National Audit Office

Report on the NHS Summarised Accounts 2006-07: Achieving Financial Balance

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 129-I Session 2007-2008 | 11 December 2007

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7 December 2007

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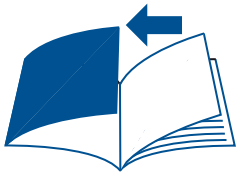


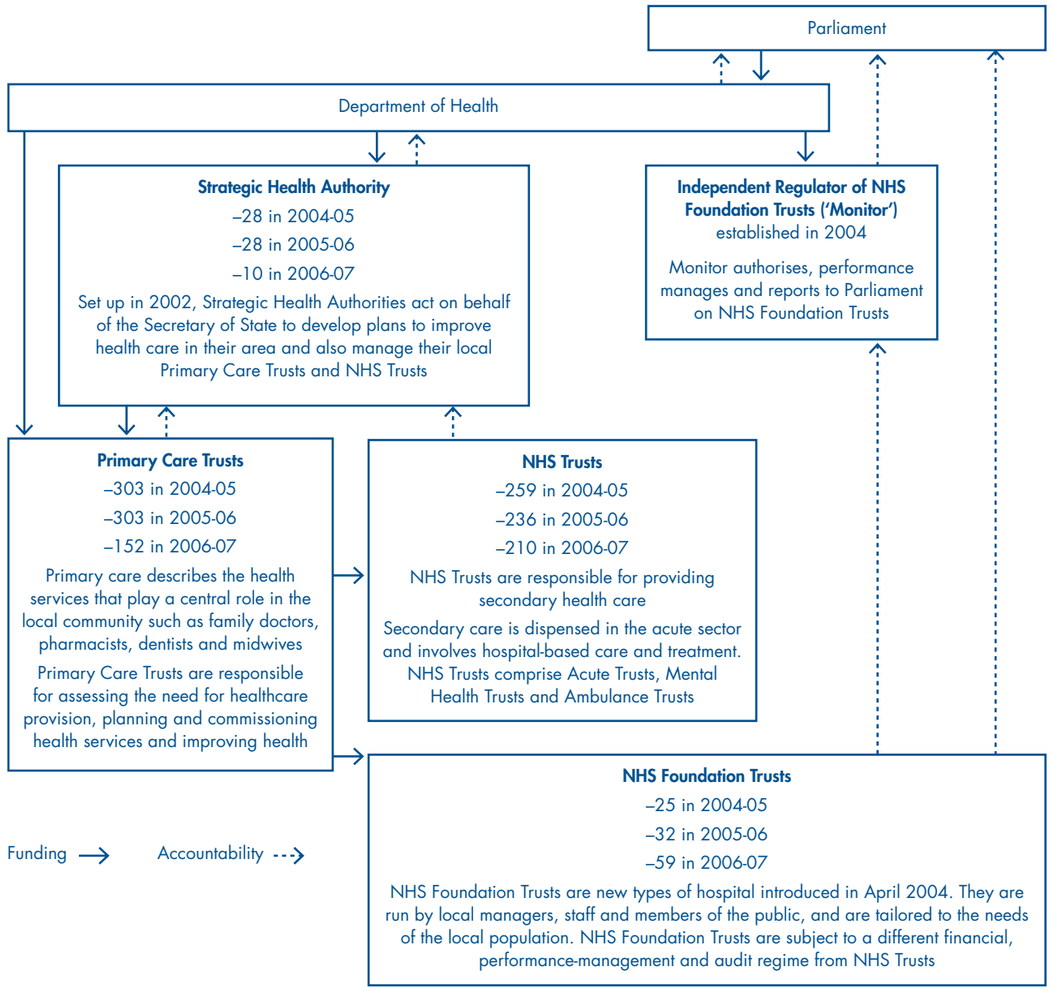
Figures overleaf

Key Facts

Funding in the NHS increased from £53.5 billion in 2001-02 to £90.7 billion in 2007-08. It will further increase to £110 billion by 2010-11 following the Comprehensive Spending Review 2007.

1 The structure of the National Health Service, 2004-05 to 2006-07

The number of organisations within the NHS reduced from 590 in 2004-05 to 372 in 2006-07

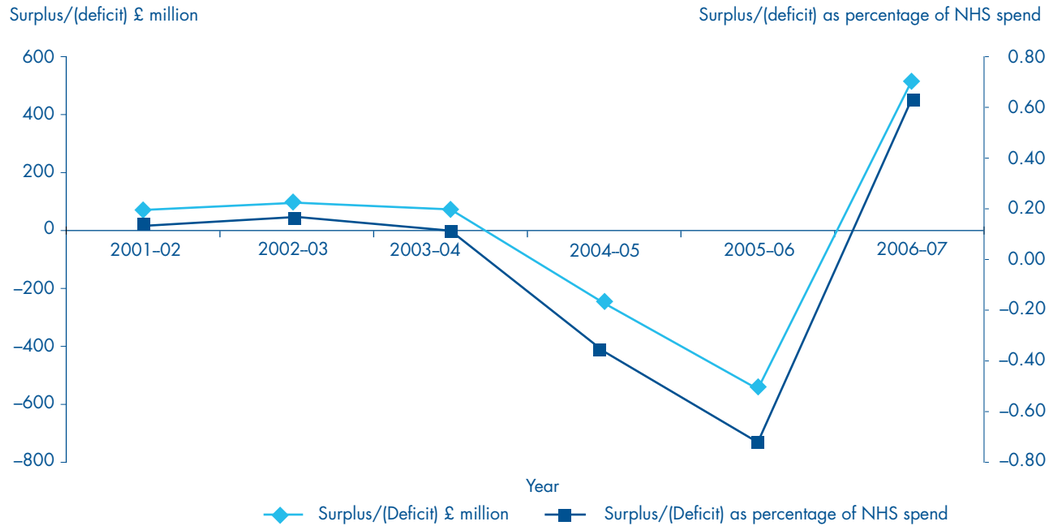


Source: National Audit Office

NOTE

A further 14 Foundation Trusts were created by 1 August 2007.

2 A surplus of £515 million, or 0.6 per cent of total available resources, was reported in 2006-07, following two years of rising deficits

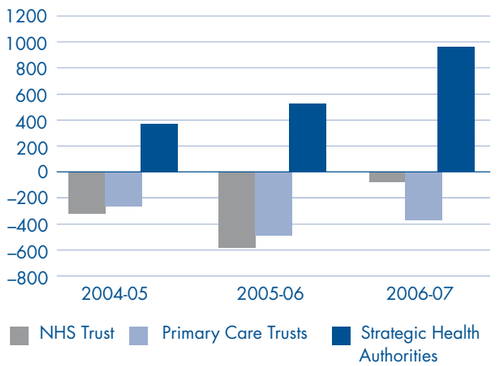


Source: National Audit Office analysis of NHS Summarised Accounts

3 The financial performance of each type of NHS organisation improved in 2006-07

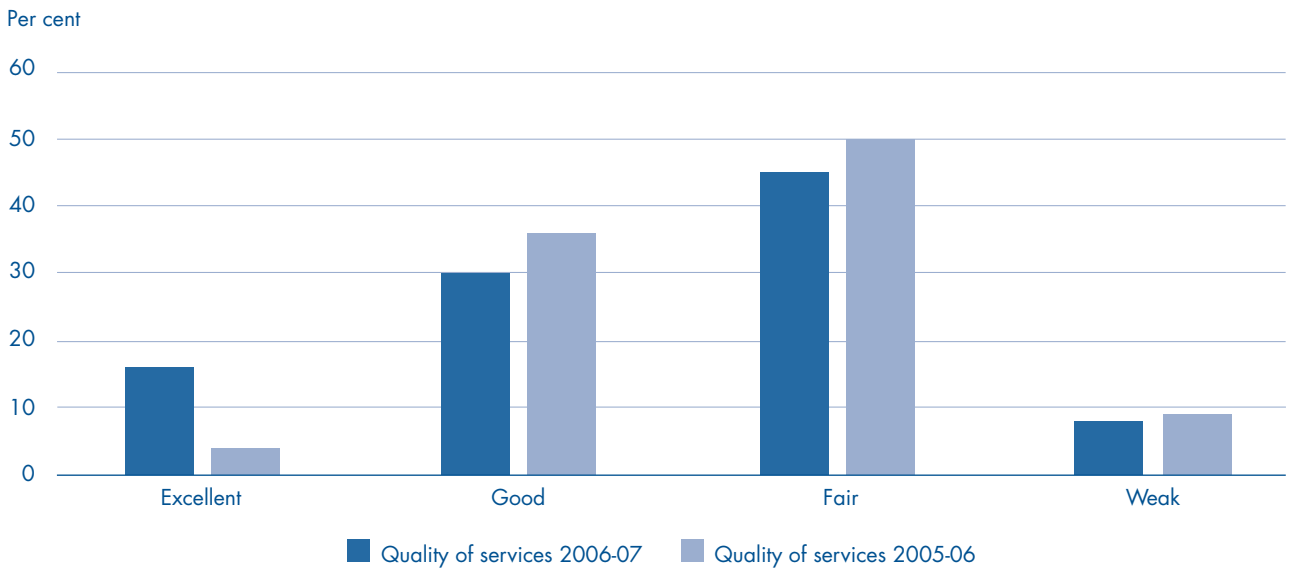
Deficits in Primary Care Trusts and NHS Trusts were offset by surpluses in Strategic Health Authorities. 22 per cent of NHS bodies recorded a deficit in 2006-07 (2005-06: 33 per cent).

Net surplus or deficit of each type of NHS organisation 2004-05 to 2006-07



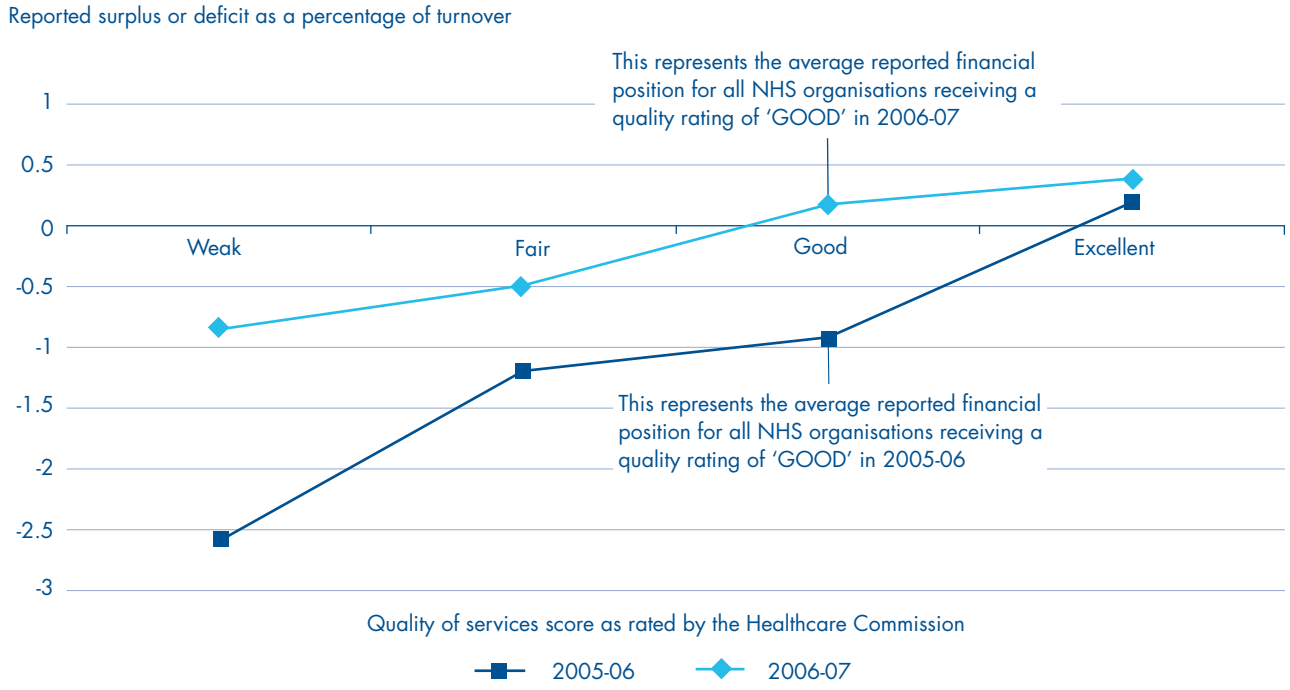
Source: National Audit Office analysis of NHS Summarised Accounts

4 According to the Healthcare Commission, more NHS organisations were rated as good or excellent on quality of services in 2006-07 (46 per cent) than in 2005-06 (40 per cent)



Source: National Audit Office analysis of Healthcare Commission, The Annual Health Check 2006-07.

5 There is a correlation between an NHS organisation's financial standing and its overall quality rating. The better performers financially generally perform better on quality



Source: National Audit Office analysis of Healthcare Commission data and NHS Summarised Accounts for 2005-06 and 2006-07

SUMMARY

1 The Department of Health (the Department) made financial recovery a priority in 2006-07 and one of its objectives was to deliver net financial balance across the NHS. This target envisaged that after deductions to recover the deficit reported in 2005-06, the sum of deficits and surpluses reported by NHS organisations would be zero.[1] The NHS delivered a net surplus of £515 million (representing 0.6 per cent of total available resources); an improvement of over £1 billion from the £547 million net deficit (representing 0.7 per cent of total available resources) reported for 2005-06.[2]

2 The financial standing of the NHS is reported in the NHS Summarised Accounts. The Comptroller and Auditor General is the statutory auditor of those accounts, and has a duty to certify and report to Parliament on them. This report has been presented along with the NHS Summarised Accounts (HC 129-II) to provide more detail of the financial performance of the NHS in 2006-07, how financial balance was achieved and the financial challenges that the NHS faces going forwards. The Comptroller and Auditor General is also the auditor of the consolidated account of NHS Foundation Trusts. NHS Foundation Trusts were created through the Health and Social Care (Community Health and Standards) Act 2003, and are authorised and regulated by the Independent Regulator of Foundation Trusts (Monitor). We have summarised the financial performance of NHS Foundation Trusts at Appendix 1 of this report.

Financial Performance of the NHS in 2006-07

3 The NHS delivered a net surplus of £515 million in 2006-07 (Figure 2). This was made up of 287 organisations delivering a gross surplus of £1,431 million and 82 organisations delivering a gross deficit of £917 million.[3] Overall, 22 per cent of NHS organisations reported a deficit (2005-06: 33 per cent). Key financial data for 2006-07 is shown in **Figure 6**.

4 Of the ten Strategic Health Authority geographical areas, which includes the Strategic Health Authority itself and those Primary Care Trusts and NHS Trusts under its control, eight finished the year in net surplus (2005-06: three). Only East of England and South East Coast Strategic Health Authority areas ended the year in net deficit. Paragraphs 1.7 to 1.17 provide further detail covering the performance of individual Strategic Health Authority areas, Primary Care Trusts and NHS Trusts.

How financial balance was achieved

5 A key priority in 2006-07 was to return the NHS to a firm and sustainable financial footing. To achieve this, both the Department and the NHS had to devise and implement decisive action in respect of funding, expenditure, and the overall financial system as applied to the NHS. The framework of this strategy was established early in 2006, and had the following key components:

- The establishment of risk reserves at Strategic Health Authority level, both locally through the top-slicing of Primary Care Trust allocations, and nationally through the Strategic Health Authorities' management of central NHS programme funds;
- Clear identification of the extent of the underlying financial problems in individual organisations, and support to those organisations with the most significant financial problems through a formal turnaround process; and
- Tight performance management of NHS finances by the Department, working through the Strategic Health Authorities, to the level of individual NHS organisations; and increased transparency of financial reporting at all levels.

6 Financial performance of NHS organisations, 2005-06 and 2006-07

In 2006-07, the NHS made a net surplus of £515 million compared with a net deficit of £547 million in 2005-06.

	Number in surplus/ breakeven	Gross surplus £ million	Number in deficit	Gross deficit £ million	Overall surplus/deficit £ million
2006-07					
Strategic Health Authorities	10	962	0	0	962
Primary Care Trusts	110	266	42	(636)	(370)
NHS Trusts	170	204	40	(281)	(77)
Overall	**290**	**1,431**	**82**	**(917)**	**515**
2005-06					
Strategic Health Authorities	10	526	0	0	526
Primary Care Trusts	195	124	108	(616)	(492)
NHS Trusts	165	114	71	(696)	(581)
Overall	**370**	**765**	**179**	**(1,312)**	**(547)**

Source: National Audit Office analysis of NHS Summarised Accounts

NOTE

Figures may not sum due to rounding.

Establishment of risk reserves

6 In 2006-07, the Department asked Strategic Health Authorities to hold top-sliced resources as risk reserves on behalf of the NHS. The Strategic Health Authorities were able to use these risk reserves to balance the overall financial position within their area – not by physically moving money around the system to bail out individual NHS organisations, but by setting the reserves against instances of overspending by NHS Trusts and Primary Care Trusts at aggregate economy level.

7 Originally £1,144 million was top-sliced during 2006-07 although £319 million of this was returned to Primary Care Trusts before the financial year ended. It is for each Strategic Health Authority to manage both the timing and method for repaying contributions made by their Primary Care Trusts within a reasonable period, not usually exceeding the three year allocation cycle, and depending on overall affordability within the Strategic Health Authority economy. The Department has asked Strategic Health Authorities to consider the position of Primary Care Trusts with the greatest health need first when considering the repayment of top-sliced funds.

8 The Department also held back £450 million from central NHS programme funds from the ten Strategic Health Authorities in 2006-07. These NHS funds, totalling £5.5 billion and which are in addition to the Primary Care Trust allocations, are for services across the NHS such as workforce training and education. Strategic Health Authorities were asked to identify savings from these central funds so that the £450 million was genuinely uncommitted. The £450 million contingency fund was distributed back to the NHS on a fair shares basis on 31 March 2007.[4] Had these funds not been returned, the NHS would still have reported a surplus of £65 million, or 0.1 per cent of the total NHS budget.

9 On 28 March 2007, the Department announced that Resource Accounting & Budgeting (RAB) income adjustments would no longer be applied to NHS Trusts, which meant that a deduction would no longer be made in respect of prior year deficits. NHS Trusts who had originally had their income deducted in 2006-07 had first call on the repayment of the £450 million contingency funds back to the NHS; as a result, £178 million was returned to those NHS Trusts, with the balance available to begin repayment of the Primary Care Trust top-slice.

Support for NHS organisations with significant financial problems

10 In February 2006 the Department began a formal turnaround programme. This identified organisations in deficit that were facing particular difficulties in achieving financial balance and gave them targeted support. Turnaround directors were appointed in the NHS, and a National Programme Office was set up in the Department to oversee the process. A total of 104 organisations (as currently configured) participated in the turnaround process. The costs of turnaround were £46.3 million, including external costs on consultants of £36.3 million. The Department reported that the aggregate performance of the turnaround organisations in 2005-06 was a deficit of £1,121 million.[5] By the end of 2006-07, the turnaround organisations were reporting an aggregate deficit of £637 million, an improvement in financial standing of £484 million. Although the formal turnaround programme ended on 31 March 2007, these organisations are forecasting further improvements in their financial standing for 2007-08. The quarter two returns for 2007-08 from these 104 organisations forecast that they will deliver an aggregate surplus of £60.3 million for 2007-08.

Management of the NHS workforce

11 After a number of years of unprecedented growth, the size of the NHS workforce levelled off in 2006-07. The last NHS Census as at 30 September 2006 showed a fall from the previous year in the number of manager posts of 2,500 and a fall in infrastructure support posts of over 8,000 (a reduction of five per cent overall). At the same time clinical capacity continues to increase – over the same period there has been an increase in the medical workforce of 3,267. Where workforce reductions are taking place, trusts are managing these through vacancy freezes, reduced use of temporary staff and redeploying staff in different ways.

12 In 2006, 80 trusts reported a vacancy freeze. In 2007 this has reduced to 30 trusts. In 2006-07, salaries paid to non-NHS staff (for example, agency staff) were £903 million. This has fallen from £1,182 million in 2005-06 and £1,338 million in 2004-05.[6] In 2006-07 the Department reports that 2,330 compulsory redundancies were made, with 82 per cent of these being in non-clinical posts. The measures taken on vacancies and temporary staffing have helped to avoid the need for further redundancies.

Local decisions on expenditure

13 In 2006-07, the Department has not expected any one NHS sector to contribute more in financial savings than any other part of the health system, except where that service has specifically contributed to a deficit. Ultimately, it is down to local NHS organisations in agreement with their local stakeholders to decide how best to use the monies allocated to ensure that they provide the most appropriate patient care and services for their patients.

14 The total allocations to Primary Care Trusts are built up by a process which identifies the potential resource requirements for all healthcare programmes which need to be commissioned and delivered by Primary Care Trusts and those it commissions. Once the total allocations are made, the vast majority of the funds are not ring-fenced by the Department. Primary Care Trusts are free to use the resources as they see fit to ensure that local priorities for healthcare are addressed. For NHS organisations looking to recover a deficit in 2006-07, one of those priorities would have been to use their allocations to get their finances onto a stable and sustainable footing. There is some evidence that difficult decisions had to be taken by NHS organisations in deficit to keep services provided within required targets, including around the pace at which new and improved service developments could be delivered. For example, the Kings Fund has reported that 14 Primary Care Trusts imposed activity limits on NHS Trusts towards the year end.[7] The Department's view is that all NHS organisations need to continue to look at the way they provide services to patients to ensure they are delivering the best possible value for money.

Why financial balance is important: the link with quality

15 The action taken by the Department and the NHS ensured that a financial surplus was delivered for 2006-07. Financial performance should not, however, be considered in isolation from clinical performance. The Department's view is that financial recovery has to take place alongside, and not at the expense of, service improvements.

16 The Department has reported that progress continued to be made on key performance targets. Significant advances have been made on progress towards meeting the 18 week maximum waiting time target. The number of cancelled operations was reduced in 2006-07 despite an overall increase in the number of admissions. In its Annual Health Check, the Healthcare Commission reported a general improvement in the quality of the service **(Figure 4)**.[8]

17 We have compared the financial standing of NHS organisations with the overall quality ratings that they were awarded by the Healthcare Commission for 2005-06 and 2006-07.[9] Our analysis shows that there is a correlation between the two **(Figure 5)**.[10] The better performing NHS organisations financially tend to be the better performers on quality, and vice versa. NHS organisations that improve their financial position should therefore see improvements in the quality of their service in the longer term.

18 We also performed the analysis as described in paragraph 17 above on just those NHS organisations that were part of the turnaround programme, in order to identify if the focus on financial recovery had impacted on quality. Our analysis shows that the general improvement in quality was not replicated by the organisations in turnaround, but these bodies did maintain their quality ratings as a group despite the targeted action that was required.

Future challenges

19 Both the Department and the NHS consider that one of the lessons they have learnt throughout some of the turbulence of the last few years is that failure to keep a very tight grip on financial performance undermines service delivery for patients.[11] Both the Department and the NHS have made good progress towards improving financial performance, not least by turning around the deficit in 2006-07. In the same period, the Healthcare Commission has reported that overall quality of care has improved.

20 There are a number of risks, however, to longer term financial stability which the Department and the NHS will need to manage in order to sustain the financial health of the NHS whilst continuing to improve the quality of service delivery. These include:

- The fact that a number of NHS organisations still have significant deficits. Eighty per cent of the gross deficit of £917 million exists in just 10 per cent of NHS organisations. The Department has identified significant reduction of the gross deficit as a key financial priority for 2007-08. Improving the financial performance of these organisations is an important factor for embedding good financial management across the NHS as a whole.
- The turnaround programme has achieved its aim of making significant improvements in the financial position of most NHS organisations that were in deficit and needed support in achieving financial balance. The Department and Strategic Health Authorities face the challenge of assisting those NHS organisations who remain in deficit, and all NHS organisations that have been part of the turnaround programme need to keep up the momentum created, now that the formal turnaround programme has ended. Our analysis of the Healthcare Commission's quality scores for the turnaround organisations shows that they face the challenge of replicating the improvements in quality already achieved by the rest of the NHS.
- Payment by Results and Practice Based Commissioning continue to bed in within the NHS. Under Payment by Results, NHS organisations receive income based on the work they perform. It is designed to reward efficiency and encourage innovation, but as income varies according to the level of activity performed, it introduces uncertainty over the level of income that will be received. Where the costs of an NHS organisation are fixed, this introduces the risk that income may not be sufficient to cover those costs, resulting in a deficit. NHS organisations need to have robust costing systems in order to understand their costs, and so be better able to maximise the potential benefits of Payment by Results.
- Practice Based Commissioning offers Primary Care Trusts the opportunity to create partnerships with patients to deliver the highest quality services. Full benefits can only be realised when Primary Care Trusts can fully anticipate and respond to healthcare needs. Practice Based Commissioning also challenges Primary Care Trusts to obtain the services they need by managing these within their resource limits.
- We have analysed whether those NHS Trusts that have significant costs fixed as a result of PFI arrangements are more likely to report a deficit. Overall this was not the case – the proportion of NHS Trusts reporting a deficit in 2006-07 is the same regardless of whether they have a PFI contract.
- The Comprehensive Spending Review (CSR) announced an above average settlement for health, with funding available to the NHS rising at four per cent per year in real terms until 2010-11 compared to the average settlement across government of 2.1 per cent. In 2010-11 the NHS budget will be £110 billion. However, the Department needs to manage future financial challenges within this settlement. A significant proportion of recent funding increases has been used to fund pay modernisation. One assumption in the CSR is to keep headline pay increases across the public sector to a level consistent with meeting the inflation target of two per cent per year; any increases above this would need to be found from elsewhere within the funding available. The CSR also requires the

Department to generate cashable efficiency savings of three per cent per year. This will be reflected in the annual uplift applied to the Payment by Results tariff, which will increase or decrease the financial pressures on NHS organisations depending on what assumptions they have made regarding the tariff in their business plans for 2007-08. The final tariff will be published as part of the NHS Operating Framework in January 2008. Any further reforms arising from Lord Darzi's final report *Our NHS, Our Future*, due to be published in June 2008, will also need to be managed within the funding provided by the CSR.

- Commissioning a Patient-led NHS has driven the restructuring of the NHS in line with **Figure 1**. The purpose of this restructuring is to release £250 million per year of savings into front-line services by reducing management costs due to the economies of scale from having fewer organisations. This is a two year programme, running until 31 March 2008. Indications from the Audit Commission and the Department are that the Department is on track to deliver these savings. The Audit Commission has reported that £90 million of recurrent savings have been identified in 2006-07. Forecast information as at quarter one for 2007-08 from the Department states that a further £154 million of savings have been identified to date. There are a number of one-off costs associated with the restructuring. The Audit Commission has reported that the costs of restructuring in 2006-07 were £192.1 million.[12] Further, they reported that continuing bodies performed better in the Audit Commission's Auditors' Local Evaluations than those who were subject to organisational change. Further costs are anticipated during 2007-08, since employees of the merged Primary Care Trusts were guaranteed employment until July 2007.

- The Department has identified the opportunity for significant savings to be made through increased productivity. It has generated a series of metrics which allow NHS organisations to benchmark themselves against the better performing organisations. The Department reports that this has highlighted over £1 billion of potential savings. Individual NHS organisations face the challenge of releasing these savings whilst continuing to improve services for patients.

PART ONE

Financial performance of the NHS in 2006-07

1.1 The *NHS Plan* of 2000 announced the most fundamental and far reaching reforms in the NHS since its foundation in 1948.[13] The plan set out a ten-year programme of reform and modernisation aimed at providing health services designed around the needs of the patient. This plan has been accompanied by an unprecedented programme of funding, which has seen expenditure increase from £53.5 billion in 2001-02 to £90.7 billion in 2007-08 **(Figure 7 overleaf)**. The Comprehensive Spending Review 2007 has detailed an above-average increase in the funding available for the NHS, which will rise to £110 billion by 2010-11. This represents a four per cent increase in real terms over the period covered by the CSR, compared to an average of 2.1 per cent across government.

Headline Financial Performance of the NHS

1.2 The Department's first financial objective for 2006-07 was to restore net financial balance in the NHS, following two years of rising deficits **(Figure 2)**. This was achieved; as a whole, the NHS reported a net surplus of £515 million for the 2006-07 financial year, representing 0.6 per cent of the total available resources. This compares to the deficit of £547 million reported in 2005-06, hence the financial position of the NHS has turned around by over £1 billion.

1.3 The overall surplus was comprised of a £962 million surplus reported in the accounts of Strategic Health Authorities, up from £526 million in 2005-06. Primary Care Trusts reported a deficit of £370 million (2005-06: £492 million deficit) and NHS Trusts a deficit of £77 million (2005-06: £581 million deficit). The proportion of NHS organisations reporting a deficit also improved; down from 33 per cent in 2005-06 to 22 per cent in 2006-07 **(see Figure 8 overleaf)**. The 22 per cent of organisations in deficit reported a gross deficit of £917 million in 2006-07, with the 78 per cent at break-even or in surplus reporting a gross surplus of £1,431 million.

In-Year Financial Performance in the NHS

1.4 The headline financial performance of the NHS as reported in the summarised accounts includes a number of adjustments which are made by the Department which arise from the NHS financial regime. To assess the in-year financial performance it is necessary to exclude these adjustments from the headline figures. **Figure 9 on page 11** shows that the in-year financial performance of the NHS in 2006-07 was a net surplus of £763 million. This is a turnaround of nearly £1.2 billion from the in-year net deficit of £407 million reported for 2005-06.

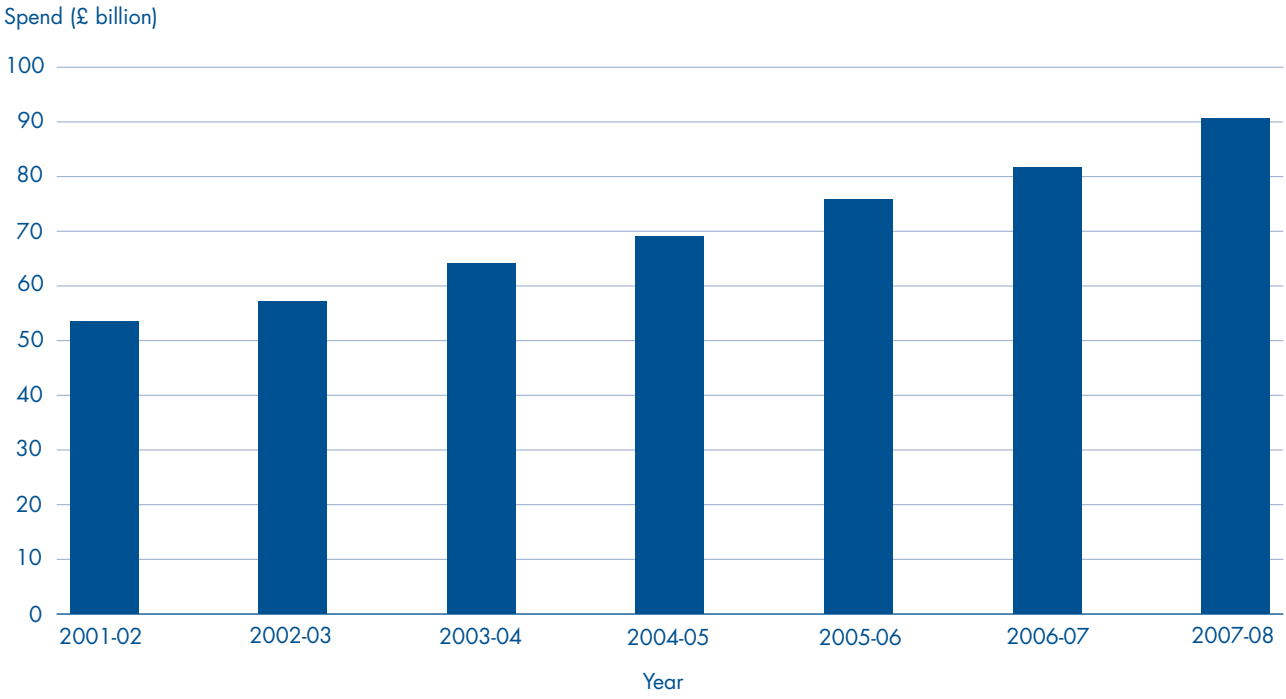
Financial Performance by type of NHS organisations

Strategic Health Authorities – performance of the SHA itself

1.5 Strategic Health Authorities are responsible for the performance management of Primary Care Trusts and NHS Trusts within their geographical area. They are allocated funds from the Department of Health and have a statutory duty to remain within their allocated funding levels in each financial year. The number of Strategic Health Authorities reduced from 28 to ten on 1 October 2006 as part of the implementation of Commissioning a Patient-led NHS.[14] All Strategic Health Authorities reported a surplus for 2006-07, meeting their statutory requirements. The Comptroller and Auditor General issued an unmodified audit opinion on the summarised accounts of Strategic Health Authorities [HC 129-II].

7 Levels of funding in the NHS, 2001-02 to 2007-08

Funding of the NHS has increased from £53.5 billion in 2001-02 to £90.7 billion in 2007-08.

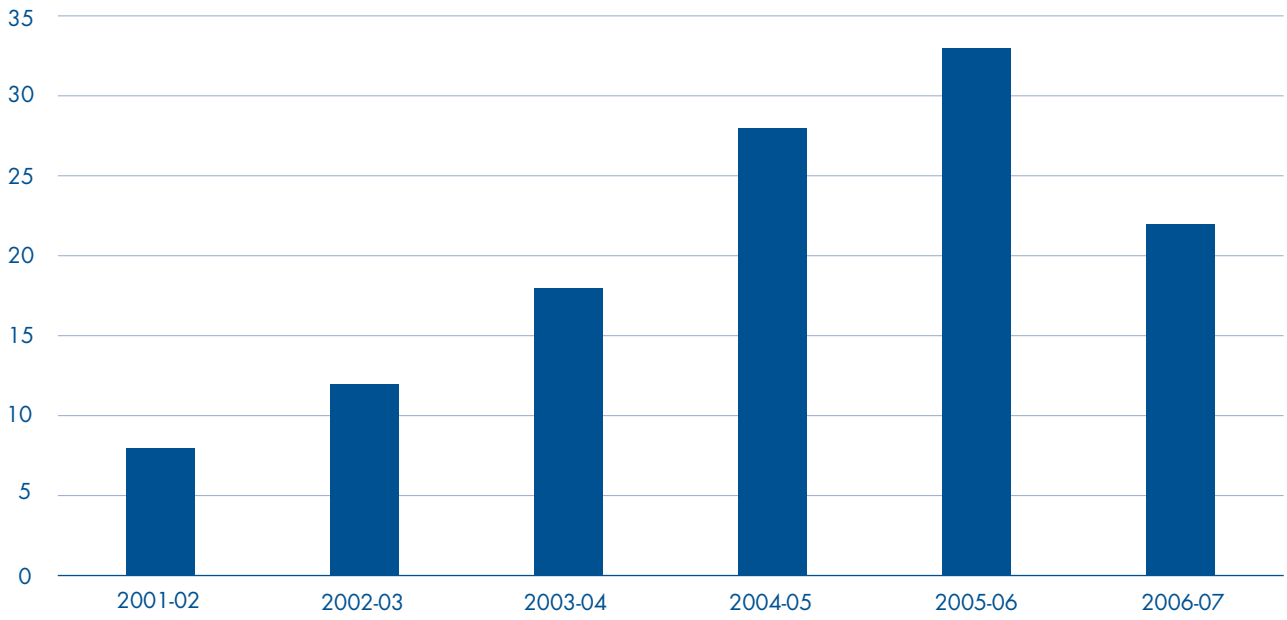


Source: HM Treasury

NOTE
All figures are outturn with the exception of 2006-07 (estimated outturn) and 2007-08 (planned outturn).

8 Proportion of NHS organisations in deficit since 2001-02

The proportion of NHS organisations in deficit in 2006-07 has decreased on the previous year for the first time since 2001-02.



Source: House of Commons Health Committee report on NHS Deficits (HC 73-I, session 2006-2007) and National Audit Office analysis of NHS Summarised Accounts.

9 In-year financial performance of the NHS, 2005-06 and 2006-07

The NHS generated an in-year surplus of £763 million in 2006-07; a turnaround of nearly £1.2 billion from 2005-06

	2006-07 £ milllion	2005-06 £ million
Headline financial performance per the summarised accounts	+515	(547)
Adjustment made to recover prior year deficits[1]	+698	+140
Adjustment from the application of contingency reserves[2]	(450)	0
Underlying in-year performance	**+763**	**(407)**

Source: National Audit Office

NOTES

1 NHS organisations have their income reduced by the amount reported as a deficit in the previous financial year. In 2006-07 a total of £547 million was deducted in this way to recover the deficit reported in 2005-06. This deduction is based on unaudited financial performance from the previous financial year, and a further £110 million was deducted to take into account the difference between the unaudited and audited financial performance in 2004-05. The Department made further corrections of £41 million meaning a total reduction of £698 million to 2006-07 budgets. From the end of 2006-07 this rule is no longer applied to NHS trusts (see paragraph 9).

2 See paragraph 1.8.

1.6 The ten Strategic Health Authorities reported a net surplus of £962 million for 2006-07 in their accounts. The surplus includes amounts top-sliced from Primary Care Trust revenue allocations during 2006-07 (see paragraph 2.8). These amounts were used to support the overall financial position within the respective Strategic Health Authority economies, in some cases by off-setting RAB deductions in NHS Trusts, and in others by contributing directly to risk reserves held by the Strategic Health Authority on their behalf. Strategic Health Authorities will manage the timing and method of repaying these contributions to Primary Care Trusts over a period not usually exceeding the three year allocation cycle. The Department has asked Strategic Health Authorities to consider Primary Care Trusts with the greatest health need first when considering repayment of the contributions. Part two of this report looks at the funding decisions which were taken to assist financial recovery in more detail.

Strategic Health Authorities – performance of the SHA economy

1.7 Strategic Health Authorities are responsible for performance management of the NHS within their geographical area. Only two of the ten Strategic Health Authority areas reported a deficit in 2006-07 (East of England and South East Coast), down from seven in 2005-06 **(Figure 10 overleaf)**. Every Strategic Health Authority area reported an improvement in financial standing in 2006-07 compared with 2005-06.

1.8 The information in figure 10 is shown after the distribution of the £450 million which was originally withheld by the Department from the Strategic Health Authorities' allocations for central NHS programmes, and which was returned to the NHS at the financial year end. The overall NHS net surplus before the application of these funds was therefore £65 million, or 0.1 per cent of the NHS revenue budget. The improvement in the financial standing of each Strategic Health Authority economy was seen both before and after the distribution of these funds.

Primary Care Trusts

1.9 Primary Care Trusts are responsible for assessing the need for healthcare provision, planning and commissioning health services, and improving health. They are allocated funds from the Department of Health and have a statutory duty to remain within allocated funding levels each financial year. The number of Primary Care Trusts was reduced from 303 to 152 on 1 October 2006 as part of the implementation of Commissioning a Patient-Led NHS. Primary Care Trusts are performance managed by, and accountable to, their Strategic Health Authority.

1.10 As the bodies which commission and fund the majority of healthcare, Primary Care Trusts incur the majority of expenditure on health. The summarised accounts for Primary Care Trusts for 2006-07 show that they spent £69.9 billion in 2006-07 with 42 Primary Care Trusts reporting a deficit. These organisations therefore breached their statutory duty to remain within allocated resource levels, and local auditors qualified their accounts accordingly. Local auditors did not qualify any accounts of Primary Care Trusts on the basis of them not being true and fair. There is no similar statutory requirement for Primary Care Trusts in total to remain within allocated funding levels, and the Comptroller and Auditor General issued an unmodified audit opinion on the summarised accounts of Primary Care Trusts (HC 129-II).

10 NHS Performance, 2006-07, by Strategic Health Authority Area

The East of England and the South East Coast were the only two Strategic Health Authority Areas to record a deficit in 2006-07

	Strategic Health Authority	Primary Care Trust		NHS Trusts		Overall	Overall	Change
Strategic Health Authority Area	Surplus £ million	Number	Surplus/ (deficit) £ million	Number	Surplus/ (deficit) £ million	2006-07 £ million	2005-06 £ million	£ million
East Midlands	80.5	9	2.8	12	(15.5)	67.8	(13.4)	81.1
East of England	62.3	14	(216.3)	22	0.9	(153.1)	(233.6)	80.5
London	180.1	31	(93.6)	38	6.5	93.0	(174.1)	267.1
North East	64.5	12	4.6	8	5.4	74.5	21.0	53.6
North West	206.4	24	(2.4)	35	(14.6)	189.3	57.9	131.5
South Central	31.6	9	(0.5)	15	6.6	37.8	(58.7)	96.6
South East Coast	30.4	8	(52.0)	16	(21.1)	(42.7)	(94.0)	51.3
South West	94.7	14	0.5	22	(39.6)	55.6	(48.6)	104.2
West Midlands	33.2	17	11.4	26	16.4	61.1	(38.2)	99.3
Yorkshire & the Humber	178.0	14	(24.4)	16	(22.3)	131.3	34.5	96.9
Total	**961.8**	**152**	**(369.9)**	**210**	**(77.3)**	**514.6**	**(547.3)**	**1,062.1**

Source: National Audit Office analysis of NHS Summarised Accounts

NOTE

Figures may not sum due to rounding.

1.11 Overall, Primary Care Trusts reported a net deficit of £370 million (2005-06: £492 million net deficit). The 42 organisations in deficit (representing 28 per cent of Primary Care Trusts) reported a gross deficit of £636 million, whereas the 110 organisations reporting balance or a surplus had a gross surplus of £266 million. The net deficit of £370 million excludes the monies which were top-sliced from Primary Care Trust allocations. The 42 Primary Care Trusts in deficit had contributed a total of £290 million by way of the top-slicing of their allocations. Without these contributions, 11 of these 42 Primary Care Trusts would have reported break-even or a surplus position, with an aggregate surplus of £54 million. The 31 Primary Care Trusts who would still have reported a deficit would have seen their aggregate gross deficit fall from £636 million to £400 million.

NHS Trusts

1.12 NHS Trusts are responsible for providing secondary health care. They receive income based on a mixture of local pricing and from the Payment by Results national tariff. Under Payment by Results they receive income, based on the work they do. The amount they receive for individual procedures is set by the national tariff which is updated annually. Payment by Results is designed to reward efficiency, as it encourages NHS Trusts to keep their costs below the level of income received as set by the tariff.

1.13 NHS Trusts have a statutory duty to break even taking one financial year with another. This duty is not defined in legislation and is generally taken to mean delivering financial balance across a three-to-five year period. At the end of 2006-07, 15 Trusts had failed in this duty, up from 1 in 2005-06 and 1 in 2004-05. However, the Department has tightened the financial regime under which NHS Trusts operate. Prior to 2006-07, financial support could be provided to NHS Trusts in deficit which allowed them to report improved financial standing. The removal of this support means that the reported position for 2006-07 is more transparent, therefore the increase in the number of bodies failing their statutory duty does not necessarily represent a worsening of performance.

1.14 Local auditors did not qualify the accounts of any NHS Trust on account of them not being true and fair. The Comptroller and Auditor General issued an unmodified audit opinion on the summarised accounts of NHS Trusts [HC 129-II].

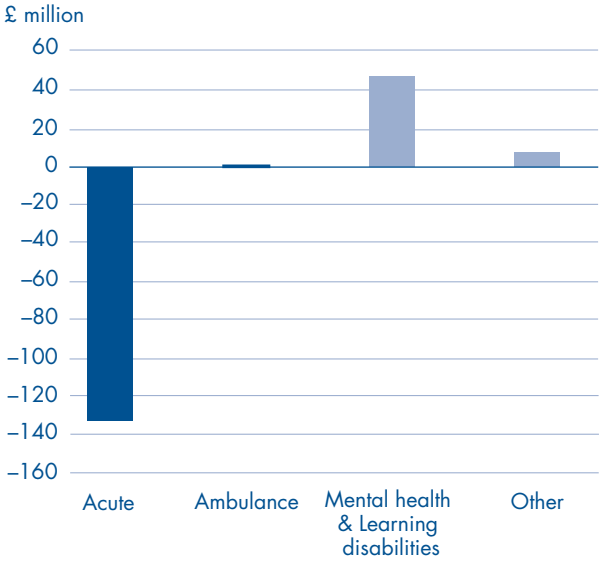
1.15 The 210 NHS Trusts reported an overall net deficit of £77 million in 2006-07, with 19 per cent of Trusts reporting a deficit. This is a significant improvement from 2005-06 when the net deficit was £581 million and 30 per cent of Trusts reported a deficit. The 19 per cent of Trusts in deficit reported a gross deficit of £281 million; this was offset by the 81 per cent of Trusts in balance or surplus reporting a gross surplus of £204 million.

1.16 The reported position of £77 million net deficit overall is after the reversal of prior year deductions following the Department's action to remove the application of Resource Accounting and Budgeting adjustments to NHS Trusts – removing the "double deficit" effect (see paragraph 2.24). This returned £178 million to NHS Trusts. As a result, the 2006-07 financial position of NHS Trusts is a more transparent reflection of in-year performance. The improvement from previous years is, however, exaggerated as prior to 2006-07 NHS Trusts were required to carry the RAB adjustments in their accounts.

1.17 Only the acute NHS Trust sector showed an overall deficit for 2006-07. Other sectors all reported a break-even or surplus position for 2006-07 **(Figure 11)**.

11 Financial performance by NHS Trust type, 2006-07

Performance ranged from mental health and learning disabilities trusts, which had a surplus of £47 million to acute trusts, which had a deficit of £133 million.



Source: Department of Health, NHS Financial Performance quarter 4 2006-07

Distribution of Financial Performance

1.18 Figures 12, 13 and 14 overleaf show the distribution of financial standing of all Primary Care Trusts for the three financial years to 2006-07. The 2004-05 and 2005-06 graphs represent 303 organisations, whereas in 2006-07 the graph represents the reorganisation of Primary Care Trusts into 152 organisations. It can be seen that:

- The proportion of Primary Care Trusts reporting balance or a surplus increased in 2006-07 despite the top-slicing of their budgets.
- Most Primary Care Trusts are able to live within their means. The overall net deficit arises due to the financial performance of a minority of organisations.
- The size of the deficits in those organisations with the poorest financial standing is increasing year-on-year.

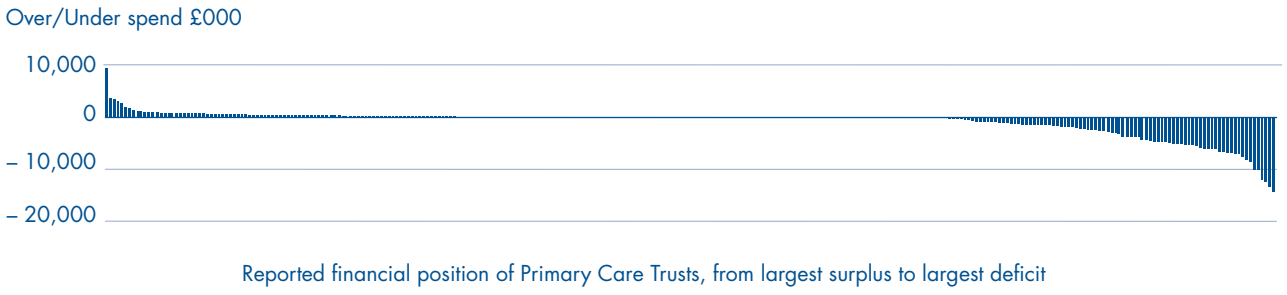
1.19 Figures 15, 16 and 17 on page 15 show the distribution of financial standing for the three financial years to 2006-07 for NHS Trusts. As with Primary Care Trusts, the number of organisations plotted varies year-on-year (259 in 2004-05, 236 in 2005-06 and 210 in 2006-07) but it can be seen that:

- The number of NHS Trusts reporting a surplus increases year-on-year.
- There is a significant reduction in the number of organisations reporting a deficit, and a reduction in size of the deficits reported between 2005-06 and 2006-07.

1.20 The distributions show that an increasing number of organisations are able to deliver balance or a surplus. Part Two of this report will consider how this has been achieved. There remains, however, a small but significant number of Primary Care Trusts and NHS Trusts for whom restoring financial balance is a significant challenge. Eighty per cent of the gross deficit of £917 million arises from just 10 per cent of organisations. In addition, 72 per cent of Primary Care Trusts and 81 per cent of NHS Trusts reported balance or a surplus for 2006-07, yet overall the Primary Care Trust and NHS Trust sectors reported a deficit. Part Three of this report will explore this challenge in more detail.

12 Performance of Primary Care Trusts in 2004-05

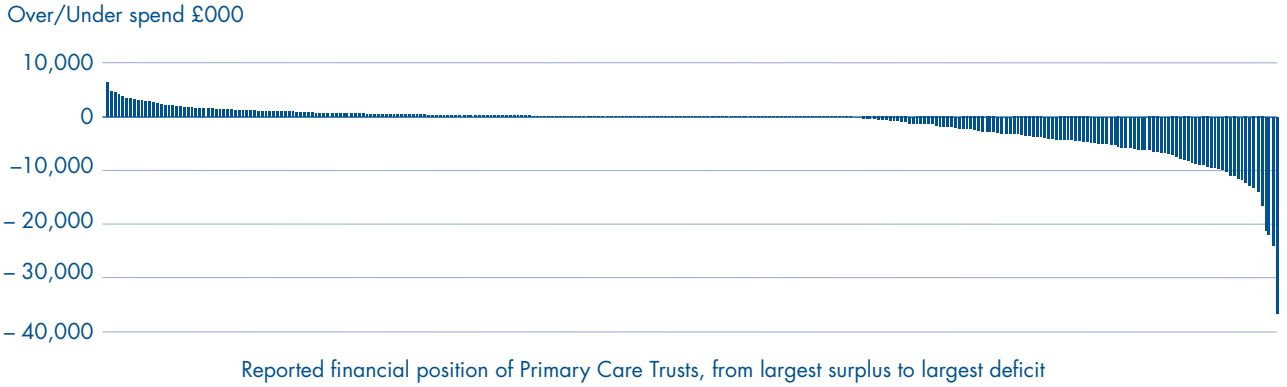
In 2004-05, a majority of Primary Care Trusts reported a break even or surplus position. Deficits were reported by 30 per cent of Primary Care Trusts



Source: National Audit Office analysis of the NHS Summarised Accounts

13 Performance of Primary Care Trusts in 2005-06

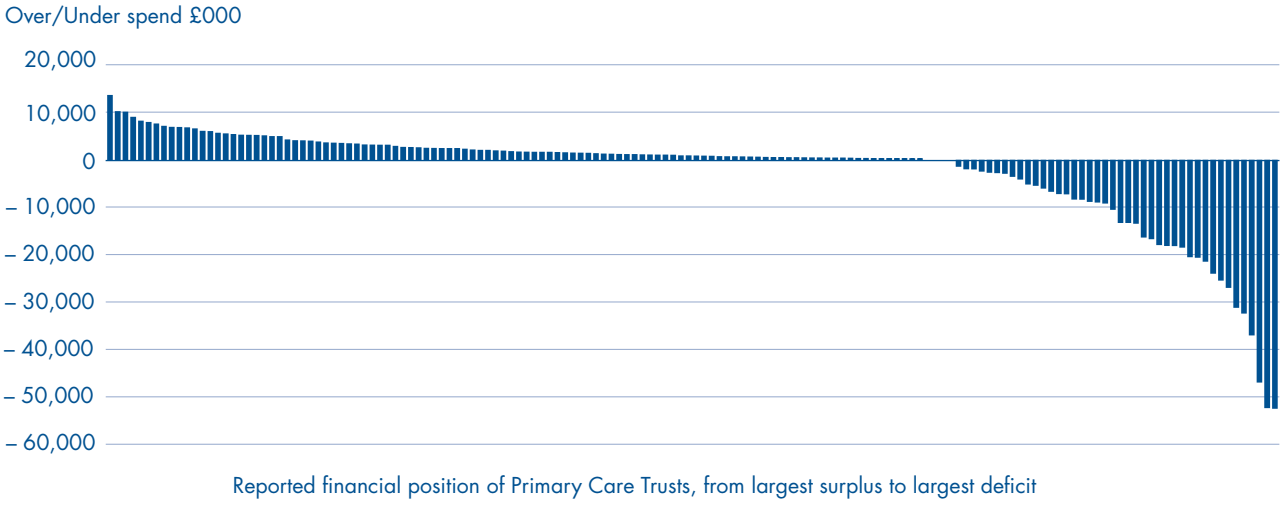
In 2005-06, the number of Primary Care Trusts reporting a deficit increased from 30 per cent to 36 per cent and the size of the largest deficits also increased over the previous year



Source: National Audit Office analysis of the NHS Summarised Accounts

14 Performance of Primary Care Trusts in 2006-07

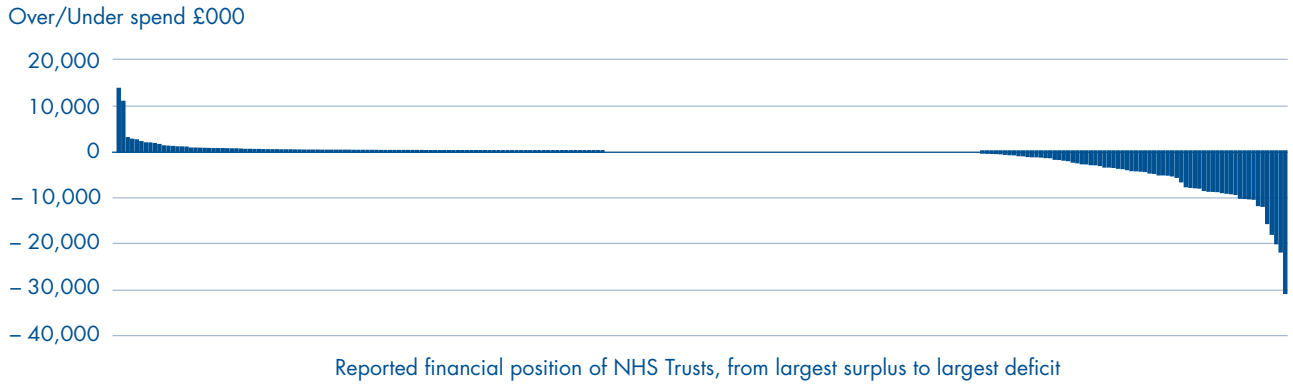
In 2006-07, there was an increase in the number of Primary Care Trusts reporting a surplus, and these surpluses were larger. There was a decrease in the proportion of Primary Care Trusts reporting a deficit, although the largest deficits continued to rise.



Source: National Audit Office analysis of the NHS Summarised Accounts

15 Performance of NHS Trusts in 2004-05

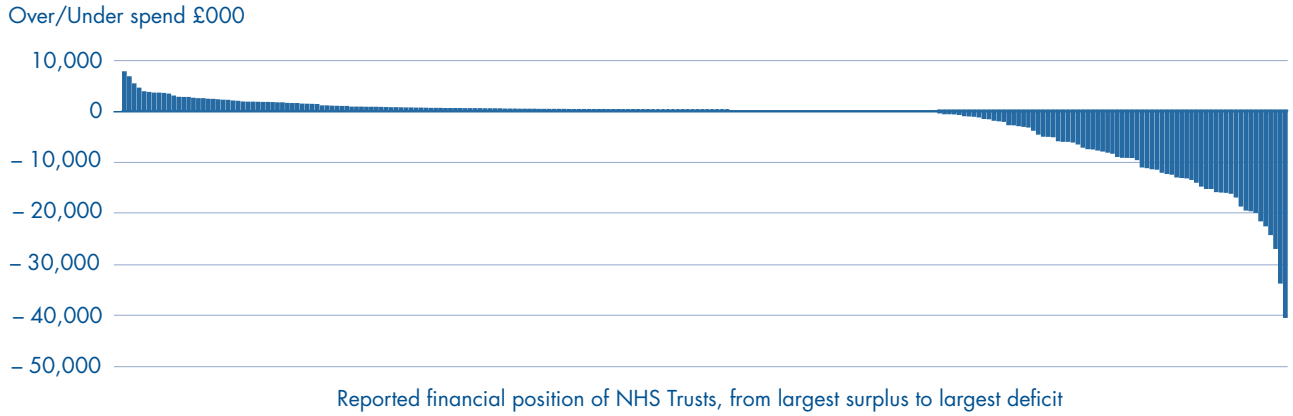
In 2004-05, a majority of NHS Trusts reported a break-even or surplus position. 26 per cent of NHS Trusts were in deficit.



Source: National Audit Office analysis of the NHS Summarised Accounts

16 Performance of NHS Trusts in 2005-06

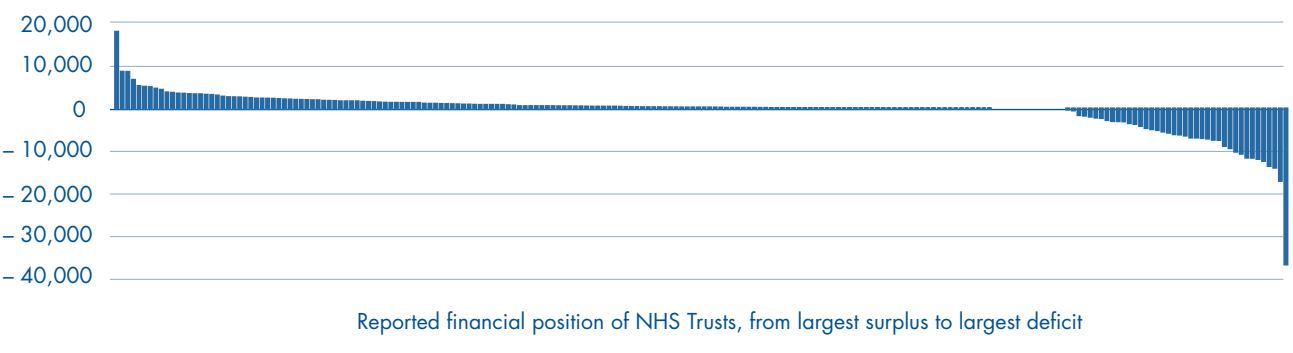
In 2005-06, the number of NHS Trusts reporting a deficit increased slightly to 30 per cent and the size of those deficits increased.



Source: National Audit Office analysis of the NHS Summarised Accounts

17 Performance of NHS Trusts in 2006-07

In 2006-07, there was a significant increase in the proportion of NHS Trusts reporting break-even or a surplus, and a reduction in the proportion reporting a deficit. The size of the deficits was also considerably reduced from 2005-06.



Source: National Audit Office analysis of the NHS Summarised Accounts

PART TWO

Restoring financial balance

2.1 The Department set the NHS three main financial objectives for 2006-07:

- **To deliver net financial balance across the NHS.** This required the total of gross deficits and gross surpluses of all NHS organisations to balance, following the reduction in resources to cover the 2005-06 deficit. This was achieved.
- **To achieve a recurrent monthly run rate balance across as many organisations as possible by the end of March 2007.** This is achieved when monthly recurrent expenditure is matched by monthly recurrent income. The Department reported that 31 organisations were not in monthly balance by March 2007.
- **To see an improvement in the financial performance** of all organisations that reported a deficit in 2005-06. Of the 123 NHS organisations reporting a deficit in 2005-06, 96 improved their financial standing in 2006-07.

2.2 The commitment to achieve financial balance for 2006-07 included recovery of the deficit from 2005-06. In the Operating Framework for 2006-07, the Department recognised that good financial management is critical to ensuring that the NHS can deliver on its objectives, stating that "excellence in financial management is a pre-requisite for high quality, sustainable services".[15]

Why financial balance is important

2.3 Both the Department and the NHS recognise that financial recovery has to take place alongside, and not at the expense of, service improvements, as failure to keep a tight grip on financial performance undermines service delivery for patients. The acknowledged link between financial performance and service performance can be demonstrated by a simple comparison of the financial standing of an NHS organisation with its quality rating as determined by the Healthcare Commission.[16]

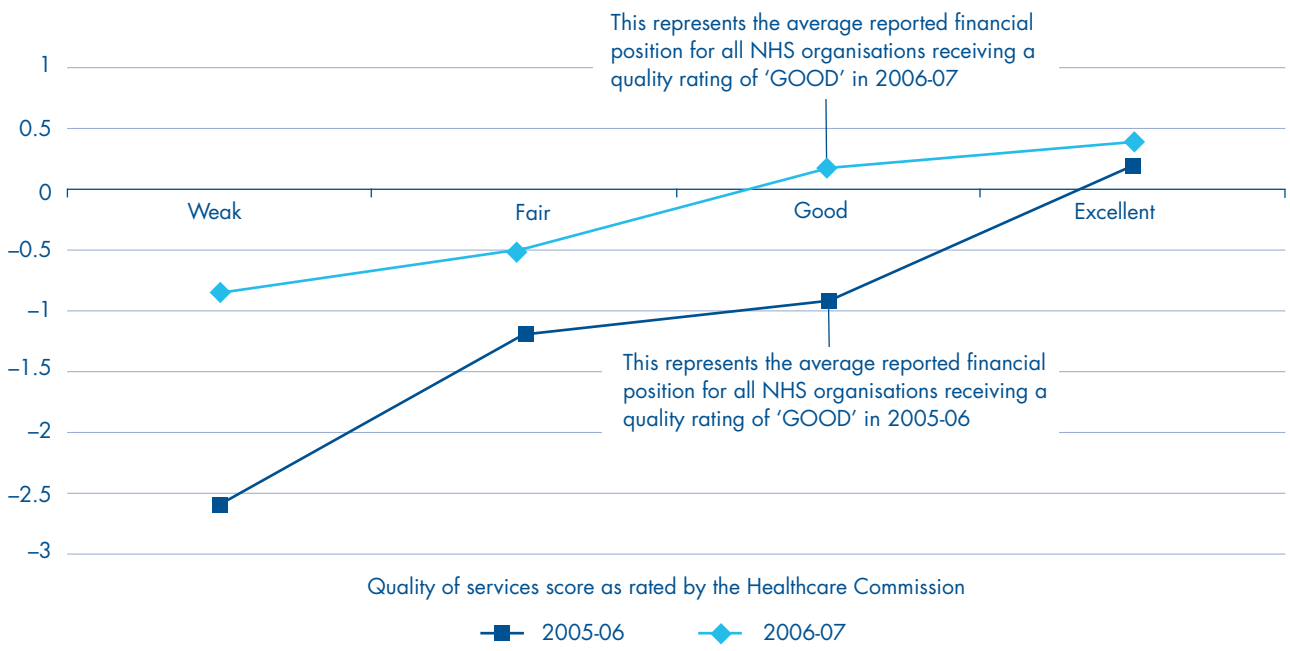
2.4 We grouped all organisations receiving a rating of excellent for quality by the Healthcare Commission and determined the average surplus or deficit reported by those organisations (on a percentage of turnover basis). This was repeated for all organisations receiving a quality rating of excellent, good, fair and weak. Results were determined for both 2005-06 and 2006-07 and are plotted on **Figure 18**.[17]

2.5 The upwards trend for both years indicates that the better an organisation performs financially, the higher quality the service it provides as rated by the Healthcare Commission. The improvement in the financial standing in the NHS has been mirrored by an improvement in the overall quality of the service as rated by the Healthcare Commission. **Figure 19** shows that the Healthcare Commission rated quality as good or excellent in 46 per cent of NHS organisations, compared with 40 per cent in 2005-06. Twice as many NHS organisations saw an improvement in their rating as showed deterioration in their rating.

2.6 A key priority in 2006-07 was to return the NHS to a firm and sustainable financial footing. To achieve this, both the Department and the NHS had to devise and implement decisive action in respect of funding, expenditure, and the overall financial system as applied to the NHS.

18 The relationship between an organisation's financial standing and its overall quality rating

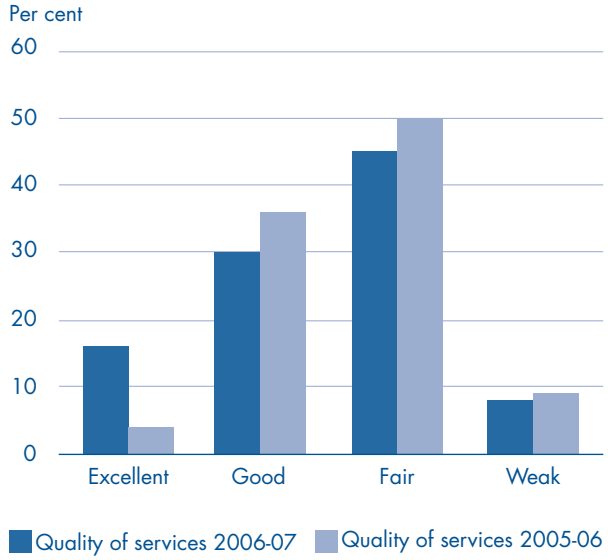
There is a correlation between financial standing and quality of service whereby the better performers financially are also better on quality



Source: National Audit Office analysis of Healthcare Commission data and NHS Summarised Accounts for 2005-06 and 2006-07

19 Comparison of quality of service scores, 2005-06 and 2006-07

The number of organisations rated "good" or "excellent" improved in 2006-07, from 40 per cent to 46 per cent



Source: Healthcare Commission

Funding decisions taken to assist financial recovery

2.7 Resources are allocated to Primary Care Trusts on the basis of a formula known as the weighted capitation formula. The underlying principle of this formula is to secure equal opportunity of access to healthcare for people in equal need. The starting point for each Primary Care Trust's allocation is the population for which it is responsible. The components of the formula are used to weight each Primary Care Trust's "crude" population according to their relative need (age, and additional need) for healthcare and the unavoidable geographical differences in the cost of providing healthcare (market forces factor).

2.8 In 2006-07, Strategic Health Authorities asked Primary Care Trusts within their economy to contribute a proportion of their allocation to support the overall financial position within the Strategic Health Authority, either by off-setting RAB deductions in their NHS Trusts, or by contributing to local risk reserves held on their behalf by the Strategic Health Authorities. Through this top-slicing, Primary Care Trusts contributed between 0.5 and three per cent of their allocations depending on local circumstances. A total of £1,144 million was originally retained by the Strategic Health Authorities in this way. Of this total, £319 million was returned to Primary Care Trusts by 31 March 2007.

2.9 The Department has given a commitment that these funds will be available to the Primary Care Trusts in future years. It is for each Strategic Health Authority to manage both the timing and method for repaying contributions made by their Primary Care Trusts within a reasonable period, not usually exceeding the three year allocation cycle, and depending on overall affordability within the Strategic Health Authority economy. The Department has asked Strategic Health Authorities to consider the position of Primary Care Trusts with the greatest health need first.

2.10 In addition to the allocations given to Primary Care Trusts, there are a number of central NHS budgets. These budgets totalled £5.5 billion in 2006-07 and are for specific programmes, including non-medical clinical training, medical education, prison healthcare, NHS bank revenue support, the ambulance radio contract, and NHS Direct. Prior to 2006-07 these were previously distributed on an individual basis by the Department but from 2006-07 they are allocated to the Strategic Health Authorities. The funds were devolved on the principle that Strategic Health Authorities had better local knowledge and could therefore better target these resources.

2.11 In 2006-07, the Department originally withheld £450 million from the Strategic Health Authorities' allocations for centrally managed programme budgets, to be held as a contingency reserve. The Strategic Health Authorities were asked by the Department to identify savings of £450 million from these programmes so that the £450 million represented genuinely uncommitted funds. In order to create these reserves, Strategic Health Authorities were required to identify savings equal to about nine per cent of the total resources available in these budgets. Just prior to the financial year end, the Department took the decision to return the £450 million to the Strategic Health Authorities. This was done on a 'fair shares' basis, meaning that resources were allocated according to the weighted capitations of each Strategic Health Authority.

Spending decisions to assist financial recovery

2.12 Following the publication of the overall NHS accounts for 2004-05, the Department initiated a centrally driven "turnaround" process, with the aim of producing financial turnaround in targeted organisations, reducing deficits and delivering a financially balanced position for the NHS.

2.13 The Department appointed KPMG to conduct a baseline assessment. Between February and October 2006, they identified a total of 104 NHS Trusts and Primary Care Trusts (as currently configured) that were either in deficit or had underlying financial problems. These entities were deemed to need improved leadership and control, particularly regarding greater involvement of the Strategic Health Authorities in service provision and the monitoring of turnaround plans. Problems with the quality of financial information were also noted.

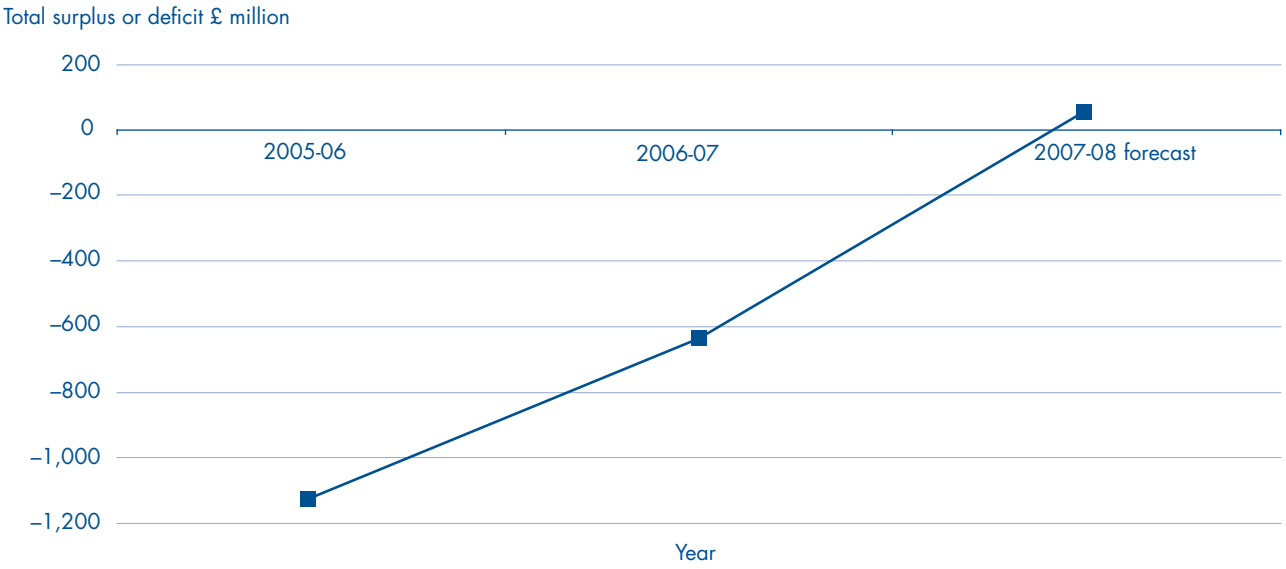
2.14 In response to the baseline assessment, dedicated Turnaround Directors were appointed by each Strategic Health Authority and a National Programme Office was set up within the Department in February 2006. Its remit was to centrally manage the turnaround process by providing independent reviewing, monitoring, and scrutiny. While the overall turnaround process was centrally driven and monitored by the National Programme Office, turnaround plans were developed and owned by the individual trusts which commissioned and funded the support they required.

2.15 Local turnaround external costs, met by individual organisations, for the period January 2006 to March 2007 were £36.3 million. Central costs during the same period were £10 million covering £2.6 million on the baseline assessment; £2.3 million on the Programme Office; and £5.1 million on the turnaround directors. The Department reported that the turnaround bodies recorded a deficit of £1,121 million in 2005-06. This figure for 2005-06 represents the financial position of 100 turnaround organisations, as it is not possible to map four Primary Care Trusts as configured in 2006-07 back to their predecessor organisations. The position of the 104 turnaround organisations as currently configured improved in 2006-07 to a deficit of £637 million. Whilst the turnaround programme formally ended on 31 March 2007, the bodies included within the programme have continued to make progress to recover their financial deficits. At quarter two in 2007-08, the Department predicts that this will be turned into a surplus of £60 million by the end of 2007-08 **(Figure 20)**.

2.16 There may be an opportunity for all NHS organisations to learn from the turnaround process even if they are not in financial difficulty and there is a need for organisations that were in turnaround to ensure that they maintain financial discipline now that the formal turnaround process has ended. Lessons from turnaround are illustrated in **Figure 21**.

20 Financial progress of the organisations in formal turnaround

The deficits of organisations entering the turnaround programme have been greatly reduced



Source: National Audit Office analysis of Department of Health data and the NHS Summarised Accounts

21 Lessons identified from the turnaround programme

The Department and its consultants have identified lessons from turnaround that can be applied to planning, monitoring, and efficiency

Planning

- Plan a surplus to provide a contingency.
- Agree plans in good time and profile across the year.
- Strategic Health Authorities must ensure consistency of plans.
- Financial plans should be linked to workforce plans.
- Plan for a minimum 2.5 per cent efficiency saving.
- Drive the delivery of the Plan.
- Engage and manage stakeholders early.

Monitoring

- Improve the transparency of financial reporting.
- Establish the ongoing/underlying position.
- Risk assess monthly.
- Set up adequate key performance measures.
- Manage within the context of an increasingly transparent funding system.

Efficiency

- Improve procurement and corporate joint ventures.
- Avoid "backloaded" savings.
- For Strategic Health Authorities, adopt a "whole health economy approach".

Source: Department of Health

2.17 However, there are a minority of organisations with residual financial problems. Eighty per cent of the gross deficit in the NHS in 2006-07 was accounted for by ten per cent of NHS organisations. Ten NHS Trusts reported deficits in excess of £10 million, and 12 Primary Care Trusts reported deficits larger than £20 million, including two above £50 million (Appendix 2).
In addition, 15 NHS Trusts are in their 5th year, or more, of recovery in 2006-07 and have therefore breached their statutory financial duty to break-even "taking one financial year with another". Action will need to be taken by Strategic Health Authorities and local management to address the deficits in these organisations. In addition to the lessons identified from the turnaround programme, the Audit Commission has also identified learning points which may be of benefit to NHS organisations seeking to put their financial management onto a stable footing.[18]

Service decisions to assist financial recovery

2.18 The Healthcare Commission have reported that the overall standard of quality improved between 2005-06 and 2006-07. The Department has also reported that key performance targets continued to be met despite the growth in the numbers of patients that the NHS treats. Elective and non-elective admissions continued to rise in 2006-07, although the rate of growth was lower than in 2005-06 **(Figure 22 overleaf)**.

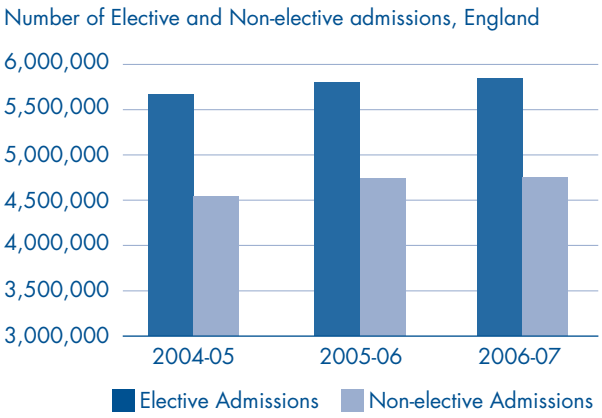
2.19 Significant progress was made in reducing waiting times during 2006-07, particularly towards the year end. Numbers waiting more than 11 weeks for an out-patient appointment fell from 35,000 to 3,000, and those waiting more than 20 weeks for an in-patient appointment fell from 61,000 to 15,000 over the same period. The largest monthly reductions in both measures occurred in March 2007. Cancelled operations and breaches (where an operation is cancelled 'at the last minute' – i.e. on, or after, the day the patient is due to arrive in hospital, which may be before the day of surgery – and not rescheduled within 28 days) also continued to fall in 2006-07 despite the rising activity **(Figure 23)**.

2.20 The national picture is one of increased quality and improved performance against targets. At the local level, however, the Department accepts that some difficult decisions needed to be taken to restore financial balance. An independent review of Primary Care Trust board papers, carried out in March 2007, indicated that 14 Primary Care Trusts had made financial savings by requiring their provider trusts to limit their activity, by "freezing non-essential elective work" or "slowing down elective work". For example, one trust decided not to meet a 20-week milestone but to maintain achievement of in-patient waiting times at the national target of 26 weeks to "avoid worsening the financial position".[19] Such decisions reflected the need for organisations to get their finances onto a stable footing in the short-term without unduly affecting clinical performance.
The Department's view is that all NHS organisations need to continue to look at the way they provide services to patients to ensure they are delivering the best possible value for money.

2.21 We have analysed separately the quality ratings for 2005-06 and 2006-07 for those NHS organisations who formed part of the formal turnaround programme. Owing to organisational change, this analysis is restricted to the 73 of turnaround bodies that are in the same configuration for both years. For the 31 bodies that were re-configured, it is not possible to include these in the analysis as the quality scores of the predecessor organisations varied from each other.

22 Number of elective and non-elective admissions, 2004-05 to 2006-07

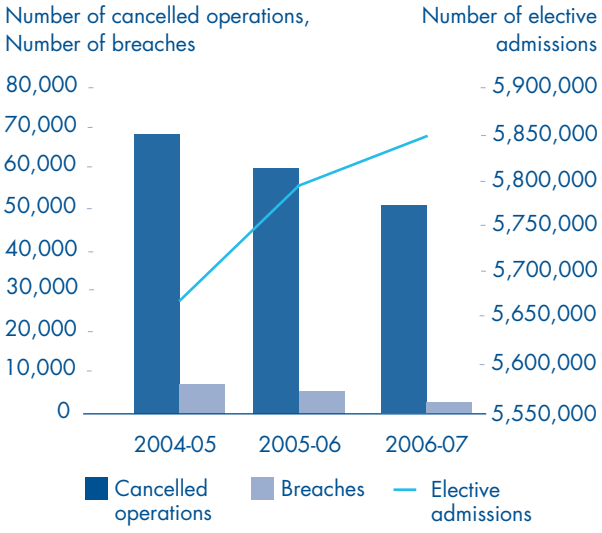
Elective and non-elective admissions to the NHS have increased over the past three years



Source: Department of Health, NHS Financial Performance quarter 4 2006-07

23 Number of cancelled operations and breaches, 2004-05 to 2006-07

Cancelled operations and breaches have decreased over the past three years despite an increase in admissions.



Source: Department of Health, NHS Financial Performance quarter 4 2006-07

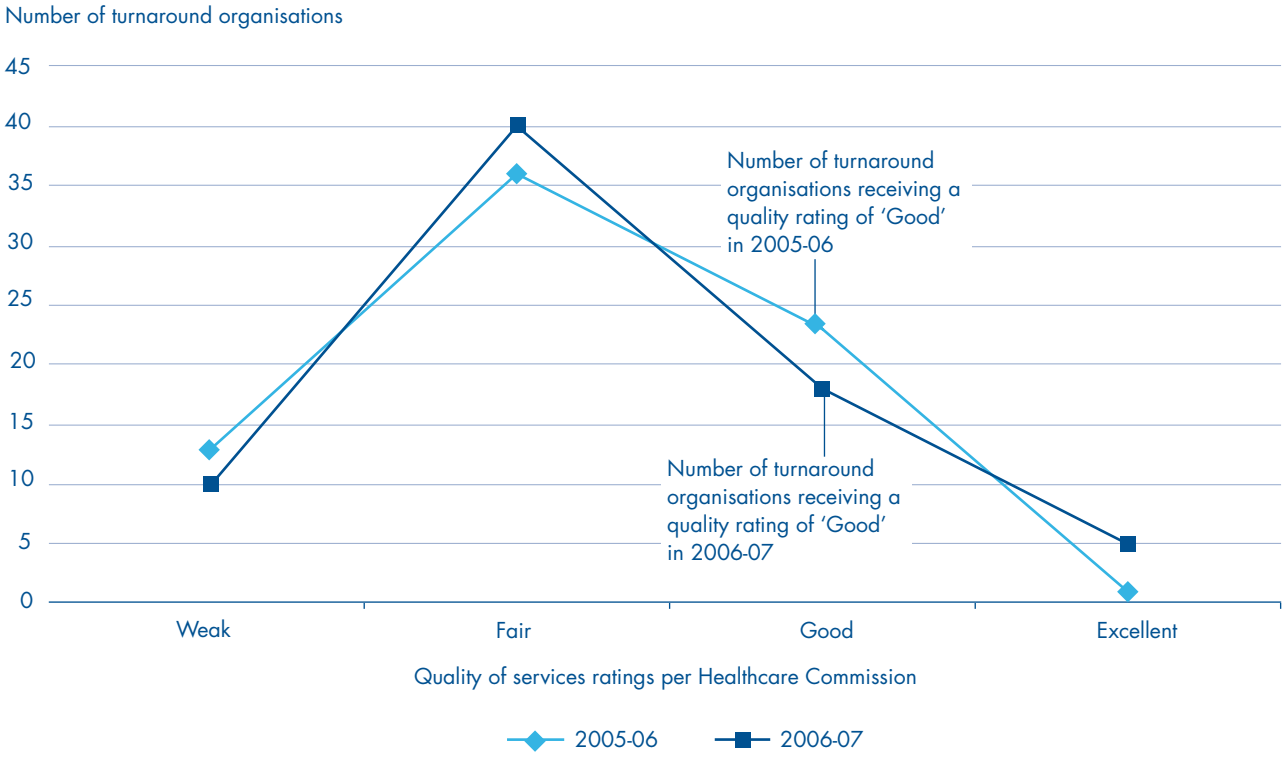
2.22 **Figure 24** shows that despite the targeted action taken to improve the financial position, there was not a significant adverse impact on quality. In 2005-06, 24 of the turnaround bodies were rated as good or excellent on quality; in 2006-07, this had reduced by just one to 23. The quality of the service has therefore been maintained by those bodies. However, the general improvement as reported by the Healthcare Commission has not been replicated to the same extent by the turnaround organisations. Clearly, there is a challenge for these organisations to catch up with the progress in quality of service that has been made elsewhere.

NHS finances are now more transparent

2.23 In 2006-07, the Department abolished the system of "cash brokerage", whereby funds could be transferred from organisations in surplus to prop up the finances of those in deficit, and replaced it with a more formal loans system. NHS Trusts may borrow cash from the Department, repaying the loan from surplus cash generated by the organisation on repayment terms varying from one to 25 years. In 2006-07 the Department issued cash loans of £771 million to 55 NHS Trusts.[20] A practical consequence of the process whereby Primary Care Trusts made contributions to reserves held by Strategic Health Authorities (see paragraph 2.8) was the release of cash to finance the loans agreed with NHS Trusts.

24 Quality scores of turnaround organisations, 2005-06 and 2006-07

2006-07 saw a marginal improvement in the quality scores given to the turnaround organisations.



Source: National Audit Office analysis of Healthcare Commission data

2.24 The Department has taken action each year since 2004-05 to improve the transparency of the NHS's financial performance. Two actions have had the most impact on the reported financial position:

- Since 2004-05, the Department has discontinued the practice of switching capital resources to revenue accounts. Prior to 2004-05, the net financial position after the switch of resources from capital to revenue was the reported headline position. Discontinuing this practice was a key factor in making deficits transparent in 2004-05 and 2005-06.
- From 2006-07, the Department also changed the way that it interpreted Resource Accounting and Budgeting (RAB) for NHS Trusts. Before 2006-07, overspending NHS Trusts had their income in the subsequent year reduced and also had to pay back the overspend. This was known as the "double deficit" scenario. In 2006-07, whilst the RAB regime is still applied to the Department as a whole, the Department decided to move NHS Trusts outside of the RAB regime. The immediate impact of this decision was to return £178 million of funds to 28 NHS Trusts from Strategic Health Authorities for 2006-07. Under the new regime, overspending NHS Trusts will still have to repay their deficits but will not have their income reduced for the following year.

2.25 These changes were part of a process designed to reveal the underlying financial performance of the individual NHS organisations. Most of the changes were made possible by the introduction of Payment by Results which for the first time fixed the basis on which trusts would be paid for their services rather than leaving this to local negotiation. During most of the 1990s and up to and including 2003-04, sufficient resources were transferred from capital to revenue to turn an overall NHS net deficit into an overall NHS net surplus.

PART THREE

Managing risks in the future

3.1 The Department set out its financial strategy for 2007-08 in its Operating Framework. This acknowledged the need for 2007-08 to be a further year of financial recovery, building on the foundations of 2006-07 to create a sustainable financial position for the future. Key objectives that the Department set were:

- The £917 million gross deficit of 2006-07 must be significantly reduced before the beginning of 2008-09.[21]
- There should be a net surplus across the NHS of at least £250 million.
- All but a small handful of organisations should be operating in recurrent balance throughout the year.[22]

3.2 In addition to achieving the aim of delivering a net surplus of at least £250 million across the NHS for 2007-08, organisations have been tasked to generate a contingency of at least 0.5 per cent of turnover (which is equivalent to at least £526 million). The Department no longer applies Resource Accounting and Budgeting (RAB) income deductions to NHS Trusts, meaning that they do not have their income reduced by the level of any prior year deficit. RAB rules are still applied to Primary Care Trusts, Strategic Health Authorities and to the Department itself. As a result, NHS Trusts are still required to make a surplus to cover their deficit in full, to avoid any negative financial impact on the Department. At the end of 2006-07, NHS trusts recorded a net deficit of £77 million, and will therefore need to make an additional surplus of £77 million in 2007-08 to cover this.

3.3 To support these objectives, the Department has further tightened the financial regime. As noted above, deductions made to NHS Trust allocations under the RAB regime in respect of deficits incurred in previous years, no longer apply. The loans system first introduced in 2006-07 to replace brokerage continues into 2007-08. Capital investment has moved away from allocations and is now financed through loans based on affordability and subject to a prudential borrowing code similar to that operated for NHS foundation trusts.

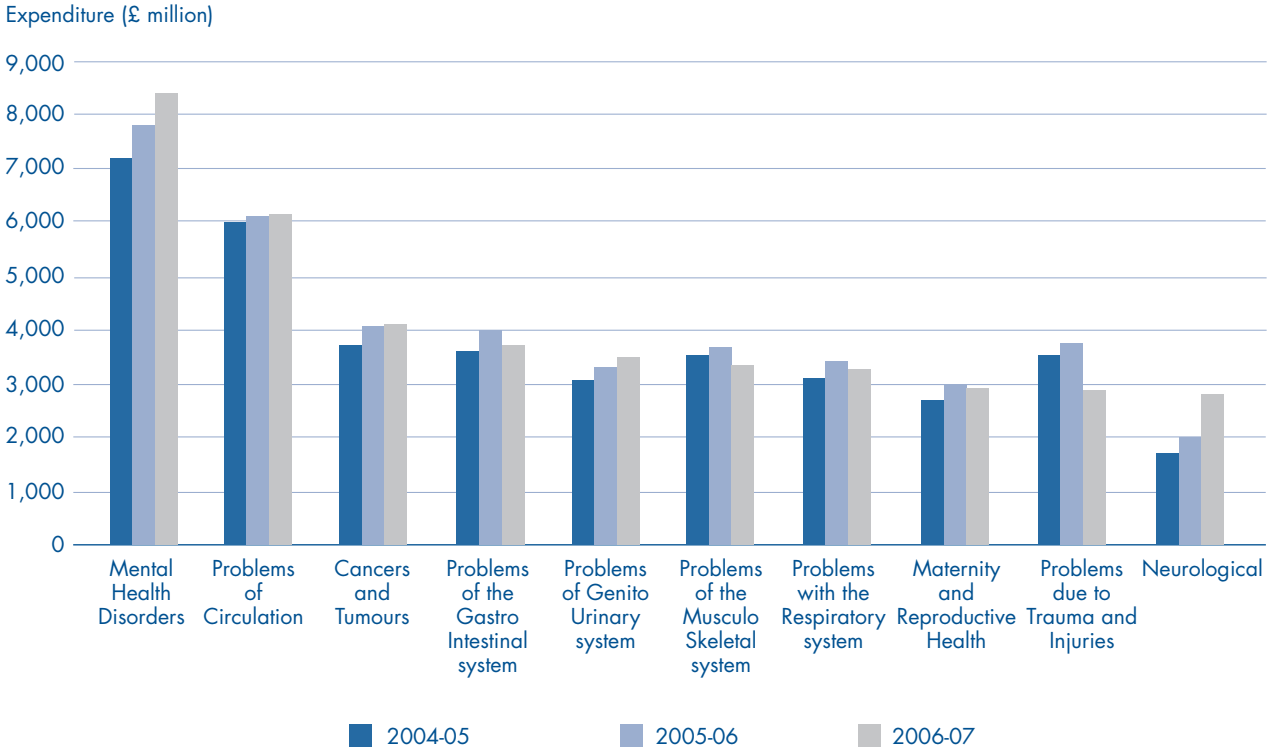
3.4 NHS organisations record what they are spending their allocations on according to the Programme Budgeting system. Programme Budgeting is a retrospective analysis of NHS expenditure across 23 categories based on major disease types – to show where the money has gone, and to provide information to prompt analysis of future spend decisions. It is still being developed by the Department. The accuracy of the data will take time to improve as uncertainties, such as how health professionals apportion their time between categories, need to be reduced. However, Programme Budgeting has the potential to be a powerful information tool, allowing NHS organisations to benchmark their expenditure against each other to identify opportunities for more effective service delivery. **Figure 25 overleaf shows** the top ten health programmes in terms of expenditure between 2004-05 and 2006-07, according to Programme Budgeting figures published by the Department.

Forecast financial performance for 2007-08 predicts further improvements in financial standing of the NHS

3.5 The second quarterly returns of 2007-08 show the NHS to be forecasting an overall surplus of £1,790 million at the end of the financial year, compared to the £515 million surplus for 2006-07 and the £853 million surplus based on the actions described in paragraph 3.2. The quarter two forecasts state that of the 341 NHS organisations, there are now only 25 forecasting a deficit position for 2007-08.

25 Expenditure on the top ten health programmes, 2004-05 to 2006-07

Spending across the top ten health programmes has increased from £38 billion in 2004-05 to £42 billion in 2006-07



Source: National Audit Office

3.6 The Department started to publish NHS financial forecasts to Parliament with an annual report for 2005-06, and then quarterly from the beginning of the 2006-07 financial year. These forecasts also included comparative quarterly forecast information for 2005-06. We welcome the publication of this information as it further increases the action taken to improve the transparency of NHS finances. **Figure 26 shows** that NHS organisations have tended to underestimate the year-end position, with final outturns showing a significant improvement over forecast outturns. This was seen most markedly in 2006-07. It is not possible to quantify how much of this trend is down to action taken by the NHS towards the year-end, and how much is down to a cautious approach to forecasting being taken by the NHS. Figure 26 excludes the contingency fund of £450 million generated by the Department from NHS central programme funds.

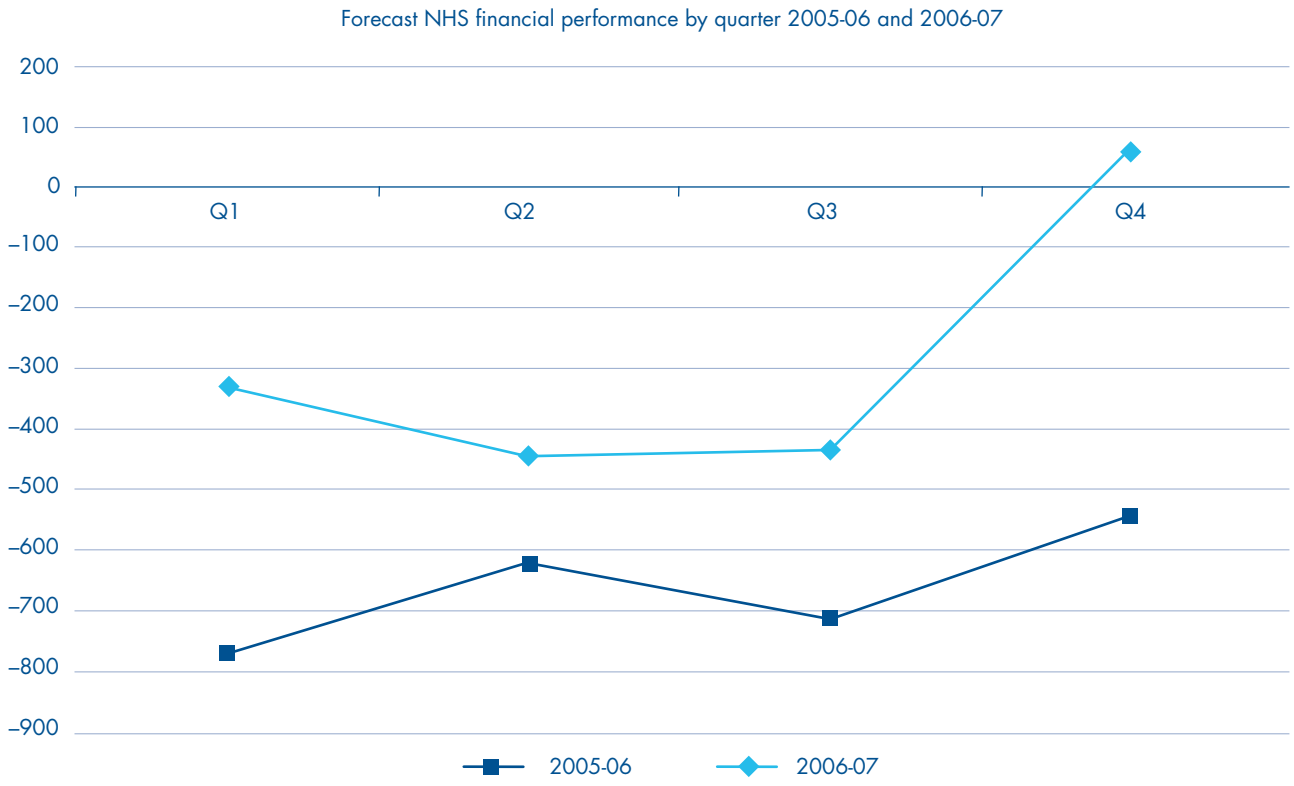
3.7 Forecasts are made by Primary Care Trusts and NHS Trusts and submitted to Strategic Health Authorities. The Strategic Health Authority then collates the information for their areas, adds information about their own financial position, and submits it to the Department. The Department then reports on the national picture. Financial decisions are taken at all levels based on the forecast data. The Strategic Health Authorities face the challenge of working with their Primary Care Trusts and NHS Trusts to improve the accuracy of their financial forecasts.

The national picture is one of financial balance, but there remains a core of NHS organisations with significant deficits

3.8 Overall the NHS is reporting a surplus. However, there remains a small but significant number of Primary Care Trusts and NHS Trusts for whom restoring financial balance is a significant challenge. Eighty per cent of the gross deficit of £917 million arises from just ten per cent of organisations. In addition, 73 per cent of Primary Care Trusts and 81 per cent of NHS Trusts reported balance or a surplus for 2006-07, yet overall the Primary Care Trust and NHS Trust sectors reported a net deficit.

26 Departmental forecasts since 2005-06

Departmental forecasts have consistently underestimated NHS outturns.



Source: National Audit Office analysis of Department of Health quarterly reports

NOTE

Financial forecasts for 2006-07 for the purpose of this figure exclude the contingency funds generated by Strategic Health Authorities. For Q1 and Q2 in 2006-07, the contingency fund created was £350 million.This was increased to £450 million in Q3. In addition, the return of £319 million of the funds top-sliced from Primary Care Trusts does not impact on the overall NHS forecast figure as these funds were transferred from Strategic Health Authorities.

3.9 Following introduction of the new loans system, 17 NHS trusts were identified where the financial challenges were such that the Department either could not give a loan because the trusts could not afford to meet the repayments, or where a loan was agreed, but the amount could only be repaid over a very extended timescale (see paragraph 2.23). The Department is working with Strategic Health Authorities to develop action plans for these organisations.

3.10 In our report on Financial Management in the NHS 2004-05, we concluded that there was no one reason why bodies fall into deficit although the Department has said that the biggest indicator of a deficit was whether an organisation had reported a deficit in the previous year. A contributory factor to this for NHS Trusts was the application of the Resource Accounting and Budgeting regime. Now that the Department has ceased to apply this regime to NHS Trusts, this should ease the additional pressure that the regime applied to NHS Trusts already in deficit.

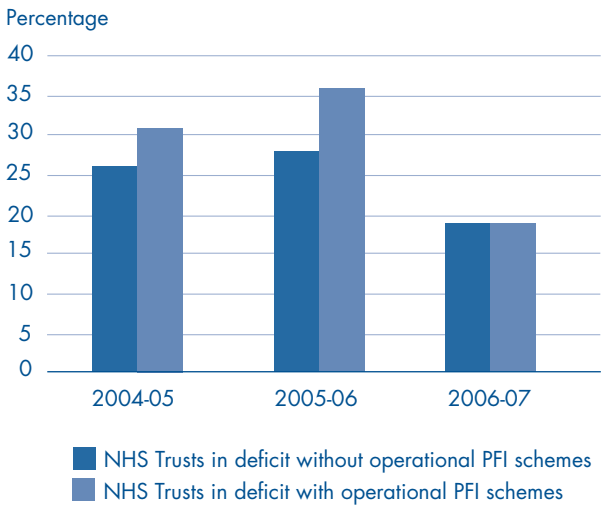
3.11 The financial pressures contributing to deficits are complex, and not always within the control of individual bodies. The Department accepted that the implementation of workforce contracts, the requirements to improve performance to meet targets, and additional activity over and above that specified in contracts all placed demands on financial management. For example, 78 per cent of Primary Care Trusts have referred to "over-performance" by their local acute hospital trusts as a financial risk or cost pressure.[23] However, the majority of NHS organisations have managed these pressures to deliver a balanced or surplus financial position.

3.12 Any large-scale hospital building programme with PFI has the potential to create cost pressures, as it commits an organisation to fixed levels of capacity and costs over a number of years. Under Payment by Results, income levels fluctuate with activity, so organisations must have sufficient flexibility elsewhere in their cost base to accommodate these fluctuations.

3.13 We have analysed the financial standing of those NHS Trusts with operational PFI projects as at 31 March 2007. Overall, 19 per cent of NHS Trusts reported a deficit for 2006-07. Our analysis shows that the presence of PFI is not an increased indicator of a deficit **(Figure 27)**. However, of the 17 NHS Trusts identified by the Department as needing special measures to restore financial balance (paragraph 3.9), 53 per cent have an operational PFI project. This compares to 35 per cent for NHS Trusts as a whole. This suggests that these NHS Trusts face the challenge of increasing the flexibility of their cost bases.

27 Proportion of NHS Trusts in deficit with and without PFI

There is no significant correlation between PFI and deficits.



Source: National Audit Office analysis of NHS Summarised Accounts

Complexities within the NHS present future financial challenges

3.14 There is a clear intention for more healthcare delivery to be at the local level, with fewer general hospitals and more specialist hospitals. Further restructuring brings financial risks associated with the movement of people and capital. More focus on health prevention and local delivery also has implications for the commissioners of healthcare.

3.15 Following the Comprehensive Spending Review 2007, the Department is taking the lead on the Public Service Agreement target for promoting better health and well-being for all. The target is aimed at tackling health inequalities and addressing public health issues such as obesity prevention and smoking cessation. Revenue allocations to Primary Care Trusts in 2006-07 and 2007-08 include a total of £553 million to support the implementation of the Choosing Health White Paper which focuses on these public health issues. Over the same two years, a further £792 million was allocated directly from the Department for public health improvements.

3.16 The majority of the funding that Primary Care Trusts receive is not ring-fenced. They may use their available resources in a way that allows them to respond to local needs and priorities, whilst ensuring that national priorities are also addressed. For NHS organisations looking to recover a deficit in 2006-07, one of those priorities would have been to use their allocations to get their finances onto a stable and sustainable footing. With a greater focus now being made on public health matters, commissioners may now find that funding these programmes is a higher priority when it comes to deciding how their allocations should be spent.

3.17 Payment by Results should be transparent, well understood, and reward providers fairly. It should also complement good clinical practice, financial efficiency, and wider reforms in the NHS. Among the financial pressures that are expected to arise from Payment by Results is the increasing need to understand costs, performance against tariffs, and benchmarking against comparators at service line and patient level. As more services are commissioned through volume-based contracts, there will be an increased emphasis on managing the financial risks involved.[24] The Audit Commission intends to publish a report on the implementation of Payment by Results later in 2007.

The NHS received an above-average funding increase in the Comprehensive Spending Review

3.18 Resource increases since the NHS Plan have enabled the NHS to increase its capacity. The Comprehensive Spending Review (CSR) for 2008-09 to 2010-11 announced an above average settlement for the NHS. Funding will increase to £110 billion by 2010-11, an average increase of 6.7 per cent per year or about four per cent in real terms. This compares to a real increase of about two per cent across government.

3.19 Assumptions within the CSR include the need to restrict headline pay increases across the public sector to a level consistent with meeting the inflation target of two per cent to 2010-11. Since the NHS Plan of 2000 announced substantial increases in the workforce numbers for the NHS, the Department and the NHS has implemented a number of pay reforms for NHS staff. New contracts were developed for GPs and Consultants, and for the majority of other NHS staff the Agenda for Change initiative established a single pay system. These pay reforms had a significant impact on the use of NHS funding, for example the Department has reported that, for 2005-06, 36 per cent of the additional funding available to the NHS that year was spent on pay.[25] The Department has accepted that they underestimated the cost of the implementation of pay modernisation, although it was able to fund these additional costs from total available resources.

3.20 No further significant pay reforms are planned by the Department in 2007-08. Any additional pay pressures will arise from the annual pay settlement. However, if the Department is not able to maintain headline pay increases within the two per cent assumed by the CSR, then it will need to find the additional resources from within existing budgets.

3.21 The Department is also expected to achieve annual cashable efficiency savings of three per cent. This means that the savings will need to be passed down throughout the NHS in the national tariff, potentially reducing the income of NHS organisations for activity performed. Individual NHS organisations will have been building assumptions regarding the tariff for 2007-08 into their business plans. If they have planned for a tariff increase above that which will be published by the Department in January 2008 in the NHS Operating Framework, there could be an increase in the financial pressure on those Trusts to meet their expenditure commitments. Work will also need to be done by the Department to put in place systems that can measure how savings are being generated to demonstrate how this requirement is being met.

3.22 The Department will also need to implement reforms arising from Lord Darzi's interim report, and his final report (expected June 2008), from within the CSR settlement. The report focuses on an NHS which is safe and locally accountable, and work is underway at the Department which may lead to an NHS constitution. It is too early to tell how far devolution in the NHS will go, but there is a clear direction of travel suggesting that responsibility for financial and clinical performance will become more localised. The Department has already begun the process of simplifying its internal governance procedures in order to support these reforms. Until the exact nature of the reforms is known, however, it is difficult for the Department to manage the funding implications, which introduces an element of uncertainty into its budgeting process.

The restructuring of the NHS has the potential to realise considerable savings

3.23 Commissioning a Patient-led NHS, published by the Department in July 2005, outlined the plans for the restructuring of the NHS. The restructuring is designed to release resources for front-line care through savings in administration costs arising from economies of scale from a reduced number of NHS organisations. It is also designed to develop stronger organisations through greater geographical fit between NHS organisations and local authorities. As a result, 28 Strategic Health Authorities were reduced in number to ten on 1 July 2006, 303 Primary Care Trusts were reduced in number to 152 on 1 October, and 29 ambulance trusts were reduced in number to 12 on 1 July 2006.

3.24 The reorganisation was designed to release £250 million recurrent savings per year into front-line care, by the end of the programme (31 March 2008). Early indications from the Audit Commission and the Department indicate that the Department is on track to deliver these savings. The Audit Commission has reported that £90 million of savings have been identified in 2006-07. Forecast information as at quarter one for 2007-08 from the Department states that a further £154 million of savings have been identified to date.

3.25 There are a number of one-off costs associated with the restructuring. The Audit Commission has reported that the costs of restructuring in 2006-07 were £192.1 million.[26] These costs include the redundancy costs of 124 Strategic Health Authority and Primary Care Trust executive directors at an average redundancy cost of £308,000. Further, they reported that continuing bodies performed better in the Audit Commission's Auditors' Local Evaluations than those who were subject to organisational change. Further costs are anticipated during 2007-08, since employees of the merged Primary Care Trusts were guaranteed employment until July 2007.

3.26 NHS Trusts have the opportunity to become NHS Foundation Trusts. This is currently restricted to the better performing NHS Trusts financially, as during the application process the trust needs to demonstrate financial viability over a three to five year period. Removing the better financial performers from NHS Trust status will mean that over time the trusts that remain are the ones furthest from being able to demonstrate long term financial viability. This may increase the challenge of delivering financial balance year-on-year for the NHS.

The Department has identified the opportunity for significant savings through increased productivity

3.27 The Department has identified potential savings through the generation of the *Better Care, Better Value* productivity metrics. These are a set of performance measures which allow NHS organisations to benchmark their performance against each other. In its year end performance report for 2006-07, the Department stated that there was the potential for Primary Care Trusts to realise £713 million in savings and for NHS Trusts in deficit to realise £302 million. These savings can be generated through improved productivity. The Department and the NHS face the challenge of finding ways to realise these savings whilst improving the performance of the service, and of measuring the financial impact of productivity gains.

The introduction of International Financial Reporting Standards may affect NHS finances

3.28 The 2007 Budget announced the Treasury's intention to adopt International Financial Reporting Standards (IFRS) for the public sector from 2008-09. This means that the NHS summarised accounts for 2008-09 will be produced using IFRS, and under the rules of IFRS these accounts will also need to include comparative information for the 2007-08 financial year, restated as if the IFRS regime had been in place for that year. The introduction of IFRS provides an opportunity for the Treasury to introduce new guidance to provide a more consistent approach to PFI accounting. The expectation is that such guidance will take account of the International Financial Reporting Interpretations Committee (IFRIC) interpretation 12: *Service concession arrangements*, to apply from 2008-09.

3.29 IFRIC 12 is based on the concept of control rather than the risks and rewards approach taken under UK GAAP. Under IFRIC 12, where the purchaser controls or regulates the service the operator provides, and retains a significant residual interest in the asset, then the property belongs on the purchaser's balance sheet.

3.30 A significant amount of investment in hospital building has been carried out via PFI arrangements. If the principles of IFRIC 12 were applied to the public sector's accounting for PFI projects, then there could be a transfer of PFI arrangements onto the public sector balance sheet and the resource implications for the Department and the NHS could be significant. Until the guidance has been published, the overall financial impact cannot be estimated. A draft of the guidance is expected from the Treasury in December 2007.

APPENDIX ONE

NHS Foundation Trusts

1 NHS Foundation Trusts are free-standing, not-for-profit organisations with a duty to provide NHS services to NHS patients according to NHS standards and principles. They are authorised and regulated by Monitor (whose statutory name is the Office of the Independent Regulator of NHS Foundation Trusts), and can borrow commercially, retain surpluses and invest to improve services for patients.

2 NHS Foundation Trusts were created through the Health and Social Care (Community Health and Standards) Act 2003. The first ten were authorised by the regulator on 1 April 2004. By 31 March 2007 there were 59 NHS Foundation Trusts; by 1 August 2007 this had increased to 73. The Government is committed to offering all NHS Trusts the opportunity to apply to attain Foundation Trust status by 2008.

3 NHS Foundation Trusts operate under a different financial and accounting regime from NHS Trusts. They follow UK Generally Accepted Accounting Practice (UK GAAP), thus providing greater transparency and comparability with the commercial sector in the UK. Key differences are that NHS Foundation Trusts have no statutory duty to break even, do not have access to brokerage or financial support from the Strategic Health Authority or the Department, and that they must account for impairments in accordance with Financial Reporting Standard 11, thus charging the impact of impairments directly to the income and expenditure account rather than being offset in reserves as in the case of NHS Trusts.

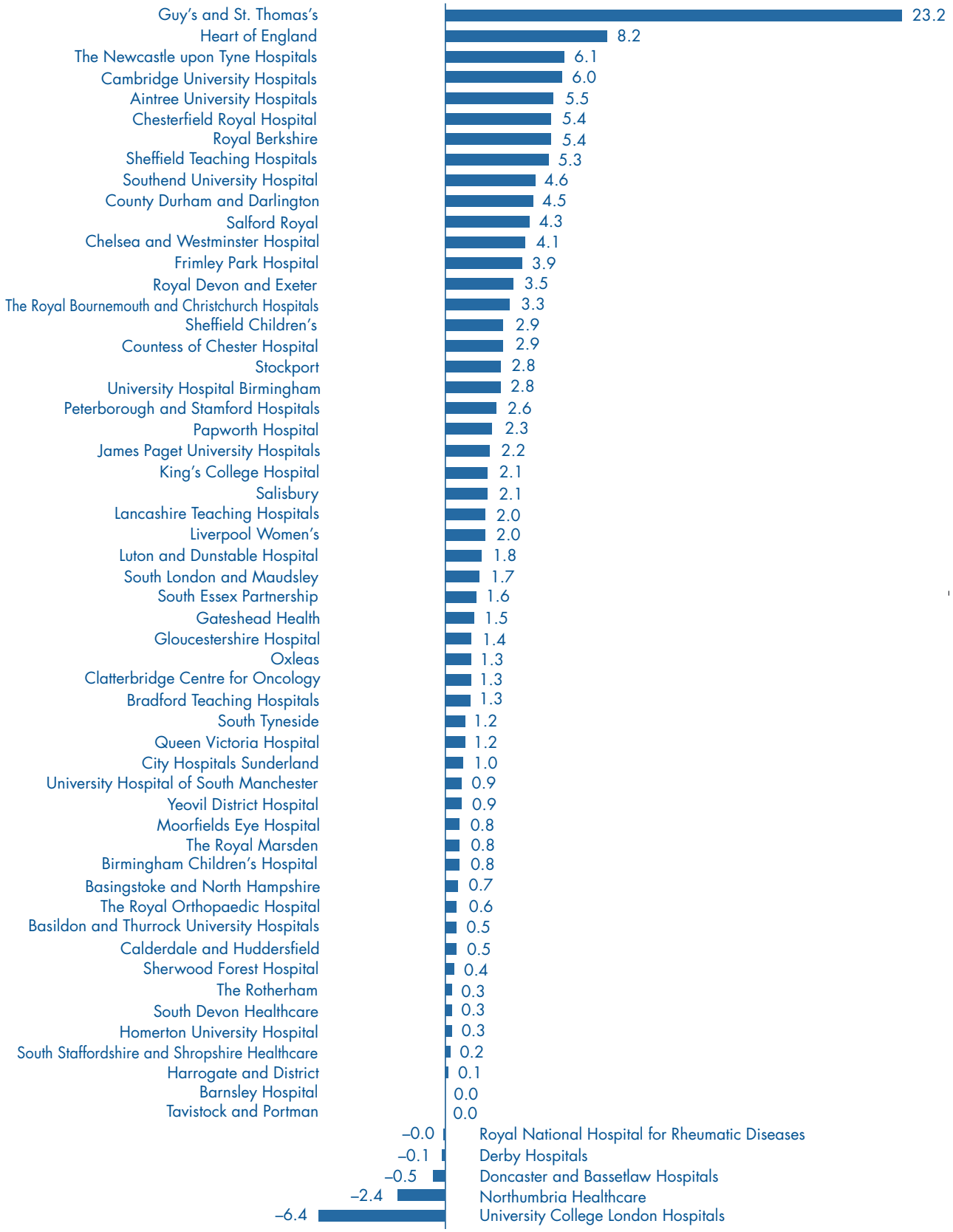
4 Monitor approves the conversion of Trusts to Foundation status and sets terms of authorisation for each body. The Foundation Trust is bound to operate within its terms of authorisation; this includes containing borrowing within limits, remaining a going concern, not to dispose of protected property without approval, and to contain the proportion of income derived from private patient charges within an agreed limit.

5 Monitor requires NHS Foundation Trusts to submit regular reports detailing financial performance and position in comparison with annual plans. The frequency of the submissions is determined by Monitor's financial risk ratings of each body, the principle being that NHS Foundation Trusts should be self-governing and the most effectively run trusts require less intervention and controls from the regulator.

Financial Performance of Foundation Trusts 2006-07

6 NHS Foundation Trusts delivered an overall net surplus of £134.4 million for 2006-07. Of 59 NHS Foundation Trusts, only five failed to deliver a surplus. Financial performance is quoted before deductions for exceptional items. This is to enable a clearer comparison with NHS Trusts. The reason for the difference is principally the accounting treatment for 'asset value impairments'. In 2006-07 deductions for exceptional items totalled £136.7 million, leaving a net deficit of £2.3 million.

Surpluses and deficits (post adjustments) by NHS foundation trust (£ million) at 31 March 2007



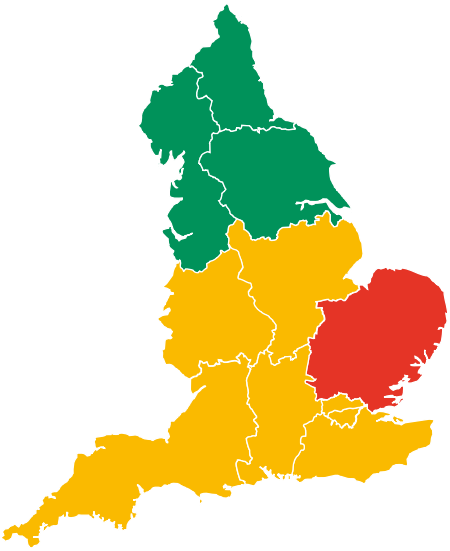
Source: Monitor, NHS Foundation Trusts: Review and Consolidated Accounts 2006-07, HC 21, Session 2007-08

APPENDIX TWO

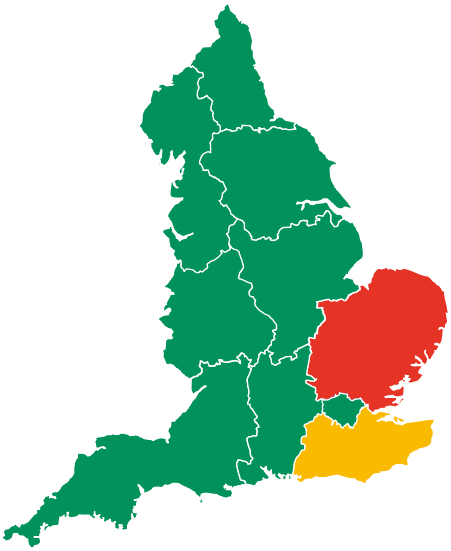
Detailed Financial Performance Data

NHS Financial Performance by Strategic Health Authority Area 2005-06 and 2006-07

2005-06 % Revenue Resource Limit



2006-07 % Revenue Resource Limit



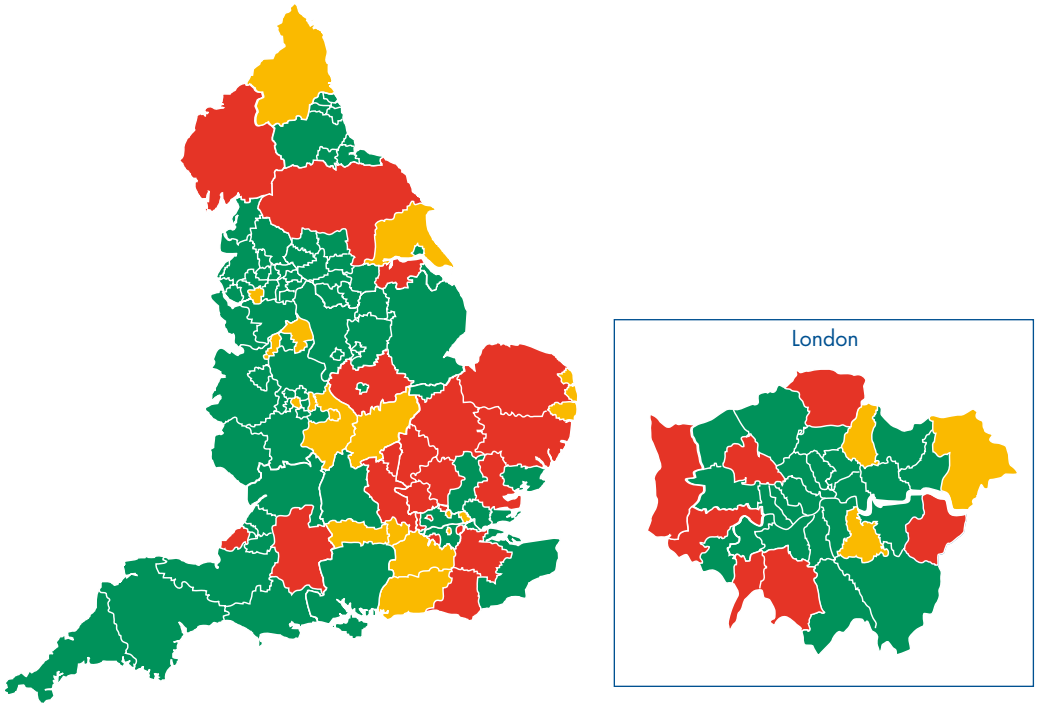
Deficit > 2% of Revenue Resource Limit

Deficit between 0% and 2% of Revenue Resource Limit

Breakeven or Surplus

Source: Department of Health, NHS Financial Performance quarter 4 2006-07

Geographical performance of Primary Care Trusts 2006-07

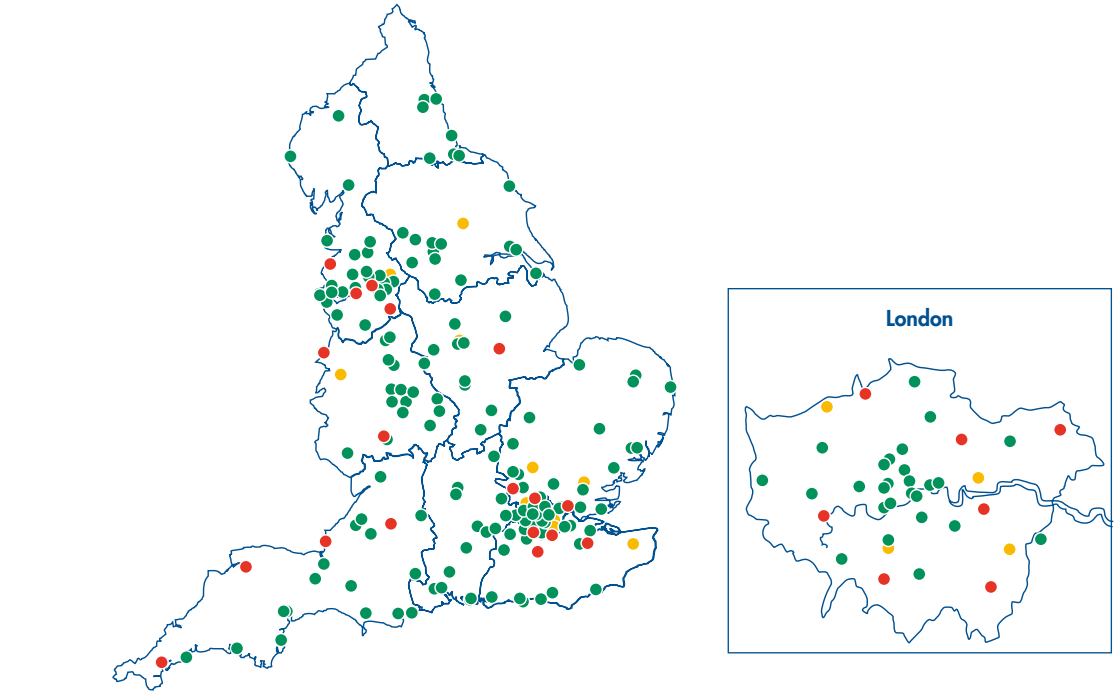


Source: Department of Health, NHS Financial Performance quarter 4 2006-07

Primary Care Trusts reporting deficits larger than £10 million in 2006-07

PCT	£000
Cambridgeshire PCT	(52,247)
Hillingdon PCT	(52,129)
Norfolk PCT	(46,686)
Cumbria PCT	(36,703)
North Yorkshire And York PCT	(32,067)
Suffolk PCT	(30,842)
West Hertfordshire PCT	(26,635)
Brent Teaching PCT	(25,074)
East And North Hertfordshire PCT	(23,625)
Kingston PCT	(21,080)
Wiltshire PCT	(20,221)
Buckinghamshire PCT	(20,123)
East Sussex Downs And Weald PCT	(18,091)
Leicestershire County And Rutland PCT	(17,755)
Mid Essex PCT	(17,744)
Bedfordshire PCT	(17,561)
Surrey PCT	(16,308)
West Kent PCT	(15,943)
Enfield PCT	(13,030)
West Sussex PCT	(12,862)
Hounslow PCT	(12,860)
Sutton And Merton PCT	(10,083)

Geographical Performance of NHS Trusts 2006-07



Source: Department of Health, NHS Financial Performance quarter 4 2006-07

NHS Trusts reporting a deficit in excess of £10 million in 2006-07

PCT	£000
Royal Cornwall Hospitals NHS Trust	(36,464)
Barking, Havering And Redbridge Hospital NHS Trust	(16,844)
United Lincolnshire Hospitals NHS Trust	(13,761)
Hinchingbrooke Health Care NHS Trust	(13,354)
Surrey And Sussex Healthcare NHS Trust	(12,155)
Mid Yorkshire Hospitals NHS Trust	(11,688)
West Hertfordshire Hospitals NHS Trust	(11,413)
Barnet And Chase Farm Hospitals NHS Trust	(11,398)
Whipps Cross University Hospital NHS Trust	(10,467)
Bromley Hospitals NHS Trust	(10,002)

APPENDIX THREE

Audit of the NHS 2006-07

1 The Comptroller and Auditor General is the statutory external auditor of the summarised accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts. The Audit Commission, or its appointed auditors, are the external auditors of the individual accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts.

2 Auditors are required to give an opinion on whether the financial statements are true and fair. The auditors of the individual accounts did not qualify any accounts in 2005-06 or 2006-07 on the grounds that the accounts were not true and fair. Auditors are also required to give a regularity opinion on Primary Care Trust and Strategic Health Authority accounts which confirms whether in their view "in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them". Regularity opinions are not currently given for NHS Trusts.

3 In 2006-07, auditors qualified the regularity opinion of 43 Primary Care Trusts. This represents an improvement from 2005-06 when the regularity opinion was qualified in one Strategic Health Authority and 110 Primary Care Trusts. The most common form of regularity qualification occurs when the organisation has breached its revenue limit as set by the Department. The Audit Commission, in its report *Review of the Financial Year 2006-07* has highlighted the audit issues arising from the audit of the individual accounts.

4 The Comptroller and Auditor General gave an unmodified opinion on the summarised accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts for 2006-07 (HC129-II). None of the issues raised by the Audit Commission were considered material to the national accounts. There was also a further reduction in the number of audit adjustments that were required to the national accounts.

Audit adjustments, 2004-05 to 2006-07

Financial Year	Unaudited position £ million	Audited position £ million	Difference £ million
2006-07	510.3	514.6	4.3
2005-06	(512.9)	(547.7)	(34.8)
2004-05	(106.1)	(221.4)	(115.3)

Source: National Audit Office

GLOSSARY

Acute Trust	An NHS Trust which provides secondary or hospital based health care services. An acute trust can cover one or more hospitals.
Agenda for Change	A pay and reform package aimed at ensuring that NHS staff are paid on the basis of equal pay for work of equal value. It applies to all directly employed NHS staff, except the most senior managers and those covered by the Doctors' and Dentists' Pay Review Body.
Annual Health Check	A comprehensive assessment and rating of the performance of each NHS Trust in England, covering a wide range of areas from quality of care to how well Trusts manage their finances, undertaken by the Healthcare Commission.
Audit Commission	The independent auditor of local authorities and health bodies. Individual NHS organisations (excluding foundation trusts) are audited either by the Audit Commission or its appointed auditors.
Auditors Local Evaluation (ALE)	A framework used by the Audit Commission's appointed auditors to assess NHS bodies' performance on five key areas. ALE scores form the 'Use of Resources' component of the Healthcare Commission's Annual Health Check.
Better Care, Better Value productivity metrics	A set of productivity metrics based around 15 high-level indicators of efficiency that identify potential areas for improvement in efficiency. These indicators can be used locally to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care and to generate ideas on how to achieve these savings. The indicators are primarily aimed at commissioners and acute hospital providers.
Breach	Where an operation is cancelled at the last minute, meaning on or after the day the patient is due to arrive in hospital (which may be before the day of surgery), and not rescheduled within 28 days.
Cash limit	A body's approved limit on cash for a given year.
Commissioning a Patient-led NHS	A Department of Health paper outlining a policy change in the way healthcare services are commissioned. The number of Strategic Health Authorities and Primary Care Trusts were reduced and the main function of Primary Care Trusts changed from providers to commissioners of healthcare services. The aim was to move from an NHS service that does things to and for its patients to one that is patient-led.
Comprehensive Spending Review (CSR)	The process where budgets for government departments are set for a three year cycle.

Elective admission	A planned, non-emergency admission.
NHS Foundation Trusts	NHS Foundation Trusts are autonomous organisations, free from central Government control, but provide healthcare according to the core NHS principles of free care, based on need and not ability to pay. They decide how to improve their services, and can retain surpluses or borrow money to support these investments. They also aim to establish strong links with their local communities, for example through local people becoming members and governors, and hence to shape their healthcare services around local needs and priorities. They are authorised and regulated by Monitor.
NHS Plan	Initiated in 2000 by the Department of Health, this is a ten-year strategy for investment and reform in the NHS.
NHS programme funds	Resources for specific central NHS programmes such as workforce training and education. These funds are not allocated to individual Primary Care Trusts, but retained and allocated by Strategic Health Authorities.
NHS Trusts	Organisations responsible for running hospitals and providing secondary healthcare.
NHS Summarised Accounts	Accounts showing the consolidated financial performance of NHS organisations. There are three sets of accounts, showing the consolidated performance of Strategic Health Authorities, Primary Care Trusts and NHS Trusts respectively.
Monitor	The Independent Regulator of NHS Foundation Trusts, responsible for authorising, monitoring and regulating NHS Foundation Trusts. It is independent of the Department of Health and accountable to Parliament.
Non-elective admission	An unplanned hospital admission (i.e. emergency or urgent), not previously arranged.
Our NHS, Our Future	A review of the way NHS delivers patient care, led by Lord Darzi.
Payment by Results (PBR)	A funding system designed to ensure that NHS finances are deployed directly in line with patient treatment. It requires Primary Care Trusts to pay service providers based on a nationally agreed tariff for actual activity undertaken, rather than fixed-price block contracts.
Private Finance Initiative (PFI)	A policy introduced by the Government in 1992 to harness private sector management and expertise in the delivery of public services, while reducing the impact of public borrowing.
Practice Based Commissioning (PBC)	A new system whereby individual or groups of general practices directly commission healthcare using their own budgets. Primary Care Trusts will oversee this process.
Primary Care Trusts (PCT)	The bodies responsible for assessing the need for healthcare provision, planning and commissioning health services and improving health.
Primary Care Trust allocations	Funding received directly by each Primary Care Trust, to deliver healthcare according to local and national priorities.
Productivity	The relationship between production of an output and one, some, or all of the resource inputs used in accomplishing the assigned task. It is measured as a ratio of output per unit of input.

Programme budgeting	A retrospective analysis of NHS expenditure across 23 categories based on major disease types.
Regularity	A fundamental requirement that resources granted by Parliament may only be used for their authorised purpose, within the revenue, capital and cash limits agreed. 'Irregular' expenditure results in a qualified regularity opinion on the body's statutory accounts. It applies to Strategic Health Authorities and Primary Care Trusts, but not to NHS Trusts or Foundation Trusts.
Resource Accounting and Budgeting (RAB)	A system of accounting and budgeting that applies to Government the principals of accruals accounting that are universal in the commercial world. It is based on expenditure incurred and income earned in an accounting period, rather than cash payments and receipts.
Revenue limit	A body's approved limit on revenue expenditure for a given year, applicable to both Strategic Health Authorities and Primary Care Trusts.
Statutory duty	A duty set out in the relevant legislation.
Strategic Health Authorities (SHAs)	The bodies responsible for performance-managing the Primary Care Trusts and NHS Trusts within their area. There are currently 10 Strategic Health Authorities.
Strategic Health Authority areas or economies	The aggregate of the Primary Care Trusts and NHS Trusts within a Strategic Health Authority's geographical catchment area, including the Strategic Health Authority itself.
Total available resources	The total funding available to the NHS in any financial year.
Top-slicing	The process whereby a proportion of funds included in Primary Care Trust allocations are withheld by the Strategic Health Authority.
True and fair	The audit opinion which confirms that the accounts are free from material error and material bias.
Turnaround	A programme implemented by the Department of Health in which "turnaround teams" are deployed to the most financially challenged NHS Trusts. The aim is to support the NHS in identifying opportunities to deliver services with greater cost-effectiveness and to make financial savings. The teams bring together specialists from the NHS and independent sector to provide more locally focused support than the existing performance management systems.

ENDNOTES

1 The term gross deficit is used to refer to the sum of the deficits reported by individual NHS organisations. The term gross surplus is similarly defined. The terms net deficit and net surplus are used to refer to the aggregate overall financial position.

2 All references to NHS financial standing exclude the performance of NHS Foundation Trusts, unless stated otherwise. This report examines revenue performance, not capital.

3 Gross surplus and gross deficit sums to a net surplus of £514 million, not to £515 million, due to rounding. In addition, three NHS organisations delivered a breakeven position for 2006-07.

4 A 'fair shares basis' means in accordance with the weighted capitation population.

5 It is not possible to map four Primary Care Trusts in the turnaround programme in 2006-07 to their 2005-06 predecessor organisations. As a result, the 2005-06 figure of £1,121 million represents 100 turnaround organisations, and all figures quoted for 2006-07 onwards represent the 104 organisations.

6 Health Committee, *Public Expenditure on Health and Personal Social Services, November* 2007

7 King's Fund Briefing, *18-week waiting times target: an update,* August 2007

8 Healthcare Commission, *The Annual Health Check 2006/2007*, October 2007

9 Ibid.

10 See paragraph 2.4 for methodology. The correlation was determined by performing an analysis of variances on the data. The correlation was determined to be significant at the one per cent level.

11 Department of Health, *the quarter*, August 2007

12 Audit Commission, *Review of the NHS financial year 2006/07*, October 2007

13 Department of Health, *The NHS Plan, A Plan for Investment, A Plan for Reform*, July 2000

14 Department of Health, *Commissioning a Patient-led NHS*, July 2005

15 Department of Health, *The NHS in England: The operating framework for 2006/07*, January 2006

16 As reported in Healthcare Commission, *The Annual Health Check 2006/2007*, October 2007

17 Our analysis covers only those organisations that received a quality rating as part of the Healthcare Commission's Annual Health Check. It therefore excludes Foundation Trusts, as their ratings were determined by Monitor.

18 Audit Commission, *Learning the Lessons from Financial Failure*, July 2006

19 King's Fund Briefing, *NHS Finances 2006/7*, August 2007

20 Audit Commission, *Review of the NHS Financial Year 2006/07*, October 2007

21 In the quarter one performance report, the Department reported that it expects the gross deficit for 2007-08 to be reduced to £204 million. Department of Health, *thequarter,* August 2007

22 Department of Health, *NHS Financial Performance Quarter Four 2006-07*, June 2007

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