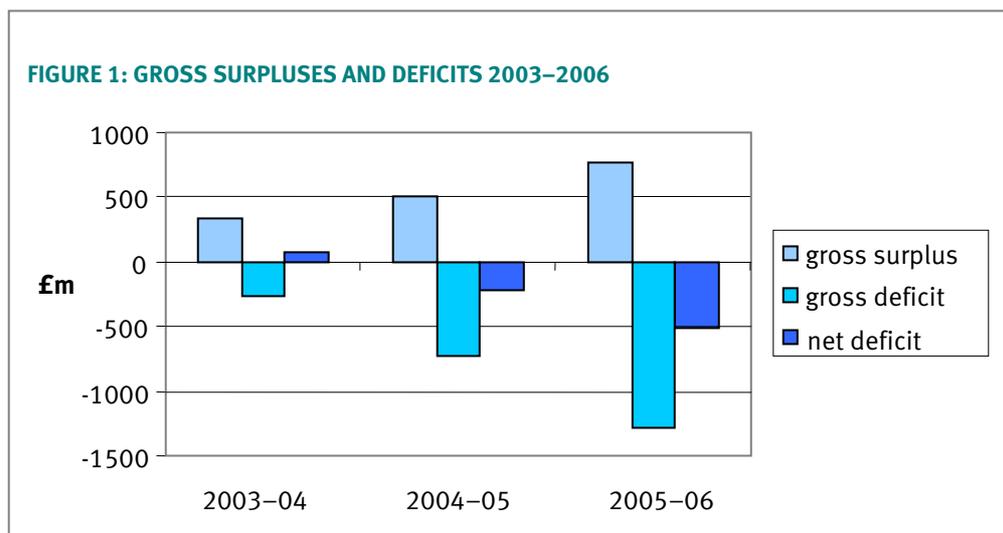


## Deficits in the NHS

### Introduction

The NHS has rarely managed to balance its books exactly; in many years it has overspent, and in some it has carried a surplus. According to the latest figures (unaudited accounts for the financial year 2005/6),<sup>1</sup> it is likely to record a substantial overspend – in gross terms, around £1.3 billion, equivalent to around £512 million net overspend after taking account of surpluses made by some NHS organisations, particularly strategic health authorities (SHAs).

While the net overspend represents slightly less than 1 per cent of the total NHS spend and affects a minority of organisations, it does represent a deterioration over time, as the chart below shows.



Many people are wondering how the NHS could overspend even by this much given the unprecedented increases in funding it has received – an average of around 9 per cent cash increase each year since 1999 and even higher levels in the last few years.

This briefing analyses what is known about the causes of current deficits.

### What is a deficit?

A deficit occurs when the expenditure of an NHS institution in a financial year exceeds the income accrued in the same period. NHS bodies are under a legal obligation to balance their income and expenditure in each year.<sup>2</sup> The bulk of NHS hospitals' income comes from primary care trusts (PCTs), which are purchasing care on behalf of their residents using money allocated by the Department of

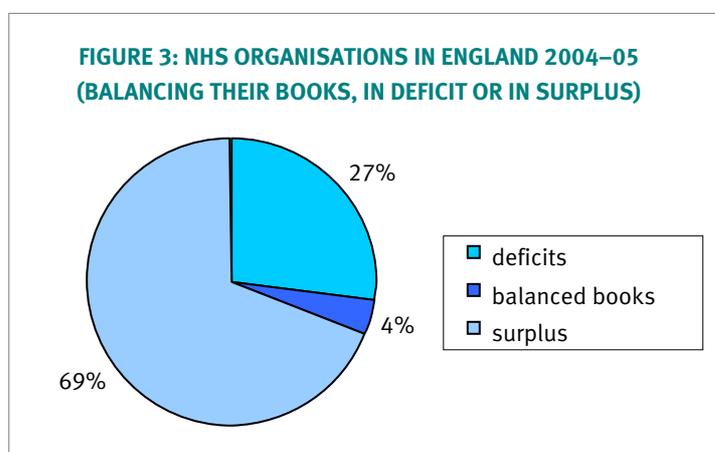
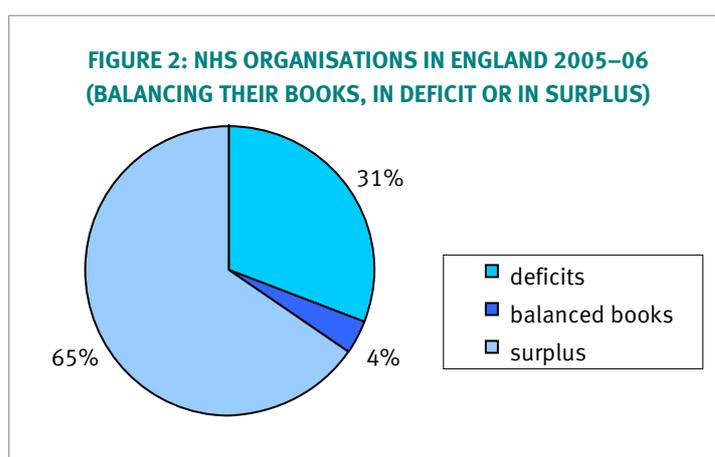
Health. The Department also holds funds to buy services centrally and the SHAs hold or oversee further budgets (of which the budget for Workforce Development Confederations (WDC) – paying for medical and other training and education – accounts for the bulk of strategic health authority spending).

The terms of the obligation to balance income and expenditure vary slightly by type of institution: PCTs are not meant to exceed their annual allocation (known as the Revenue Resource Limit) and should balance their books each year. Hospitals are also expected to balance income and expenditure in each year, but trusts with deficits may be allowed by their strategic health authority to achieve financial balance over a three-year period (or even over five years in exceptional cases).

## Scale of deficits

The unaudited figures released for 2005/2006 report a year-end deficit for NHS organisations in England: a gross deficit of £1.277 billion, with a gross surplus of £765 million: a total net deficit of £512 million. This represents a slight overall improvement from the mid-year projections of a net deficit of £623 million, but falls some way short of the government's plan for a net deficit of about £200 million.

As the charts below show, although the majority of NHS institutions are in surplus or have balanced their books, slightly more organisations have slipped into deficit (174), when compared with the previous year (159). It also represents a worsening situation compared to the forecasts made in December 2005 when 133 organisations predicted a deficit.



The worst deficits, as the government has pointed out, are concentrated in a minority of organisations (70 per cent of the gross deficit is to be found in 11 per cent of organisations). What has changed since last year (and the mid year projections) is the scale of financial problems in some trusts. There are now 15 organisations with deficits amounting to more than 10 per cent of their turnover. Last year (2004-05) there were only three reporting deficits on that scale, whereas in the previous year there were none. The gross deficits in the 102 organisations subject to ‘turnaround’ programmes, initiated by the Department of Health in December 2005 to restore the financial health of the worst performers, has doubled, slipping from a combined gross deficit of £476 million in 2004-05 to £915 million in 2005-06.

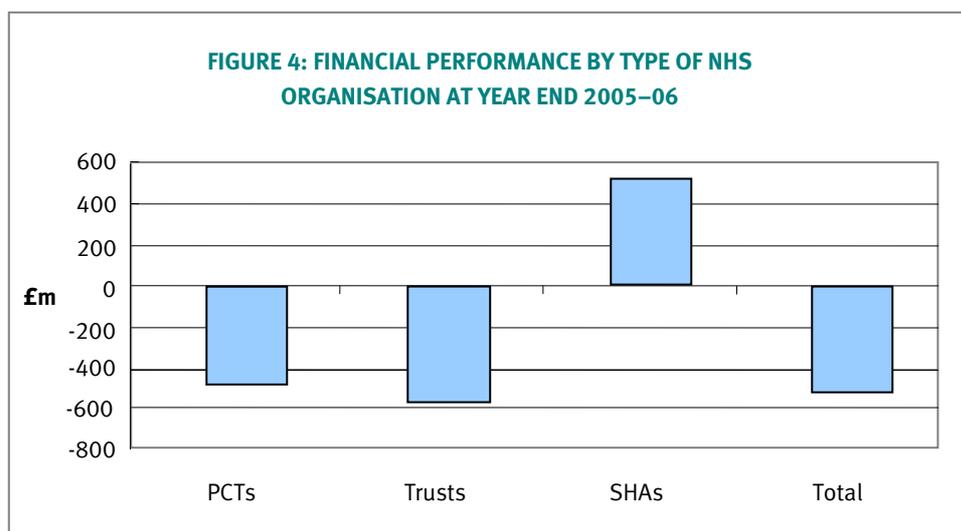
It is important to note that all the projected figures include planned borrowing from the NHS Bank and estimates of cash savings. The former must be repaid at some point and the latter may not, of course, materialise. The number of organisations with an underlying financial issue is therefore higher than the 31 per cent shown in the chart above.

Foundation trusts are not included in any of these figures as they have a separate financial regime administered under the aegis of Monitor, the foundation trust regulator. The latest figures for 2005-06 report a net deficit across all foundation trusts of £24 million.<sup>3</sup>

This briefing analyses the deficits in England. However, other countries in the UK are also affected. Small deficits have also been experienced by NHS trust boards in Scotland in recent years. In 2003/4, the net deficit was £14.2 million a small percentage (0.2 per cent) of the Revenue Resource Limit (RRL) of £5.8 billion. The Audit Committee of the Scottish Parliament warned last year that the underlying financial situation was considerably worse.<sup>4</sup> Audit Scotland has identified a ‘funding gap’ of £183 million for 2005/6.<sup>5</sup> The NHS Wales is also forecasting a ‘significant deficit position’ for 2005/6 according to the official Auditor.<sup>6</sup> The NHS in Northern Ireland is expected to break even.<sup>7</sup>

## Who is in deficit?

As the chart below shows, the largest surpluses were projected by SHAs – mainly on the Workforce Development Confederation budgets.



The 2005-06 figures show that 68 hospitals were reporting a deficit and 106 PCTs. Geographically, a significant part of the gross deficit was predicted by organisations in the south and east of England.

## What do we know about the causes of deficits?

The government has made clear its view that deficits are largely the result of poor management within individual institutions. The implication is that the solutions generally lie within the control of managers at individual institutions. The Department of Health's auditors, KPMG, commissioned a number of private sector 'turnaround' teams, to carry out an initial analysis of those NHS organisations with the severest financial problems. A summary<sup>8</sup> of the KPMG report to the Department suggested a more complicated set of factors and circumstances. Problems identified included:

- lack of management skills to deal with deficits and deliver turnaround
- poor-quality information
- SHAs allowing 'unproductive behaviour' between trusts and PCTs
- failure to implement cost improvement programmes early enough, with a lack of consideration for lead times
- lack of detailed implementation plans and unrealistic plans
- lack of ownership of plans within the organisation; and
- assumptions that savings would be delivered evenly, month by month across the year.

Scrutiny of trusts' own documents (such as annual reports) and Public Interest Reports (PIRs) issued by the Audit Commission provides further insight into the multiple causes of deficits. PIRs are issued when an auditor feels there is something 'significant' that needs to be brought to the attention of the public and the NHS body in question. The number of PIRs issued has increased sharply, from 2 in 2003 and in 2004, to 27 in 2005/6. The increase in PIRs is partly a reflection of the growing scale of financial problems within the NHS, but also reflects the Audit Commission's own advice to auditors to take more prompt action in cases where they were concerned.<sup>9</sup>

Three main groupings of causes emerge from the PIRs and official trust papers.

- 1 Local management problems** These include poor leadership and management and unique local circumstances, for instance, capital projects funded under the private finance initiative (PFI) that have cost more than expected, or where there have been unforeseen delays or other problems with specific land or building sales.
- 2 Local health economy problems** These include problems caused by proximity to other institutions in financial trouble – some hospitals depend on one PCT for up to 90 per cent of their income, for example. This can affect two or three trusts, but sometimes whole areas, or 'health economies' are affected.
- 3 National policies and decisions** These include cost pressures arising from actions or policies that were centrally driven, such as recent new contractual deals for NHS staff, or the cost of implementing NICE guidance. Other centrally decided policies such as payment by results (PbR) can have an adverse effect on individual trust and PCT finances. For example, the gradual shift to Payment by Results (PbR) (where hospitals are paid a set tariff for each procedure or treatment calculated using national average costs), will have a differential effect on trusts: those hospitals with above-average costs face financial pressure as local prices move down to tariff. So, too, do hospital trusts whose locally negotiated prices were lower than the tariff because they are limited in how quickly they are allowed to move their prices up to tariff. PCTs whose local prices rise when tariffs are introduced pay more for the same activity and the income adjustment they received to compensate them is now being phased out more rapidly than they had expected.

Other issues that have contributed to the problems include changes to accounting practices. For example, the rigours of the Resource Allocation and Budgeting (RAB) procedures (introduced in 2001) require that a deficit in any year is deducted from income in the following year. Individual organisations with a deficit cannot broker and then start the next year at zero; the brokerage is now borrowing and must be repaid. In addition, of course, the organisation must also tackle the root causes of its overspending.

Another change has been progressive phasing out of 'capital to revenue transfers,' eliminated from 2004/5, which allowed trusts to switch money from maintenance or capital budgets to revenue budgets.<sup>10</sup>

## 1 Local management problems

### *Management quality: specific points*

Only a minority of institutions come in for specific management criticism in the PIRs: examples include a trust that failed to hire enough finance staff to service its needs; a PCT that had such poor monitoring data that it was unaware that nearly £1 million had been paid to the local hospital for extra work and one example of highly creative accounting in which expenditure of more than £2 million on medical equipment was 're-classified' as an asset, thereby turning a big deficit into a £20,000 surplus. This last example was later reversed by the official accountants, who commented that 'the desire to present a small surplus at year end has compromised the integrity of the production of accurate annual accounts.' This was the only example of this sort of problem from a total of 27 reports.

### *Management quality: general failings*

The most striking feature of the NHS bodies covered in the reports is that nearly all of them have had significant underlying deficits for some time. For PCTs, in a few cases, these were inherited from previous health authorities, resulting in a deficit at the inception of the institutions in 2002. What the PIRs refer to is a universal tendency to deal with underlying deficits through a series of short-term measures rather than tackling the root problem (of spending more than their income.) These include the following examples.

- Switching money from buildings and repairs to revenue. This has resulted in a maintenance backlog of £32 million in one trust.
- Using 'non-recurrent' monies. This means using money earmarked for 'one-off' projects, for example, an IT project that did not begin until the following financial year.
- Relying on financial support from other NHS institutions. This can take different forms, including 'planned' support from other trusts (brokerage) but also more short-term cash 'loans' from other trusts and the NHS Bank. All are repayable under Department of Health guidelines issued in 1999.<sup>11</sup> However, in the past this support has not always been clearly identified as a loan rather than income in the accounts. Under the changes to accounting practices introduced in 2001, an amount equal to the previous year's deficits should be subtracted from the budget for the next year. Some trusts are arguing that this accelerates indebtedness to an absurd degree, with one trust forecasting a cumulative deficit of £100 million by 2009, despite projecting small (in-year) surpluses from 2006-8.
- Relying on saving and efficiency targets that are not achieved. Many of the savings plans designed to reduce overspenders are classified as 'aspirational' by the auditors. One example is PCT savings plan relying on the assumption of no further growth in demand for hospital services, which, the auditors note 'would be inconsistent with historical patterns.'

## 2 Local health economy problems

A common feature of nearly all the reports is the interlinked nature of deficits: very few trusts appear to have deficits in isolation. In the case of hospital trusts, the local PCT (or PCTs) are sometimes also experiencing problems, leading to disagreements and disputes over payment for work done. An often-repeated theme is the need for trusts to work out their recovery plans jointly (with PCTs and other trusts) rather than separately, although there is little evidence of this happening effectively. In some cases, for instance the PIRs on Surrey and Sussex SHA or the Thames Valley SHA, there is a more underlying problem concerning the configuration of services in the area as a whole (for instance duplication of services across different sites). The implication is that radical restructuring of services is required, above and beyond any financial recovery plans drawn up at trust level.

## 3 National policies and decisions

### *Meeting targets*

Many of the PIRs refer to the spending in excess of income as being justified, at the time, in order to meet targets (to treat inpatients, outpatients and A&E attendees within a certain time limit). In some cases, contracts were drawn up with the private sector to treat patients in order to meet the targets (one trust spent £2 million in one year on private treatment, which accounted for a quarter of its deficit for that year) or hiring locum and agency staff. One trust, which had failed to meet its A&E target (to treat nearly all patients within four hours), subsequently spent £2 million on extra staff to meet the target. The access target was met, but its deficit was worsened as a result.

This theme is also widely reflected in trust board papers and annual reports. One trust forecasts that an extra £3 million is required to meet targets in 2006/7, a figure which it openly acknowledges is currently 'unfunded' by the PCT.

The Audit Commission has noted 'the view that exists in some NHS bodies that central government targets are in direct competition with the achievement of financial balance.' However, the government's own guidance, issued in 1999, made it clear that for hospital trusts, the three-year break-even period could be extended if the actions needed to make good a deficit might 'seriously threaten the achievement of national performance targets' and lead to 'unacceptable service consequences.'<sup>12</sup>

A corollary of the increased activity by hospital trusts is the inability of PCTs to control the demand for hospital services. This situation arises because referrals are made by GPs who are not under the control of the PCTs, and hospitals will never send away sick patients. In some cases, PCTs have been aware of the extra activity and have felt bound to pay for it. In one case, £2.3 million was handed over to the local acute trust, leaving the auditors to note the 'absence of agreed schemes between the trusts and PCTs to manage activity levels.' In other cases the PCT has refused to pay for work already done by the acute trust causing a larger deficit in the hospital trust.

### *Pay costs*

Pressures of costs, including those of implementing the new pay contracts and Agenda for Change, feature frequently in explanations for increased unplanned expenditure. One trust estimates that 'pay modernisations', including the consultants' contract, cost an unanticipated £5.5 million in 2004/5. The auditors for another trust note that the consultants' contract cost an additional £1.1 million in 2004/5 and add 'we did not identify any performance improvement observations from our watching brief on workforce contracts.'

### *Payment by Results, efficiency and the national tariff*

None of the PIRs refer to PbR, the new payment system being progressively rolled out across the NHS, as a direct cause of financial problems.

PbR uses prices based on a national average of costs and is designed, among other things, to put pressure on high-cost trusts to be more efficient, but will also represent potential extra income for low-cost trusts. A crude indicator of hospital efficiency is the Reference Cost index, a summary measure of a hospital's total cost that has been used since 1997. It ranks hospitals relative to the English average of 100. The Reference Cost index is mentioned on several occasions in the PIRs as an indicator of relative inefficiency: some of the trusts in deficit have average or slightly above average costs. Overall there is no simple relationship between efficiency and deficits: about half the deficit-affected trusts are broadly efficient, with an index rating of below 100.

The lack of impact of PbR is perhaps due to the relative novelty of the policy: PbR will apply to the bulk of hospital activity only from April 2006. It is likely to have a profound impact on all trusts.

Some of the auditors register concerns about the potential for PbR, however, to deliver any financial gains in the future for the trusts in question. Several hospital trusts have built in assumptions about their future income, based on over-optimistic assumptions about growth in activity. One auditor comments 'it is not clear to me whether local PCTs will be able to afford the increase in commissioning expenditure implied by the Trust's future recovery plans.' Another questions the anticipated gains from PbR as they 'are outside the control of the Trust.'

Some of the efficient trusts (who stand to gain automatically from the introduction of the national tariff) raise similar doubts about the profitability of PbR in their own board papers. One trust, faced with attempts by the PCT to place limits on their activity, note that this appears to be a return to the 'block contracts of the past' (a form of contracting that PbR is designed to replace). Another has calculated that PbR is, on paper, worth £19 million, which the PCTs do not appear to have.

### **Dealing with the deficits**

Since the deficit projections became public in December 2005, there has been a number of initiatives to address the problem. As well as the 'turnaround' teams (commissioned from auditors KPMG) sent into 18 of the worst performing trusts, the Audit Commission is shortly to issue a report analysing the causes of deficits and financial failures in the NHS.

Meanwhile, one region, London, has responded to the overspend by 'top slicing' 1 per cent of the resources of those PCTs not in deficit (on average several million pounds per PCT), to offset deficits.

Restoring the financial health of NHS institutions has been made a priority by the Department of Health. The latest guidance to the NHS makes clear that achieving financial balance is needed not just as a matter of good practice, but also as a foundation for the success of PbR and patient choice.<sup>13</sup> The Department of Health recognises that the new incentive-based reforms will bring some 'financial volatility' in addition to any turbulence generated by underlying deficits. It is not yet clear, however, to what extent 'achieving financial balance' will be at the expense of other NHS goals, such as waiting times targets.

### **Conclusion**

The causes of deficit experienced by trusts subject to PIRs are complex and solutions are likely to take time to take effect. The government is correct in asserting that a 'culture' of management prevailed that prioritised service delivery above achieving financial balance. That culture, however, appears to have been sanctioned from the top and it is clear that the trusts, their auditors, and the SHAs have been aware of the persistence of underlying deficits for some time and short term nature of the financial measures used to temporarily 'balance' the books, without addressing their underlying causes.

Much now depends on the quality of the financial planning and leadership within individual trusts. However, this analysis of the deficits would suggest that only part of the problem lies at the level of better management of the institution. Even with a perfectly engaged and competent leadership, a trust

is likely to struggle if the health economy is unfavourable and relationships between providers and commissioners are poor.

In addition, the exogenous shocks from centrally initiated policies may not be amenable to local control. The full financial impact of the pay settlements is only now becoming obvious at institutional level.

As previous analyses have shown, the new market-style reforms, including PbR and patient choice remain unknown quantities, with the potential to deliver substantial gains but also substantial losses at an institutional level, particularly to those trusts already damaged by deficits.

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<sup>1</sup> Department of Health, NHS organisations forecast surplus and deficits 2005-06: Month 12

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4135757&chk=i3vuBj](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4135757&chk=i3vuBj)

<sup>2</sup> 'All NHS trusts are required by Section 10 of the National Health Service and Community Care Act 1990 to ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to the revenue account. This duty has been interpreted to mean that over a three- (or exceptionally five-) year period, trusts are required to achieve break-even position in their income and expenditure account, that is, their income must match their expenditure.' Audit Commission (2004). *Achieving First Class Financial management in the NHS*.

<sup>3</sup> <http://www.monitor-nhsft.gov.uk/publications.php?id=902>

<sup>4</sup> <http://www.scottish.parliament.uk/business/committees/audit/reports-05/auro5-05-01.htm>

<sup>5</sup> [http://www.audit-scotland.gov.uk/news/press\\_releases/2005/nhsoverview05pr.pdf](http://www.audit-scotland.gov.uk/news/press_releases/2005/nhsoverview05pr.pdf)

<sup>6</sup> [http://www.wao.gov.uk/assets/englishdocuments/NHS\\_finances\\_english.pdf](http://www.wao.gov.uk/assets/englishdocuments/NHS_finances_english.pdf)

<sup>7</sup> <http://www.nics.gov.uk/press/hss/o6o41ob-hss.htm>

<sup>8</sup> <http://www.dh.gov.uk/assetRoot/04/12/71/88/04127188.pdf>

<sup>9</sup> [www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=english%5E574&ProdID=9D9D1EE5-F613-4e6b-9560-F74D2BEAFB5C&SectionID=sect1](http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=english%5E574&ProdID=9D9D1EE5-F613-4e6b-9560-F74D2BEAFB5C&SectionID=sect1)

<sup>10</sup> NAO NHS (England) Summarised Accounts 2002/3 [http://www.nao.org.uk/publications/nao\\_reports/03-04/0304505ii.pdf](http://www.nao.org.uk/publications/nao_reports/03-04/0304505ii.pdf)

<sup>11</sup> Department of Health, Health Service Circular HSC 1999/146 Guidance to Health Authorities and NHS Trusts on break-even duty, provisions and accumulated deficits.

<sup>12</sup> Department of Health, Health Service Circular HSC 1999/146 Guidance to Health Authorities and NHS Trusts on break-even duty, provisions and accumulated deficits.

<sup>13</sup> [http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4127117&chk=BgslVK](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127117&chk=BgslVK)