Q199 Chairman:** To clear up a problem that is still confusing me, under this Government—the Labour Government—you accept that there is a dramatic increase in spending and the output has also improved, but confirm to me whether productivity has increased. What is the ratio between inputs and outputs? Has it improved?
***Mr Nicholson:*** The evidence produced by the Office for National Statistics over the last five years shows that on average we have increased our productivity, which includes quality, and all the stuff around coronary heart disease and cancer is improved by 1.6% on average per year.

**Q200 Chairman:** The last thing is a very important point. Remember our conversation on the current financial year, 2006–07. You gave various guarantees about 2006–07. Are you guaranteeing to us that a smaller proportion of bodies would be in deficit?
***Mr Nicholson:*** I do not think I can guarantee anything to you, but our plan and expectation, as I sit here, is that there will be a smaller number of organisations in deficit this year than last year.
**Chairman:** And the bodies still showing a deficit will be showing a smaller deficit than in 2005–06.
***Mr Nicholson:*** Similar, again.

**Q201 Chairman:** And overall the NHS will be in surplus.
***Mr Nicholson:*** In balance, this year. In surplus, next year.
**Chairman:** So not a guarantee but an expectation.
***Mr Nicholson:*** An expectation.
**Chairman:** Thank you. That concludes our hearing.

**Supplementary memorandum submitted by the Department of Health**

Question 129 (Mr Richard Bacon): *Can you provide us with a table showing the amount of increased spending, the total spending and in each year the total on salaries, so that we can see how much has gone on salaries out of the increase, and how much was left for other things?*

NHS REVENUE EXPENDITURE AND HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF COST GROWTH SINCE 2003–04

| | *2003–04 to 2005–06* |
|---|---|
| NHS Revenue Expenditure Growth: England[1] | 19% |
| HCHS Pay Bill Growth (excluding Agency)[2] | 25% |
| Workforce Growth (Census FTEs) | 7% |
| Pay Inflation | 17% |

Notes:

1. Expenditure figures are on a Stage 2 Resource Budgeting Basis and include a technical adjustment for trust depreciation.
2. Total Expenditure in 2005–06 based on Provisional Accounts, further detail not yet available, so percentage Agency spend is assumed to be at the same proportion as for 2004–05.

Question 132 (Mr Richard Bacon): *Well, if you could send us figures on how many hospitals have reduced the number of nurses they employ I would be interested to see that?*

Workforce information from all NHS organisations is collected annually as at 30 September. Trust data for 2006 has been collected and is being validated. The 2006 data will be available in the new year and we will send a copy to the Committee when the information is published.

The number of voluntary and compulsory redundancies by trust, for the first half of the financial year 2006–07, was placed in the House of Commons library on 30 October (please see excel file—attached separately).

The 901 trust compulsory redundancies breaks down as follows:

| | |
|---|---|
| Medical | 11 |
| Nurse | 135 |
| Midwives | 0 |
| Allied Health Professionals | 8 |
| Health Care Scientists | 13 |
| Non clinical | 734 |

VOLUNTARY AND COMPULSORY REDUNDANCIES BY TRUST AS AT 30 SEPTEMBER 2006

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | Foundation | NORTH WEST | 0 | 0 |
| AIREDALE NHS TRUST | Acute | YORKSHIRE AND THE HUMBER | 0 | 0 |
| AIREDALE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| ASHFORD AND ST PETER'S HOSPITALS NHS TRUST | Acute | SOUTH EAST COAST | 1 | 0 |
| ASHTON, LEIGH AND WIGAN PCT | PCT | NORTH WEST | 0 | 0 |
| AVON AND WILTSHIRE MHP NHS TRUST | Mental Health | SOUTH WEST | 0 | 0 |
| BARKING AND DAGENHAM PCT | PCT | LONDON | 0 | 0 |
| BARKING, HAVERING AND REDBRIDGE HOSP NHS TRUST | Acute | LONDON | 0 | 1 |
| BARNET AND CHASE FARM HOSPITALS NHS TRUST | Acute | LONDON | 0 | 0 |
| BARNET PCT | PCT | LONDON | 0 | 0 |
| BARNET, ENFIELD AND HARINGEY MH NHS TRUST | Mental Health | LONDON | 0 | 0 |
| BARNSLEY PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 1 |
| BARTS AND THE LONDON NHS TRUST | Acute Other | LONDON | 0 | 8 |
| BASSETLAW PCT | PCT | EAST MIDLANDS | 0 | 0 |
| BATH AND NORTH EAST SOMERSET | PCT | SOUTH WEST | 0 | 0 |
| BEDFORD HOSPITALS NHS TRUST | Acute | EAST OF ENGLAND | 0 | 10 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| BEDFORD PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| BEDFORDSHIRE AND LUTON MH AND SOCIAL CARE NHS TRUST | Community with Mental Health | EAST OF ENGLAND | 0 | 3 |
| BEXLEY CARE PCT | PCT | LONDON | 0 | 0 |
| BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHSTRUST | Mental Health | WEST MIDLANDS | 0 | 0 |
| BIRMINGHAM CHILDREN'S HOSPITAL NHS TRUST | Childrens Services | WEST MIDLANDS | 0 | 0 |
| BIRMINGHAM EAST AND NORTH PCT | PCT | WEST MIDLANDS | 0 | 0 |
| BIRMINGHAM WOMEN'S HEALTH CARE NHS TRUST | Acute Other | WEST MIDLANDS | 0 | 9 |
| BLACKBURN WITH DARWEN PCT | PCT | NORTH WEST | 0 | 0 |
| BLACKPOOL PCT | PCT | NORTH WEST | 0 | 0 |
| BLACKPOOL, FYLDE AND WYRE HOSPS NHS TRUST | Acute | NORTH WEST | 1 | 0 |
| BLACKWATER VALLEY AND HART PCT | PCT | SOUTH COAST | 3 | 6 |
| BOLTON HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 2 |
| BOLTON PCT | PCT | NORTH WEST | 0 | 0 |
| BOLTON, SALFORD AND TRAFFORD MENTAL HEALTH NHS TRUST | Mental Health | NORTH WEST | 0 | 8 |
| BOURNEMOUTH AND POOL PCT | PCT | SOUTH WEST | | |
| BRADFORD CITY TEACHING PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| BRADFORD DISTRICT CARE NHS TRUST | Care Trust | YORKSHIRE AND THE HUMBER | 0 | 0 |
| BRADFORD SOUTH AND WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| BRENT TEACHING PCT | PCT | LONDON | 0 | 0 |
| BRIGHTON AND HOVE CITY PCT | PCT | SOUTH EAST COAST | 0 | 1 |
| BRIGHTON AND SUSSEX UNIV HOSPS NHS TRUST | Acute | SOUTH EAST COAST | 2 | 5 |
| BROADLAND PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| BROMLEY HOSPITALS NHS TRUST | Acute | LONDON | 0 | 1 |
| BROMLEY PCT | PCT | LONDON | 0 | 1 |
| BUCKINGHAMSHIRE HOSPITALS NHS TRUST | Multi Service | SOUTH COAST | 0 | 1 |
| BURTON HOSPITALS NHS TRUST | Acute | WEST MIDLANDS | 7 | 7 |
| BURY PCT | PCT | NORTH WEST | 0 | 0 |
| CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST | Foundation | YORKSHIRE AND THE HUMBER | 0 | 0 |
| CALDERDALE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| CALDERSTONES NHS TRUST | Learning Disability | NORTH WEST | 0 | 0 |
| CAMBS & PETERBOROUGH MH PARTNERSHIP NHS TRUST | Mental Health | EAST OF ENGLAND | 0 | 0 |
| CAMDEN AND ISLINGTON MENTAL HEALTH SOCIAL CARE NHS TRUST | Care Trust | LONDON | 0 | 0 |
| CAMDEN PCT | PCT | LONDON | 0 | 0 |
| CENT MANCHESTER/MANCHESTER CHILD NHS TRUST | Acute Other | NORTH WEST | 1 | 0 |
| CENTRAL AND NORTH WEST LONDON MH NHS TRUST | Mental Health | LONDON | 0 | 0 |
| CENTRAL AND NORTH WEST LONDON MH NHS TRUST | Mental Health | LONDON | 0 | 0 |
| CENTRAL LANCASHIRE PCT | PCT | NORTH WEST | 0 | 0 |
| CHELSEA AND WESTMINSTER HEALTHCARE NHS TRUST | Acute Other | LONDON | 0 | 0 |
| CHESHIRE AND WIRRAL PARTNERSHIP NHS TRUST | Mental Health | NORTH WEST | 0 | 0 |
| CHESHIRE WEST PCT | PCT | NORTH WEST | 1 | 1 |
| CHESTERFIELD PCT | PCT | EAST MIDLANDS | 3 | 0 |
| CHRISTIE HOSPITAL NHS TRUST | Acute Other | NORTH WEST | 0 | 0 |
| CITY AND HACKNEY TEACHING PCT | PCT | LONDON | 0 | 0 |
| CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST | Foundation | NORTH EAST | 0 | 0 |
| CLATTERBRIDGE CENTRE FOR ONCOLOGY NHS FOUNDATION TRUST | Foundation | NORTH WEST | 0 | 0 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| CORNWALL AND ISLES OF SCILLY PCT | PCT | SOUTH WEST | 0 | 0 |
| CORNWALL PARTNERSHIP NHS TRUST | Community with Mental Health | SOUTH WEST | 0 | 0 |
| COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST | Foundation | NORTH WEST | 0 | 0 |
| COUNTY DURHAM | PCT | NORTH EAST | 2 | 0 |
| COUNTY DURHAM AND DARLINGTON ACUTE HOSPITALS NHS TRUST | Acute | NORTH EAST | 0 | 4 |
| COVENTRY TEACHING PCT | PCT | WEST MIDLANDS | 0 | 0 |
| CRAVEN, HARROGATE AND RURAL DISTRICT PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| CRAVEN, HARROGATE AND RURAL DISTRICT PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| CROYDON PCT | PCT | LONDON | 0 | 0 |
| DARLINGTON PCT | PCT | NORTH EAST | 0 | 0 |
| DARTFORD AND GRAVESHAM NHS TRUST | Acute | SOUTH EAST COAST | 0 | 0 |
| DERBY CITY | PCT | EAST MIDLANDS | 0 | 0 |
| DERBY HOSPITALS NHS FOUNDATION TRUST | Acute | EAST MIDLANDS | 0 | 0 |
| DERBYSHIRE DALES & SOUTH DERBYSHIRE PCT | PCT | EAST MIDLANDS | 0 | 0 |
| DERBYSHIRE MENTAL HEALTH SERVICES NHS TRUST | Mental Health | EAST MIDLANDS | 0 | 0 |
| DEVON PARTNERSHIP NHS TRUST | Community with Mental Health | SOUTH WEST | 1 | 1 |
| DEVON PCT | PCT | SOUTH WEST | 0 | 0 |
| DONCASTER AND SOUTH HUMBER HLTHCARE NHS TRUST | Mental Health | YORKSHIRE AND THE HUMBER | 0 | 0 |
| DONCASTER CENTRAL PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| DONCASTER EAST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| DONCASTER WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| DORSET HEALTH CARE NHS TRUST | Community with Mental Health | SOUTH WEST | 0 | 0 |
| DORSET PCT | PCT | SOUTH WEST | 0 | 0 |
| EALING HOSPITAL NHS TRUST | Acute | LONDON | 0 | 4 |
| EALING PCT | PCT | LONDON | 0 | 0 |
| EAST AND NORTH HERTFORDSHIRE NHS TRUST | Acute | EAST OF ENGLAND | 0 | 15 |
| EAST CAMBRIDGESHIRE AND FENLAND PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| EAST HAMPSHIRE PCT | PCT | SOUTH COAST | 0 | 4 |
| EAST KENT COASTAL PCT | PCT | SOUTH EAST COAST | 0 | 0 |
| EAST KENT HOSPITALS NHS TRUST | Acute | SOUTH EAST COAST | 1 | 14 |
| EAST LANCASHIRE HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| EAST LANCASHIRE PCT | PCT | NORTH WEST | 0 | 0 |
| EAST LONDON AND THE CITY MH NHS TRUST | Mental Health | LONDON | 0 | 0 |
| EAST MIDLANDS AMBULANCE SERVCE NHS TRUST | Ambulance | EAST MIDLANDS | 0 | 1 |
| EAST SUFFOLK PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| EAST SURREY PCT | PCT | SOUTH EAST COAST | 1 | 0 |
| EAST SUSSEX HOSPITALS NHS TRUST | Acute | SOUTH EAST COAST | 0 | 7 |
| EAST YORKSHIRE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| EASTERN CHESHIRE PCT | PCT | NORTH WEST | 0 | 0 |
| EASTERN HULL PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| EASTERN WAKEFIELD PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| EASTLEIGH AND TEST VALLEY SOUTH PCT | PCT | SOUTH COAST | 0 | 0 |
| ENFIELD PCT | PCT | LONDON | 0 | 0 |
| EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST | Acute | LONDON | 0 | 2 |
| ESSEX RIVERS HEALTHCARE NHS TRUST | Acute | EAST OF ENGLAND | 0 | 1 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| FAREHAM AND GOSPORT PCT | PCT | SOUTH COAST | 0 | 1 |
| FIVE BOROUGHS PARTNERSHIP NHS TRUST | Mental Health | NORTH WEST | 0 | 0 |
| GATESHEAD HEALTH NHS FOUNDATION TRUST | Foundation | NORTH EAST | 0 | 0 |
| GEORGE ELIOT HOSPITAL NHS TRUST | Acute | WEST MIDLANDS | 0 | 7 |
| GLOUCESTERSHIRE PARTNERSHIP NHS TRUST | Mental Health | SOUTH WEST | 0 | 0 |
| GLOUCESTERSHIRE PCT | PCT | SOUTH WEST | 0 | 2 |
| GOOD HOPE HOSPITAL NHS TRUST | Acute | WEST MIDLANDS | 0 | 5 |
| GREAT ORMOND STREET HOSPITAL NHS TRUST | Childrens Services | LONDON | 0 | 7 |
| GREATER PETERBOROUGH PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| GREENWICH TEACHING PCT | PCT | LONDON | 0 | 0 |
| GUILDFORD AND WAVERLEY PCT | PCT | SOUTH EAST COAST | 0 | 4 |
| GUY'S AND ST THOMAS' NHS FOUNDATION TRUST | Foundation | LONDON | 0 | 0 |
| HAMBLETON AND RICHMONDSHIRE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| HAMBLETON AND RICHMONDSHIRE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| HAMMERSMITH AND FULHAM PCT | PCT | LONDON | 0 | 0 |
| HAMMERSMITH HOSPITALS NHS TRUST | Acute Other | LONDON | 0 | 3 |
| HAMPSHIRE PARTNERSHIP NHS TRUST | Mental Health | SOUTH COAST | 0 | 2 |
| HARINGEY TEACHING PCT | PCT | LONDON | 0 | 10 |
| HARROGATE AND DISTRICT NHS FOUNDATION TRUST | Foundation | YORKSHIRE AND THE HUMBER | 0 | 0 |
| HARROW PCT | PCT | LONDON | 0 | 2 |
| HARTLEPOOL PCT | PCT | NORTH EAST | 0 | 0 |
| HAVERING PCT | PCT | LONDON | 0 | 0 |
| HEART OF BIRMINGHAM TEACHING PCT | PCT | WEST MIDLANDS | 0 | 2 |
| HEART OF ENGLAND NHS FOUNDATION TRUST | Foundation | WEST MIDLANDS | 0 | 0 |
| HEATHERWOOD AND WEXHAM PARK HOSPS NHS TRUST | Acute | SOUTH COAST | 0 | 0 |
| HEREFORD HOSPITALS NHS TRUST | Acute | WEST MIDLANDS | 0 | 0 |
| HEREFORDSHIRE PCT | PCT | WEST MIDLANDS | 0 | 0 |
| HERTFORDSHIRE PARTNERSHIP NHS TRUST | Community with Mental Health | EAST OF ENGLAND | 0 | 0 |
| HEYWOOD MIDDLETON AND ROCHDALE PCT | PCT | NORTH WEST | 0 | 0 |
| HILLINGDON PCT | PCT | LONDON | 0 | 0 |
| HINCHINGBROOKE HEALTH CARE NHS TRUST | Acute | EAST OF ENGLAND | 4 | 12 |
| HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST | Foundation | LONDON | 0 | 0 |
| HOUNSLOW PCT | PCT | LONDON | 0 | 0 |
| HUDDERSFIELD CENTRAL PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST | Acute | YORKSHIRE AND THE HUMBER | 0 | 0 |
| HUMBER MENTAL HEALTH TEACHING NHS TRUST | Community with Mental Health | YORKSHIRE AND THE HUMBER | 1 | 2 |
| IPSWICH HOSPITAL NHS TRUST | Acute | EAST OF ENGLAND | 2 | 0 |
| ISLE OF WIGHT PCT | PCT | SOUTH COAST | 0 | 12 |
| ISLINGTON PCT | PCT | LONDON | 0 | 0 |
| KENSINGTON AND CHELSEA PCT | PCT | LONDON | 0 | 17 |
| KENT AND MEDWAY NHS & SC PARTNERSHIP NHS TRUST | Mental Health | SOUTH EAST COAST | 0 | 4 |
| KETTERING GENERAL HOSPITAL NHS TRUST | Acute | EAST MIDLANDS | 0 | 0 |
| KING'S COLLEGE HOSPITAL NHS TRUST | Acute Other | LONDON | 1 | 2 |
| KINGSTON HOSPITAL NHS TRUST | Acute | LONDON | 0 | 0 |
| KINGSTON PCT | PCT | LONDON | 0 | 30 |
| KNOWSLEY PCT | PCT | NORTH WEST | 0 | 0 |

| | Trust Type | SHA | Voluntary | Compulsory |
|---|---|---|---|---|
| LAMBETH PCT | PCT | LONDON | 0 | 1 |
| LANCASHIRE AMBULANCE SERVICE NHS TRUST | Ambulance | NORTH WEST | 0 | 0 |
| LANCASHIRE CARE NHS TRUST | Mental Health | NORTH WEST | 0 | 0 |
| LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | Foundation | NORTH WEST | 0 | 0 |
| LANGBAURGH PCT | PCT | NORTH EAST | 0 | 0 |
| LEEDS MENTAL HEALTH TEACHING NHS TRUST | Mental Health | YORKSHIRE AND THE HUMBER | 0 | 0 |
| LEEDS NORTH WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| LEEDS TEACHING HOSPITALS NHS TRUST | Acute Other | YORKSHIRE AND THE HUMBER | 0 | 0 |
| LEEDS WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| LEEDS WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| LEEDS WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| LEICESTER CITY WEST PCT | PCT | EAST MIDLANDS | 0 | 0 |
| LEICESTER CITY WEST PCT | PCT | EAST MIDLANDS | 0 | 0 |
| LEICESTERSHIRE PARTNERSHIP NHS TRUST | Mental Health | EAST MIDLANDS | 0 | 1 |
| LEWISHAM PCT | PCT | LONDON | 0 | 3 |
| LINCOLNSHIRE PARTNERSHIP NHS TRUST | Mental Health | EAST MIDLANDS | 0 | 0 |
| LINCOLNSHIRE SOUTH WEST TEACHING PCT | PCT | EAST MIDLANDS | 0 | 0 |
| LIVERPOOL PCT | PCT | NORTH WEST | 0 | 0 |
| LIVERPOOL WOMENS HOSPITAL NHS FOUNDATION TRUST | Foundation | NORTH WEST | 0 | 0 |
| LONDON AMBULANCE SERVICE NHS TRUST | Ambulance | LONDON | 0 | 0 |
| LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST | Foundation | EAST OF ENGLAND | 0 | 0 |
| LUTON PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| MAIDSTONE AND TUNBRIDGE WELLS AND NHS TRUST | Trust | SOUTH EAST COAST | 0 | 0 |
| MANCHESTER HEALTH AND SOCIAL CARE NHS TRUST | Care Trust | NORTH WEST | 0 | 0 |
| MANCHESTER PCT | PCT | NORTH WEST | 0 | 0 |
| MAYDAY HEALTHCARE NHS TRUST | Acute | LONDON | 1 | 1 |
| MEDWAY NHS TRUST | Acute | SOUTH EAST COAST | 0 | 1 |
| MERSEY CARE NHS TRUST | Mental Health | NORTH WEST | 0 | 0 |
| MID ESSEX HOSPITAL SERVICES NHS TRUST | Acute | EAST OF ENGLAND | 0 | 42 |
| MID STAFFORDSHIRE GEN HOSPITALS NHS TRUST | Acute | WEST MIDLANDS | 59 | 0 |
| MID YORKSHIRE HOSPITALS NHS TRUST | Acute | YORKSHIRE AND THE HUMBER | 10 | 4 |
| MIDDLESBROUGH PCT | PCT | NORTH EAST | 0 | 0 |
| MID-HAMPSHIRE PCT | PCT | SOUTH COAST | 0 | 0 |
| MILTON KEYNES GENERAL HOSPITAL NHS TRUST | Acute | SOUTH COAST | 0 | 0 |
| MILTON KEYNES PCT | PCT | SOUTH COAST | 0 | 5 |
| MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST | Foundation | LONDON | 0 | 0 |
| MORECAMBE BAY HOSPITAL | 0 | NORTH WEST | 0 | 0 |
| NEW FOREST PCT | PCT | SOUTH COAST | 0 | 0 |
| NEWCASTLE PCT | PCT | NORTH EAST | 0 | 0 |
| NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST | Foundation | NORTH EAST | 0 | 0 |
| NEWHAM PCT | PCT | LONDON | 0 | 0 |
| NEWHAM UNIVERSITY HOSPITAL NHS TRUST | Acute | LONDON | 1 | 4 |
| NORFOLK AND NORWICH UNI HOSP NHS TRUST | Acute | EAST OF ENGLAND | 13 | 9 |
| NORFOLK AND WAVENEY MH PARTNERSHIP NHS TRUST | Mental Health | EAST OF ENGLAND | 0 | 0 |
| NORTH BRISTOL NHS TRUST | Acute | SOUTH WEST | 0 | 0 |
| NORTH CHESHIRE HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 0 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| NORTH CUMBRIA ACUTE HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| NORTH CUMBRIA PCT | PCT | NORTH WEST | 0 | 0 |
| NORTH EAST AMBULANCE SERVICE | Ambulance | NORTH EAST | 0 | 0 |
| NORTH EAST LINCOLNSHIRE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| NORTH EAST LONDON MENTAL HEALTH NHS TRUST | Mental Health | LONDON | 0 | 4 |
| NORTH HAMPSHIRE HOSPITALS NHS TRUST | Acute | SOUTH COAST | 0 | 0 |
| NORTH KIRKLEES PCT | PCT | YORKSHIRE AND THE HUMBER | 1 | 0 |
| NORTH LANCASHIRE PCT | PCT | NORTH WEST | 0 | 0 |
| NORTH LINCOLNSHIRE AND GOOLE HOSPS NHS TRUST | Acute | YORKSHIRE AND THE HUMBER | 0 | 0 |
| NORTH LINCOLNSHIRE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| NORTH MIDDLESEX UNIVERSITY HOSP NHS TRUST | Acute | LONDON | 1 | 9 |
| NORTH NORFOLK PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| NORTH SHEFFIELD PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| NORTH STAFFS COMBINED HC NHS TRUST | Community with Mental Health | WEST MIDLANDS | 1 | 3 |
| NORTH SURREY PCT | PCT | SOUTH EAST COAST | 0 | 0 |
| NORTH TEES AND HARTLEPOOL NHS TRUST | Acute | NORTH EAST | 10 | 0 |
| NORTH TEES PCT | PCT | NORTH EAST | 0 | 0 |
| NORTH TYNESIDE PCT | PCT | NORTH EAST | 0 | 0 |
| NORTH WARWICKSHIRE PCT | PCT | WEST MIDLANDS | 0 | 0 |
| NORTH WEST LONDON HOSPITALS NHS TRUST | Acute | LONDON | 0 | 33 |
| NORTHAMPTON GENERAL HOSPITAL NHS TRUST | Acute | EAST MIDLANDS | 0 | 0 |
| NORTHAMPTON PCT | PCT | EAST MIDLANDS | 0 | 0 |
| NORTHAMPTONSHIRE HEALTHCARE NHS TRUST | Community with Mental Health | EAST MIDLANDS | 0 | 0 |
| NORTHERN DEVON HEALTHCARE NHS TRUST | Acute | SOUTH WEST | 0 | 0 |
| NORTHUMBERLAND, TYNE AND WEAR NHS TRUST | Mental Health | NORTH EAST | 1 | 1 |
| NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST | Foundation | NORTH EAST | 0 | 0 |
| NORWICH PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| NOTTINGHAM CITY PCT | PCT | EAST MIDLANDS | 0 | 0 |
| NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST | Acute Other | EAST MIDLANDS | 0 | 2 |
| NOTTINGHAMSHIRE HEALTHCARE NHS TRUST | Mental Health | EAST MIDLANDS | 0 | 0 |
| NOTTINGHAMSHIRE COUNTY | PCT | EAST MIDLANDS | 0 | 0 |
| NTH CUMBRIA MH AND LEARNING DISAB NHS TRUST | Mental Health | NORTH WEST | 1 | 4 |
| NUFFIELD ORTHOPAEDIC NHS TRUST | Orthopaedic | SOUTH COAST | 0 | 0 |
| OLDHAM PCT | PCT | NORTH WEST | 0 | 0 |
| OXFORD CITY PCT | PCT | SOUTH COAST | 0 | 0 |
| OXFORD RADCLIFFE HOSPITAL NHS TRUST | Acute Other | SOUTH COAST | 11 | 19 |
| OXLEAS NHS FOUNDATION TRUST | Mental Health | LONDON | | |
| PENNINE ACUTE HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| PENNINE CARE NHS TRUST | Mental Health | NORTH WEST | 0 | 0 |
| PETERBOROUGH & STAMFORD HOSPITALS NHS FOUNDATION TRUST | Acute | EAST OF ENGLAND | 0 | 0 |
| PLYMOUTH HOSPITALS NHS TRUST | Acute | SOUTH WEST | 2 | 3 |
| PLYMOUTH TEACHING PCT | PCT | SOUTH WEST | 0 | 0 |
| POOLE HOSPITALS NHS TRUST | Acute | SOUTH WEST | 0 | 0 |
| PORTSMOUTH CITY TEACHING PCT | PCT | SOUTH COAST | 0 | 0 |
| PORTSMOUTH HOSPITALS NHS TRUST | Acute | SOUTH COAST | 0 | 5 |
| QUEEN ELIZABETH HOSPITAL KINGS LYNN NHS TRUST | Acute | EAST OF ENGLAND | 0 | 20 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| QUEEN ELIZABETH HOSPITAL NHS TRUST | Acute | LONDON | 0 | 29 |
| QUEEN MARY'S SIDCUP NHS TRUST | Acute | LONDON | 40 | 34 |
| REDBRIDGE PCT | PCT | LONDON | 0 | 0 |
| RICHMOND AND TWICKENHAM PCT | PCT | LONDON | 0 | 0 |
| ROB JONES AND A HUNT ORTHOPAEDIC NHS TRUST | Orthopaedic | WEST MIDLANDS | 0 | 0 |
| ROTHERHAM PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| ROYAL BERKSHIRE HOSPITAL NHS FOUNDATION TRUST | Acute | SOUTH COAST | 1 | 0 |
| ROYAL BOURNEMOUTH AND CHRISTCHURCH NHS FOUNDATION TRUST | Acute | SOUTH WEST | 3 | 1 |
| ROYAL BROMPTON AND HAREFIELD NHS TRUST | Acute Other | LONDON | 0 | 0 |
| ROYAL CORNWALL HOSPITALS NHS TRUST | Acute | SOUTH WEST | 0 | 1 |
| ROYAL DEVON AND EXETER NHS FOUNDATION TRUST | Acute | SOUTH WEST | 0 | 0 |
| ROYAL FREE HAMPSTEAD NHS TRUST | Acute Other | LONDON | 0 | 0 |
| ROYAL LIVERPOOL BROADGREEN HOSPS NHS TRUST | Acute Other | NORTH WEST | 0 | 0 |
| ROYAL LIVERPOOL CHILDRENS NHS TRUST | Childrens Services | NORTH WEST | 0 | 0 |
| ROYAL ORTHOPAEDIC HOSPITAL NHS TRUST | Orthopaedic | WEST MIDLANDS | 0 | 0 |
| ROYAL SURREY COUNTY HOSPITAL NHS TRUST | Acute | SOUTH EAST COAST | 0 | 11 |
| ROYAL UNITED HOSPITAL BATH NHS TRUST | Acute | SOUTH WEST | 6 | 4 |
| ROYAL WOLVERHAMPTON HOSPITAL NHS TRUST | Acute | WEST MIDLANDS | 0 | 0 |
| RUGBY PCT | PCT | WEST MIDLANDS | 0 | 0 |
| SALFORD PCT | PCT | NORTH WEST | 0 | 0 |
| SALFORD ROYAL NHS FOUNDATION TRUST | Acute Other | NORTH WEST | 0 | 0 |
| SANDWELL & WEST BIRMINGHAM HOSPS NHS TRUST | Acute | WEST MIDLANDS | 24 | 100 |
| SANDWELL MH SOCIAL CARE NHS TRUST | Care Trust | WEST MIDLANDS | 0 | 0 |
| SCARBOROUGH AND NE YORKS NHS TRUST | Multi Service | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SCARBOROUGH, WHITBY AND RYEDALE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SCARBOROUGH, WHITBY AND RYEDALE PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SEFTON PCT | PCT | NORTH WEST | 0 | 0 |
| SELBY AND YORK PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SELBY AND YORK PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SHEFFIELD CARE NHS TRUST | Care Trust | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST | Foundation | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SHEFFIELD SOUTH WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SHEFFIELD WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SHERWOOD FOREST HOSPITALS NHS TRUST | Acute | EAST MIDLANDS | 0 | 0 |
| SHREWSBURY AND TELFORD HOSPITAL NHS TRUST | Acute | WEST MIDLANDS | 0 | 0 |
| SHROPSHIRE COUNTY PCT | PCT | WEST MIDLANDS | 0 | 0 |
| SOLIHULL PCT | PCT | WEST MIDLANDS | 0 | 3 |
| SOMERSET PARTNERSHIP NHS AND SOC CARE NHS TRUST | Mental Health | SOUTH WEST | 0 | 0 |
| SOMERSET PCT | PCT | SOUTH WEST | 0 | 0 |
| SOUTH BIRMINGHAM PCT | PCT | WEST MIDLANDS | 1 | 0 |
| SOUTH CENTRAL AMBULANCE SERVICE NHS TRUST | Ambulance | SOUTH COAST | 4 | 0 |
| SOUTH DEVON HEALTH CARE NHS TRUST | Acute | SOUTH WEST | 0 | 0 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| SOUTH DOWNS HEALTH NHS TRUST | Community with Mental Health | SOUTH EAST COAST | 0 | 11 |
| SOUTH EAST COAST AMBULANCE SERVICE NHS TRUST | Ambulance | SOUTH EAST COAST | 0 | 0 |
| SOUTH EAST SHEFFIELD PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SOUTH GLOUCESTERSHIRE PCT | PCT | SOUTH WEST | 0 | 0 |
| SOUTH HUDDERSFIELD PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SOUTH LEEDS PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SOUTH LONDON AND MAUDSLEY NHS TRUST | Mental Health | LONDON | 0 | 0 |
| SOUTH MANCHESTER UNIV HOSP NHS TRUST | Acute Other | NORTH WEST | 0 | 0 |
| SOUTH STAFFORDSHIRE HEALTHCARE NHS FOUNDATION TRUST | Foundation | WEST MIDLANDS | 0 | 0 |
| SOUTH STOKE PCT | PCT | WEST MIDLANDS | 14 | 6 |
| SOUTH STOKE PCT | PCT | WEST MIDLANDS | 0 | 0 |
| SOUTH TEES HOSPITALS NHS TRUST | Acute | NORTH EAST | 0 | 5 |
| SOUTH TYNESIDE NHS FOUNDATION TRUST | Foundation | NORTH EAST | 0 | 0 |
| SOUTH TYNESIDE PCT | PCT | NORTH EAST | 0 | 0 |
| SOUTH WARWICKSHIRE GEN HOSPS NHS TRUST | Acute | WEST MIDLANDS | 0 | 1 |
| SOUTH WARWICKSHIRE PCT | PCT | WEST MIDLANDS | 0 | 0 |
| SOUTH WEST AMBULANCE SERVICE NHS TRUST | Ambulance | SOUTH WEST | 0 | 0 |
| SOUTH WEST YORKSHIRE MENTAL HEALTH NHS TRUST | Mental Health | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SOUTH WILTSHIRE PCT | PCT | SOUTH WEST | 0 | 0 |
| SOUTH YORKSHIRE AMBULANCE SERVICE NHS TRUST | Ambulance | YORKSHIRE AND THE HUMBER | 0 | 0 |
| SOUTHAMPTON CITY PCT | PCT | SOUTH COAST | 0 | 0 |
| SOUTHAMPTON UNIVERSITY HOSPS NHS TRUST | Acute Other | SOUTH COAST | 3 | 5 |
| SOUTHEND UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | Foundation | EAST OF ENGLAND | 0 | 0 |
| SOUTHERN NORFOLK PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| SOUTHWARK PCT | PCT | LONDON | 0 | 2 |
| ST GEORGE'S HEALTHCARE NHS TRUST | Acute Other | LONDON | 0 | 5 |
| ST HELENS AND HALTON PCT | PCT | NORTH WEST | 0 | 0 |
| ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| ST MARY'S NHS TRUST | Acute Other | LONDON | 1 | 5 |
| STAFFORDSHIRE AMBULANCE SERVICE NHS TRUST | Ambulance | WEST MIDLANDS | 0 | 0 |
| STOCKPORT NHS FOUNDATION TRUST | Multi Service | NORTH WEST | 0 | 0 |
| STOCKPORT PCT | PCT | NORTH WEST | 0 | 0 |
| SUFFOLK COASTAL PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| SUFFOLK MH PARTNERSHIP NHS TRUST | Community with Mental Health | EAST OF ENGLAND | 1 | 3 |
| SURREY AND BORDERS PARTNERSHIP NHS TRUST | Mental Health | SOUTH EAST COAST | 0 | 0 |
| SURREY AND SUSSEX HEALTHCARE NHS TRUST | Acute | SOUTH EAST COAST | 0 | 6 |
| SUTTON AND MERTON PCT | PCT | LONDON | 0 | 5 |
| SW LONDON AND ST GEORGE'S MENTAL HLTH NHS TRUST | Mental Health | LONDON | 0 | 0 |
| SWINDON AND MARLBOROUGH NHS TRUST | Acute | SOUTH WEST | 17 | 57 |
| SWINDON PCT | PCT | SOUTH WEST | 0 | 0 |
| TAMESIDE AND GLOSSOP ACUTE SERVS NHS TRUST | Acute | NORTH WEST | 3 | 3 |
| TAMESIDE AND GLOSSOP PCT | PCT | NORTH WEST | 0 | 0 |
| TAUNTON AND SOMERSET NHS TRUST | Acute | SOUTH WEST | 3 | 1 |

| | *Trust Type* | *SHA* | *Voluntary* | *Compulsory* |
|---|---|---|---|---|
| TAVISTOCK AND PORTMAN NHS TRUST | Mental Health | LONDON | 0 | 0 |
| TEES EAST AND NTH YORKS AMBULANCE SERV NHS TRUST | Ambulance | YORKSHIRE AND THE HUMBER | 0 | 0 |
| TEES, ESK AND WEAR VALLEYS NHS TRUST | Mental Health | NORTH EAST | 2 | 9 |
| TELFORD AND WREKIN PCT | PCT | WEST MIDLANDS | 0 | 1 |
| THE CARDIOTHORACIC CNTR—LIVERPOOL NHS TRUST | Acute Other | NORTH WEST | 1 | 0 |
| THE HILLINGDON HOSPITAL NHS TRUST | Multi Service | LONDON | 0 | 0 |
| THE LEWISHAM HOSPITAL NHS TRUST | Acute | LONDON | 0 | 47 |
| THE MID CHESHIRE HOSPITALS NHS TRUST | Acute | NORTH WEST | 0 | 3 |
| THE ROYAL MARSDEN HOSPITAL NHS FOUNDATION TRUST | Foundation | LONDON | 0 | 0 |
| THE ROYAL NAT ORTHOPAEDIC HOSP NHS TRUST | Orthopaedic | LONDON | 0 | 0 |
| TORBAY CARE PCT | PCT | SOUTH WEST | 0 | 0 |
| TOWER HAMLETS PCT | PCT | LONDON | 0 | 0 |
| TRAFFORD HEALTHCARE NHS TRUST | Multi Service | NORTH WEST | 0 | 0 |
| TRAFFORD PCT | PCT | NORTH WEST | 0 | 0 |
| UNITED BRISTOL HEALTHCARE NHS TRUST | Acute Other | SOUTH WEST | 0 | 0 |
| UNITED LINCOLNSHIRE HOSPITALS NHS TRUST | Acute | EAST MIDLANDS | 5 | 0 |
| UNITED LINCOLNSHIRE HOSPITALS NHS TRUST | Acute | EAST MIDLANDS | 0 | 0 |
| UNIV HOSPS COVENTRY & WARWICKSHIRE NHS TRUST | Acute | WEST MIDLANDS | 0 | 0 |
| UNIVSERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST | Foundation | LONDON | 0 | 0 |
| UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST | Foundation | WEST MIDLANDS | 0 | 0 |
| UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE HOSPITAL NHS TRUST | Acute | WEST MIDLANDS | 80 | 25 |
| WAKEFIELD WEST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| WALSALL HOSPITALS NHS TRUST | Acute | WEST MIDLANDS | 0 | 2 |
| WALSALL TEACHING PCT | PCT | WEST MIDLANDS | 0 | 2 |
| WALTHAM FOREST PCT | PCT | LONDON | 0 | 0 |
| WALTON NEUROLOGY CENTRE NHS TRUST | Acute Other | NORTH WEST | 1 | 0 |
| WANDSWORTH PCT | PCT | LONDON | 0 | 17 |
| WARRINGTON PCT | PCT | NORTH WEST | 0 | 0 |
| WEST HERTFORDSHIRE HOSPITALS NHS TRUST | Acute | EAST OF ENGLAND | 0 | 3 |
| WEST HERTS PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| WEST HULL PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 0 |
| WEST LONDON MENTAL HEALTH NHS TRUST | Mental Health | LONDON | 2 | 0 |
| WEST MIDDLESEX UNIVERSITY NHS TRUST | Acute | LONDON | 0 | 2 |
| WEST MIDLANDS AMBULANCE NHS TRUST | Ambulance | WEST MIDLANDS | 3 | 2 |
| WEST NORFOLK PCT | PCT | EAST OF ENGLAND | 0 | 0 |
| WEST SUFFOLK HOSPITALS NHS TRUST | Acute | EAST OF ENGLAND | 2 | 2 |
| WEST WILTSHIRE PCT | PCT | SOUTH WEST | 0 | 49 |
| WEST YORKSHIRE AMBULANCE SERVICE NHS TRUST | Ambulance | YORKSHIRE AND THE HUMBER | 0 | 0 |
| WESTMINSTER PCT | PCT | LONDON | 0 | 4 |
| WESTON AREA HEALTH NHS TRUST | Acute | SOUTH WEST | 0 | 0 |
| WHIPPS CROSS UNIVERSITY HOSP NHS TRUST | Acute | LONDON | 0 | 1 |
| WHITTINGTON HOSPITAL NHS TRUST | Acute | LONDON | 0 | 5 |

| | Trust Type | SHA | Voluntary | Compulsory |
|---|---|---|---|---|
| WINCHESTER AND EASTLEIGH HLTHCRE NHS TRUST | Acute | SOUTH COAST | 0 | 0 |
| WIRRAL HOSPITAL NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| WIRRAL PCT | PCT | NORTH WEST | 1 | 0 |
| WOLVERHAMPTON CITY PCT | PCT | WEST MIDLANDS | 0 | 0 |
| WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST | Acute | WEST MIDLANDS | 23 | 12 |
| WORCESTERSHIRE MH PARTNERSHIP NHS TRUST | Mental Health | WEST MIDLANDS | 0 | 0 |
| WORTHING AND SOUTHLANDS HOSPITALS NHS TRUST | Acute | SOUTH EAST COAST | 0 | 0 |
| WRIGHTINGTON, WIGAN AND LEIGH NHS TRUST | Acute | NORTH WEST | 0 | 0 |
| YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST | Foundation | SOUTH WEST | 0 | 0 |
| YORK HOSPITALS NHS TRUST | Acute | YORKSHIRE AND THE HUMBER | 0 | 0 |
| YORKSHIRE WOLDS AND COAST PCT | PCT | YORKSHIRE AND THE HUMBER | 0 | 1 |
| | | | 385 | 901 |

Question 134 (Mr Richard Bacon): *How much was spent on planning new hospitals and extensions that were not built.*

Central records are only kept on schemes with a capital value of over £25 million. Schemes below that level are managed locally and any write-offs of this kind are declared in the accounts of the trust concerned.

Paddington Basin

The Paddington Basin project team estimated abortive development costs at £15 million as outlined in the National Audit Office's Report published in May this year.

Essex Rivers Healthcare NHS Trust

Essex Rivers NHS Trust was a 4th Wave PFI scheme given the go-ahead to proceed in 2001—estimated capital value of £186 million. The trust decided to withdraw from the Colchester General Hospital PFI project in June 2006 following the PFI re-appraisal exercise. The Trust has advised the Department that they estimate their abortive development costs were about £4 million.

This scheme was out to tender as a PFI project and had reached an advance stage of development. The contractor involved has submitted a claim in relation to its abortive design costs and this is currently being considered by the trust and the Department.

East Kent Hospital NHS Trust

The East Kent Hospital scheme was a 4th Wave PFI scheme given the go-ahead to proceed in 2001—estimated capital value of £250 million. The scheme was cancelled in 2003. The trust reported to the Department that their abortive development costs were about £432,000.

Bradford Teaching Hospitals NHS Foundation Trust

The Bradford Hospital scheme was a 4th wave PFI scheme given the go-ahead to proceed in 2001—estimated capital value of £116 million. The scheme was cancelled in 2004. The trust reported to the Department that their abortive development costs were approximately £719,000.

Printed in the United Kingdom by The Stationery Office Limited
3/2007 355246 19585