

Chief Executive's Report to the NHS

June 2006



DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document purpose	For Information
Gateway reference	6684
Title	Chief Executive's Report to the NHS: June 2006
Author	DH
Publication date	7 June 2006
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , NHS Trust Board Chairs, Special HA CEs, Communications Leads
Circulation list	Local Authority CEs, NDPBs, Voluntary Organisations
Description	This report describes activity in the NHS over the past year including information on financial performance
Cross reference	Chief Executive's Report to the NHS: December 2005 Chief Executive's Report to the NHS: May 2005
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact details	Performance and Delivery Team Department of Health Quarry House, Quarry Hill Leeds LS2 7UE
For recipient's use	

Chief Executive's Report to the NHS

June 2006

Contents

Foreword from Sir Ian Carruthers OBE, Acting NHS Chief Executive	2
Chapter 1: Faster access to NHS services	4
Chapter 2: Saving lives	8
Chapter 3: Improving health and improving healthcare	10
Chapter 4: Health reform to support delivery of a patient-led NHS	13
Chapter 5: Workforce	16
Chapter 6: NHS financial performance	18

Foreword from Sir Ian Carruthers OBE, Acting NHS Chief Executive

The NHS is at a crucial point in its journey to becoming a truly patient-led service. We are half way through the ten-year programme of investment and reform that was launched with the NHS Plan, and this report shows how far we have come in the first five years. Although there are challenges ahead, this audit of activity within the NHS shows we are not only delivering more and improved health services, but also a much better quality of care for patients. I pay tribute to the commitment, determination and innovation of all those staff within the NHS who have helped make this possible. Thank you.

If you ask ordinary people about their personal experience of the National Health Service, it is usually very positive. Yet if you ask them about the overall state of the NHS, they are less satisfied. This may be due in part to the recent publicity around NHS finances and job losses. The last few months have certainly been challenging. Financial problems are being addressed in a significant minority of organisations; the reconfiguration of Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and Ambulance Trusts has taken time and effort; and we are continuing to press ahead with implementing our health reforms.

Nevertheless, we should not forget the wider picture. We must remember that people come first, and that is why there is an absolute determination across the service to get the best possible care and treatment for patients. The achievements of the last five years are impressive. By next year, spending on the NHS will have trebled in a decade, and whilst increases of this scale are not sustainable in the long-term, the extra resources are already making big differences everywhere. This is demonstrated throughout this report, and provides us with a strong foundation on which to build.

Waiting times are shorter than ever. Most people who need surgery are in hospital within nine weeks, four out of five people get a first outpatient appointment within eight weeks, and almost everyone going to A&E is seen within four hours. Meanwhile lives are being saved through reductions in deaths from cancer, circulatory disease, coronary heart disease and suicides. Investment has also made a big difference to stroke services, diabetes, mental health, and the care of the elderly.

There is a financial blot on the landscape, but we should put it in perspective. The unaudited deficit for 2005/06, just over £500 million, represents less than one per cent of the annual NHS budget. More than two-thirds of this sum was accounted for by about one-tenth of all NHS organisations. This does not excuse the overspend in individual cases and it is essential that the deficits are vigorously tackled. It is imperative that we now focus on three things:

- First, by the end of 2006/07, restoring the NHS to net balance. A lot of hard work is going on throughout the country to achieve this.
- Second, deploying teams of turnaround experts to help those organisations facing the biggest financial challenges.

- Third, through improving patient care and outcomes, continuing to deliver high-quality NHS services. This means concentrating on improving productivity, through greater workforce efficiency, enhanced clinical effectiveness, and smarter procurement.

I accept this may mean workforce reductions in some parts of the country. Uncertainty about employment is difficult for anyone, and I sympathise with any member of staff affected. However, much of the adverse comment in media quarters is not based on fact, but derived from extrapolations of anecdotal evidence, or inaccurate press reports.

A recent survey by NHS Employers showed that while some Trusts are planning redundancies, many others are using alternative methods to reduce their workforce spend – such as freezing posts, redeploying staff, redesigning roles, and reducing the use of expensive agency employees and temporary workers. The bottom line is that compulsory redundancies will be kept to an absolute minimum.

Contrary to what our critics claim, reform is not the reason for the overspend or the jobs losses, it is the solution. The reforms are introducing greater financial transparency – in some cases uncovering problems hidden for years – and providing incentives to ensure that the NHS can return to financial balance. They are also providing more benefits to patients, through greater choice, more personalised services, and new ways of working. As we set out in the recent White Paper on out-of-hospital care, we are gradually shifting more services closer to home in a safe and convenient setting, which is what the public tell us they want.

It is therefore essential we press ahead with the reforms, including developing our innovative partnerships with the private sector. We should see the increasing involvement of independent providers as complementary rather than controversial to the NHS, because patients will need the extra capacity and choice they bring as public demand for our health services develops.

There is a lot happening in the NHS that is worthy of praise, and I am proud to draw attention to it. At the same time, we should not underestimate the challenges that remain. We must get a grip on financial recovery, continue to improve patient care, and embed and accelerate the reforms. Throughout, it is essential that the Department of Health listens to the NHS and hears from those facing hard times. Everyone – whether manager or clinician, staff or supplier, patient or politician – wants even better health services. From my experience, I believe that the right environment is now in place to tackle the difficult issues and build a health service fit for the future.

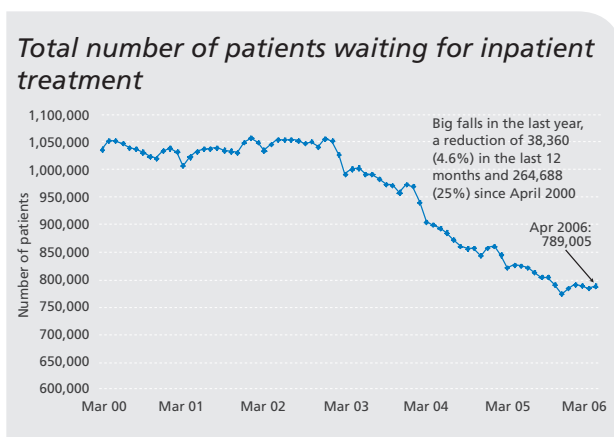


Sir Ian Carruthers OBE
Acting NHS Chief Executive

Chapter 1: Faster access to NHS services

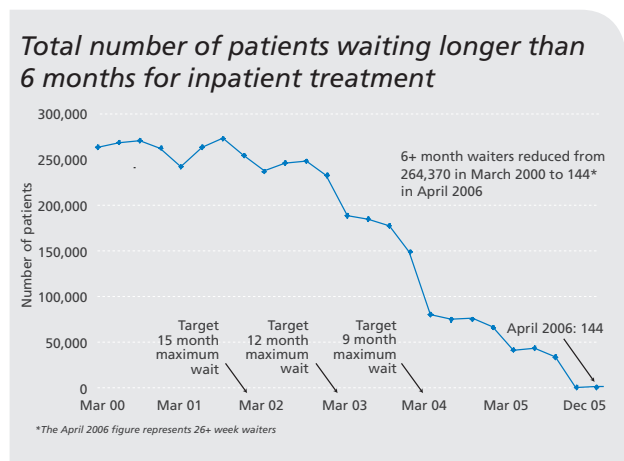
Patients can now expect faster access to NHS services than ever before and waiting times are at an all time low. This is the result of a programme of increased investment and reform, and the introduction of new services making accessing the right care at the right time easier for patients. Performance across some of the wide range of NHS services is set out below. These achievements are a direct result of the hard work of all those working in the NHS.

Inpatient access



- 1,050,000 patients waiting in 2000
- 790,000 patients waiting today
- This represents a reduction of 25% in the last six years
- Numbers are continuing to fall
- 5,700,000 general and acute elective admissions in 2005/06

- Over 270,000 patients waiting over six months in 2000
- Today patients can now expect a maximum six month wait
- The average wait is much shorter – currently 7.6 weeks
- There has been a reduction of more than 25% in cancelled operations since 2001/02 – this means that almost all (99%) operations are carried out on their planned date



Outpatient access

Total number of patients waiting longer than 13 weeks for an outpatient appointment

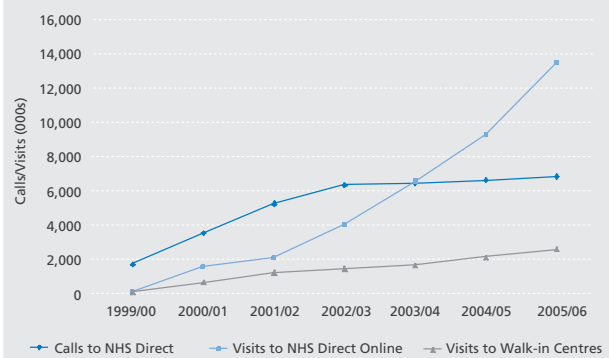


- Four of the seven new Commuter Walk-In Centres have opened since November 2005 at Manchester Piccadilly, London Liverpool Street, Canary Wharf and Newcastle, offering patients increased choice and an easy and convenient way to access NHS services – the other three will open by the end of 2006
- An increase in usage of NHS Walk-In Centres of over 21% during 2005/06
- There has been a record number of calls received by NHS Direct – 6.8 million during 2005/06

- Patients can now expect a maximum 13 week wait
- The average wait is much shorter – currently 6.1 weeks
- Over 83% of outpatients are waiting under eight weeks

Increased use of new services

Greater use of new services convenient to patients



“I visited Leeds NHS Walk-In Centre (WiC) after two days of earache. I wasn’t registered with a local GP and was already at work so the WiC was ideal for me. Within 20 minutes of walking through the door I was seen by a doctor and diagnosed with an ear infection. She consequently prescribed me some antibiotics which I collected from the onsite pharmacy and was back in work within a couple of hours.”

Quote from a patient visiting Leeds NHS Walk-In Centre

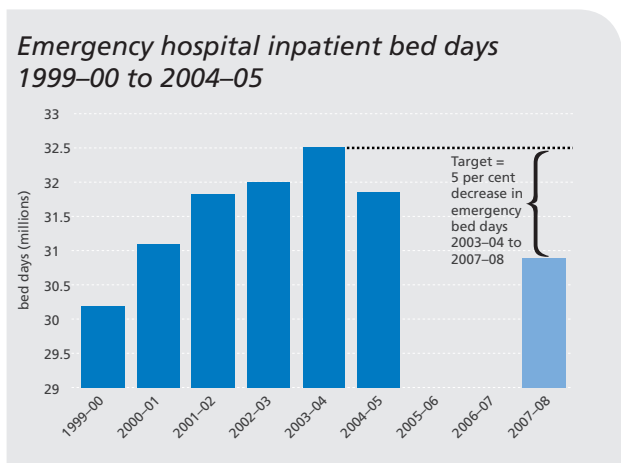
Primary care access

Ninety percent of all NHS consultations take place in primary care and PCTs report that almost all patients can now see a GP within 48 hours. However a gap remains between what PCTs report and what patients say. While PCTs report close to 100% success, patient surveys typically show that 80-90% of patients either see a doctor within two days or choose to wait longer.

The seven-point patient access “guarantee” launched in September 2005 has become the driving force behind the new access Directed Enhanced Service. Practices will be rewarded on the basis of what their patients think about the access the practice has provided – an important step in ensuring that practices respond to what their patients want.

Management of long term conditions in primary care

- On target to reduce emergency bed days by 5% by 2008 – this can only be achieved by ensuring that care is rooted in primary care settings and underpinned by new partnerships across the whole health and social care spectrum
- In March 2006, over 1,000 NHS community matrons and 800 other case managers were providing support to around 45,000 people with the most complex healthcare needs
- A guide was published in February this year to support people with long term conditions to self care



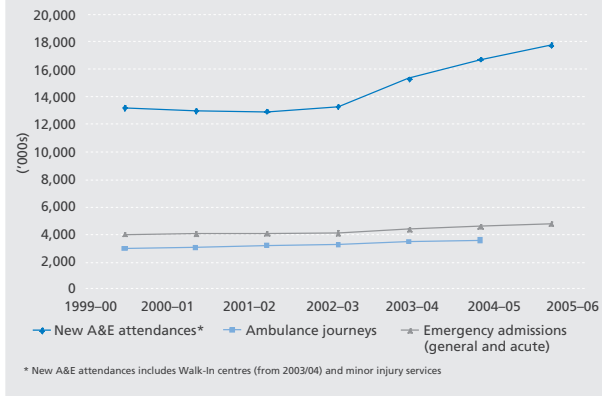
“The White Paper has set out our route map for the future of community services. Some of the key recommendations – particularly around shifting more care into community settings – will bring about massive changes to the way the NHS works, but more importantly to patients’ experiences of it. This shift will contribute to the delivery of the maximum 18 week patient pathway by 2008. By making better use of the wide range of expertise in the NHS and by giving patients choice we are increasingly seeing more care provided to patients in settings that are more convenient for them.”

Dr David Colin-Thomé, National Clinical Director for Primary Care and National Clinical Adviser for the 18 week programme, Department of Health

Emergency care

- Performance across emergency care continues to be sustained despite dealing with increases in demand
- Nationally between April 2005 and March 2006, 98.2% of patients spent less than four hours from arrival to admission, transfer or discharge in all types of accident and emergency (A&E) services, exceeding the operational standard
- 76.2% of category A (immediately life threatening) ambulance calls were responded to within 8 minutes during 2004/05

Increased demand for emergency care



"I visited the department three times within two weeks. Although I saw a different doctor each time, the first two doctors I saw both came to find out how I was on my third visit, they were very caring. Overall I was very impressed. I had never been to A&E before and it wasn't at all like I imagined."

Quote from a patient visiting Royal Surrey County Hospital Accident and Emergency Department

Next steps

By the end of 2008, patients will be able to expect a maximum wait of 18 weeks from GP referral to hospital treatment. Most patients will be treated more quickly. This is one of the most significant reforms in the history of the NHS and it will significantly improve the patient experience.

The NHS must move away from traditional ways of working and radically redesign services to remove any unnecessary delays and eliminate hidden waits. For example, much time can be saved by synchronising diagnostic tests where appropriate.

This is ambitious. Waiting times for diagnostic tests have never been measured before. The first step in eliminating these hidden waits is to be able to measure them. The NHS has begun measuring this for the first time this year, in order to establish a complete picture of how long patients are waiting now so that we know the true scale of the challenge involved in delivering a maximum 18 week wait by 2008.

Publication of this data will focus attention on diagnostics as never before and some of the data will show long waits for some diagnostic tests in some areas. This is a necessary and important first step on the road to delivering the 18 week pathway. For the first time in the history of the NHS, the way we measure waiting times is changing and the entire patient journey will be measured as one.

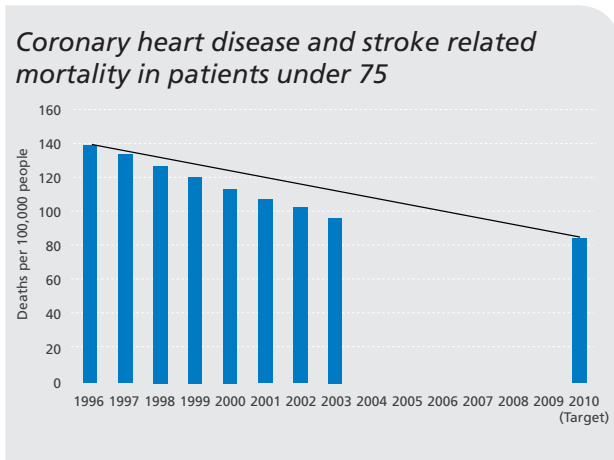
It will not always be appropriate for a patient to access consultant-led, hospital services in order to be treated. The 18 week maximum wait complements the recent White Paper *'Our Health, Our Care, Our Say'* which set out a series of measures to improve services provided to patients in a community setting.

It is important to ensure we modernise the way in which care is provided, as well as reducing waiting times. Combined, these reforms will mean that patients get the right care, at the right time, in a place convenient to them.

Chapter 2: Saving lives

The NHS is continuing to make advances in the quality of care it offers to patients who are diagnosed with serious diseases. Mortality rates from both cancer and coronary heart disease are falling and are both on course to meet the goals set out in the NHS Plan to improve these specialist services for patients.

Coronary heart disease services

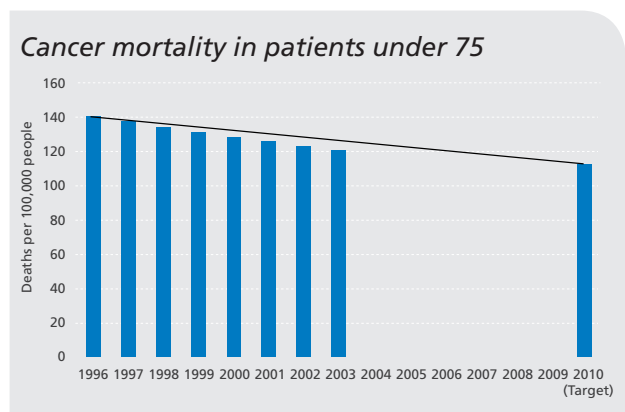


- The NHS is on track to deliver a 40% reduction in the cardiovascular disease (CVD) mortality rate for people under 75 by 2010
- Quality of care continues to rise following the introduction of the Quality and Outcomes Framework (QOF) which measures how PCTs care for their local patients with CVD

Cancer services

- The mortality rate for people under 75 diagnosed with cancer has fallen by almost 14% – meaning 43,000 lives have been saved since 1997
- Nearly 99% of people with cancer are treated within 31 days of diagnosis and over 91% are treated within 62 days of being urgently referred by their GP
- Over 99% of people with suspected cancer are seen by a specialist within two weeks of being referred urgently by their GP – this figure was 63% in 1997

- PCTs are on average achieving 95% of available CVD Quality Indicator Points in the QOF
- ‘Chapter 8’ of the National Service Framework for coronary heart disease is beginning to be implemented across the NHS to cover arrhythmias and sudden cardiac death to further reduce the number of deaths from CVD
- A growing number of Trusts are now offering rapid access services for Transient Ischaemic Attacks (or ‘mini strokes’), and more centres are introducing thrombolysis for acute stroke
- Specialist stroke services are now offered nationwide following publication of the Older Peoples National Service Framework



- Over 600,000 more women aged 65 to 70 have been invited for breast screening since 2001 due to expansion of screening services
- The number of consultants treating people with cancer has increased by 45% in just over 10 years
- Over 1,200 pieces of new modern equipment have been delivered to diagnose and treat cancer since 2001

“Since the *Cancer Plan*, doctors and nurses caring for patients have been able to improve the quality of care and offer better treatments faster to improve patients’ lives. We have developed multidisciplinary teams (which many other countries do not have) which meet to agree the best treatment for patients and by doing so deliver high quality care. We have more specialist nurses and key workers to help and support patients and their carers as they move through their journey.

Finally we have been able to work with patients to improve the services we offer.”

Dr David Levy FRCP, FRCR Clinical Oncologist, Weston Park Hospital, Sheffield Teaching Hospitals NHS Foundation Trust

Chapter 3: Improving health and improving healthcare

In 2004 the Department of Health produced *Choosing Health: Making Healthy Choices Easier*, setting out the role of the NHS in the prevention of illness as well as cure by making it easier for people to make healthier choices and offering them practical help to adopt healthier lifestyles. *Choosing Health* laid out a challenging programme of practical action aimed at saving thousands of lives in years to come. *Choosing Health* highlights action over six key priorities for delivery based on more people making healthy choices:

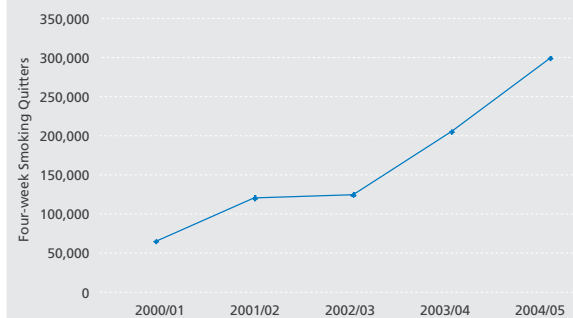
- tackling health inequalities
- reducing the numbers of people who smoke
- tackling obesity
- improving sexual health
- improving mental health and well-being and,
- reducing harm from alcohol and encouraging sensible drinking.

Even before the report was published the NHS was committed to improving the health of the population and this work has continued at pace.

Reducing the number of people who smoke

- Since *Choosing Health* (November 2004) the NHS has helped over 350,000 people give up smoking at four weeks and this continues to rise
- Over 225,000 calls have been received by the smoking cessation helpline since January 2005
- By the end of 2006 the NHS as an organisation will be smoke-free
- The NHS is anticipating an increased demand for cessation services in the build up to the nationwide ban of smoking in public places from 2007 – the service is preparing to meet this need

Number of smokers who had successfully quit at four weeks follow-up through NHS Stop Smoking Services



Kirsty decided to go along to her local NHS Stop Smoking Service in Poole, where a cessation adviser, Kay, took her through the various stages of giving up, from planning to quitting (using Zyban) to dealing with withdrawal symptoms.

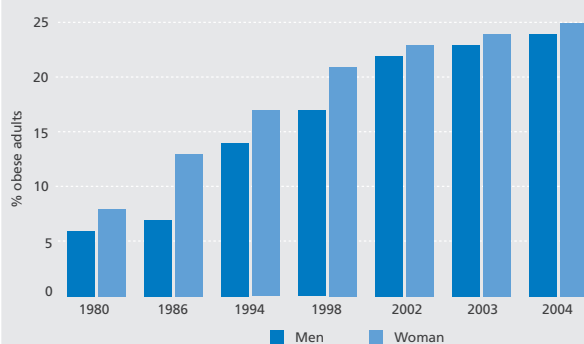
"The Stop Smoking Service made a huge difference compared with other times when I had tried to give up on my own. Kay is very bubbly and fun, so going to my stop smoking appointments with her was more like going to see a friend to get some advice."

Quote from Kirsty in Poole who has benefited from improved smoking cessation services

Tackling obesity

- Obesity continues to rise posing serious concerns over its long term impact on the health of the population as research shows that it is strongly linked to increased risks of stroke, angina, heart attacks and type 2 diabetes
- A new *Obesity Bulletin* was launched in May to provide six-monthly updates on the latest developments in the fight against obesity to a range of key stakeholders, including SHAs, PCTs, and Local Authorities
- At the beginning of May, SHAs, PCTs and GP Practices were sent copies of the *Obesity Care Pathway* which provides evidence based guidance to support primary care clinicians in identifying and treating children, young people and adults who are overweight and obese
- 100,000 pedometers have been distributed to inactive adults across the country – in addition to 9,000 distributed to

Increase in the percentage of Men and Women who are obese



Heights and weights of adults in GB, 1980; Dietary and Nutritional Survey of British Adults, 1986; Health Survey for England, 1991–2004

school children as part of a pilot scheme – encouraging both groups to exercise

- This year, a network of NHS Health Trainers have started working in the Spearhead PCTs (the bottom 20% of PCTs in terms of health and deprivation indicators) to help people from different communities on a variety of different health issues, including obesity, but all with the intention of improving lifestyle behaviour

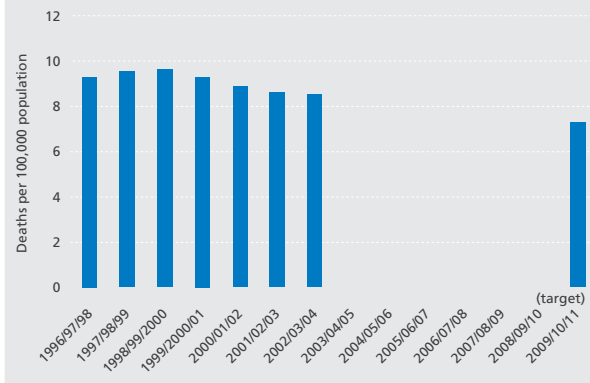
Alan was referred to the Bolsover Wellness Scheme late last year by his GP. His weight had crept up to more than 114kg (18st). "I was very limited physically and because of your limitations you bang the weight on. I was in my 50s and feeling like damaged goods, but having someone to encourage me has helped me build up until I'm doing things I never thought I could." He now attends Creswell Leisure Centre three times a week and is supported by Jane Holland, an NHS Health Trainer who offers encouragement and advice.

Quote from Alan, a patient who has benefited from the services of an NHS Health Trainer

Increasing quality in mental health care

- The rate of suicide in England is now at its lowest since records began
- NHS and Local Authority expenditure on Mental Health has increased by 25% in real terms between 2001/02 and 2005/06
- During 2005/06, crisis and home treatment teams provided 84,000 episodes of home treatment for people who would otherwise have been admitted to hospital
- At the end of March 2006, around 19,000 people were receiving care from assertive outreach teams, an increase of 7% on the previous year
- There are now 50% more Consultant Psychiatrists, 75% more Clinical Psychologists and 20% more Mental Health Nurses than in 1997

Decreasing death rates from intentional self harm and injury from undermined intent



Ann, from Doncaster, has suffered from depression. Two years ago, her GP recommended that she underwent a course of cognitive behavioural therapy (CBT). Because of the therapy, Ann has been able to come off her medication and today uses the techniques she has learned to maintain her mental well-being.

“Psychological therapy has made a huge difference to my life and basically helped me to keep functioning. CBT involves helping yourself by recognising and challenging negative thoughts. It is now very much part of my every day existence and has helped me to get an entirely new, far more positive outlook on life.”

Quote from Ann, a patient in Doncaster who has benefited from improved mental health services

Chapter 4: Health reform to support delivery of a patient-led NHS

As this report demonstrates, recent years have seen substantial improvements in our health services. These improvements are down to the commitment and creativity of NHS staff and record levels of investment.

But we need to do more to make the long-lasting improvements that everyone wants for the NHS. Services should be continually improving not because they are meeting nationally set targets, but because they are listening and responding to patients, carers and local communities.

Health reform which embraces the following gives the NHS the structure, support and culture to do this:

- *Greater choice for patients and stronger commissioning*
Patients and service users are given a greater say and more choice over where and when they receive their NHS care, and effective commissioners will support patient choice and the development of more responsive, patient-centred services.
- *A wider selection of providers and more freedom for staff*
For choice to be meaningful, there needs to be a wider range of high-quality, convenient and personalised services for patients to choose from and NHS staff should be encouraged to innovate, improve care and the patient experience.
- *Money following the patient*
The money to pay for treatment follows each patient to the organisation they have

chosen – so the best providers thrive and those that are unresponsive or wasteful are encouraged to improve.

- *Safe, fair and high-quality care*
This will all happen within a clear set of rules and standards so patients are guaranteed safe, fair and high-quality NHS care, wherever they choose to receive it.

What we have done so far

The NHS has already started to embed these changes. Examples include:

- Since January 2006 patients have been offered a choice of at least four hospitals when referred for hospital treatment. They now have a wider selection of providers to choose from, including 41 NHS Foundation Trusts (including Mental Health Trusts) and 19 Independent Sector Treatment Centres, introducing an incentive for providers to respond better to the needs of their patients.
- From April 2005, practices have been able to receive an “indicative budget” from Primary Care Trusts (PCTs) that they can use to improve the delivery of services through Practice Based Commissioning (PBC).
- We have decided on the new configuration of SHAs, PCTs and Ambulance Trusts to ensure that the NHS can commission the very best services for their local people from a wider range of providers, deliver the very best value for money, and address health inequalities.

- The Payment by Results (PbR) system, where money follows the patient, has been extended to cover electives, non-electives, A&E and outpatients in hospitals. A PbR code of conduct and assurance framework has been put in place to ensure providers and commissioners work together for the maximum benefit of patients.
- In primary care, where most NHS care is provided through contracts with GPs, we have agreed new contractual arrangements which have improved quality and access, for example through the Qualities and Outcomes Framework (QOF).

What we still have to do

There are a number of important steps still to take and further implementation of reform is an important priority for the NHS this year.

- There will be further steps towards the implementation by 2008 of Free Choice, where patients referred to hospital will be able to choose from any approved provider in England.
- All PCTs are now committed to having arrangements in place for universal coverage of practice based commissioning by December 2006. PCTs will provide practices with indicative budgets covering (as a minimum) prescribing and the services covered by PbR, benchmarking information about their patients' use of services, the offer of support and an incentive payment, and agree a clear accountability and governance framework within which PBC will operate.
- The Government is committed to giving all NHS providers the opportunity to become NHS Foundation Trusts (NHSFT), with further waves of applicants over

the coming months and a support tool being rolled out to all NHS Trusts, to help them identify what they need to do to become NHS Foundation Trusts by 2008. Independent Sector capacity will also continue to increase with Wave 2 adding a further 250,000 procedures to NHS capacity.

- Following the recent reconfiguration of NHS organisations, all PCTs will take part in a development programme – similar to that for assessing NHS Trust preparedness for NHSFT status – to ensure they are strong organisations able to drive forward health reforms, including commissioning the very best services.
- Publishing a commissioning framework which will enable best practice commissioning to be introduced so local patient needs are met by their PCTs.
- PbR will continue to be expanded, operating at present in shadow form for adult critical care, and being piloted for mental health next year. £22bn worth of services will be covered by PbR in 2006/07, compared to £9bn in 2005/06. PbR is expected to be fully implemented for acute services commissioned from NHS Trusts and Foundation Trusts by the end of 2008/09.

Stakeholder and clinical engagement

Alongside the implementation of the reforms, further policy development is underway to extend the levers for self-improvement across health and social care. While the current reach of reform incentives is well underway in the commissioning and provision of hospital services, the fuller programme of reform will take several years to embed.

Reference groups have been established for each of the main areas of policy development, drawing upon expertise from across health and social care and stakeholder organisations.

Further editions to the *Health Reform in England* documents will be published during Summer 2006 and will be available on the Department of Health website at:

<http://www.dh.gov.uk/HealthReform>

- Health Reform in England: Update
- Health Reform in England: Framework for future of provider reform
- Health Reform in England: Framework for commissioning, PBC and national contract template for 2007/08, this includes
 - Model contracts for commissioning
 - Strengthening commissioning – case studies and good practices
- Health Reform in England: Framework for management and regulation of the healthcare system
- Health Reform in England: Framework for future workforce development

Chapter 5: Workforce

Investment and reform

The NHS spends around 60% of its budget on its workforce and much of the extra funding received has gone towards an expansion in the workforce. This has contributed to a reduction in waiting times, improved access to services and high quality treatment and care.

More staff have been appointed and trained. Staff contracts have been reformed and new structures and roles give staff greater opportunity to develop and progress.

Workforce expansion

The extra investment in staffing has been targeted at staff directly involved in patient care, whether as qualified people – physiotherapists, nurses, doctors, scientists or the like – or in the increasing numbers of helpers and assistants – nurse auxiliaries, care assistants, phlebotomists and others.

As a result of increases in training places, and national and local recruitment and retention initiatives, we have more staff working in the NHS than ever before. In September 2005, over 1.3 million people were employed in the NHS, an increase of over 307,000, or 29%, since 1997. Between September 1997 and September 2005, the total number of doctors employed in the NHS increased by over 32,700 and the number of NHS nurses by 85,300.

We are now moving away from year-on-year growth in the NHS workforce to more of a steady state where there

is a closer match between demand and supply. We expect workforce growth to stabilise over the next few years.

A number of NHS Trusts are reducing posts this year as a means of generating savings to reach financial balance and provide better value for money. Trusts are managing reductions through expected turnover, recruitment freezes, reducing the use of agency staff and redeploying staff in different ways. Trusts are planning to keep compulsory redundancies to an absolute minimum.

Employers recognise the need to handle workforce reductions sensibly and to ensure opportunities are also available for new nursing and medical graduates. NHS Employers are working with NHS Trusts to share best practice. Overall, these changes are not just a result of local financial deficits, but are a reflection of increases in productivity due to more technology and better, more streamlined working practices.

New Ways of Working

The *'Our Care, Our Health, Our Say'* White Paper published in January 2006 puts the focus on having the right workforce in place to deliver personalised services. There will be a shift of staff from the acute sector into the primary care sector as more care is undertaken in a community setting in order to deliver this goal. The public tell us that this is what they want and it is the right thing to do when it delivers better patient care with better value for money.

Investment in the NHS supports new ways of working which, together with the new IT systems and the spread of best practice, are leading to service improvements and better value for money.

There is more that the NHS can do to improve efficiency in terms of strengthening frontline capacity through increases in productivity and skill mix and reducing spend on agency staff. Where Trusts are adopting best practice, it is frequently the case that more patients can be treated with the same or less staff. Efficient Trusts are already doing this by using their staff resources to the full. Trusts are seeking to re-organise services and make better use of facilities including increasing the amount of surgery undertaken as daycases, taking steps to reduce delayed discharges and length of stay.

Chapter 6: NHS financial performance

Introduction

The annual revenue allocation to the NHS in 2005/06 was £66.6 billion.

The unaudited draft accounts report a net revenue overspend across the NHS (excluding NHS Foundation Trusts) in 2005-06 of £512 million. The net revenue overspend represents around 0.8% of the revenue resources available to the NHS. The increase in resources for the NHS in 2005/06 was £5,543 million, or 9.1%.

The deficit is the net result of gross deficits of £1,277 million and gross surpluses of £765 million. The net deficit has increased on a like for like basis – excluding organisations that are now NHS Foundation Trusts – from £216 million in 2004/05.

Returning to financial balance

We expect the NHS to have returned to net financial balance in 2006/07. In addition, we are aiming for all overspending organisations to have monthly balance of income and expenditure, ('run rate' balance), by the end of 2006/07.

There will however be some exceptional cases where an organisation cannot achieve run rate balance in 2006/07 without an undue impact on patient services.

However, where one organisation overspends, an organisation elsewhere in the system needs to underspend for the NHS as a whole to be in financial balance. It is important, therefore, that organisations return to financial balance as quickly as possible.

Geographical spread of performance

The table below shows the financial performance of SHAs over the last three years.

TSHA	2003/04 final a/cs surplus/ (deficit)		2004/05 final a/cs surplus/ (deficit)		2005/06 month 12 surplus/ (deficit)		2005/06 improvement/ (deterioration)	
	£m	% turnover	£m	% turnover	£m	% turnover	£m	% turnover
North East	10	0.3%	22	0.6%	20	0.5%	(2)	0.0%
North West	28	0.3%	47	0.5%	58	0.6%	11	0.1%
Yorks and The Humber	15	0.3%	35	0.6%	36	0.5%	2	0.0%
East Midlands	16	0.4%	15	0.3%	(11)	-0.2%	(26)	-0.5%
West Midlands	9	0.2%	(19)	-0.3%	(36)	-0.5%	(17)	-0.3%
East of England	(5)	-0.1%	(144)	-2.4%	(214)	-3.3%	(70)	-1.1%
London	19	0.2%	(82)	-0.8%	(168)	-1.5%	(86)	-0.8%
South East Coast	(10)	-0.2%	(35)	-0.7%	(89)	-1.7%	(54)	1.0%
South Central	1	0.0%	(45)	-1.1%	(58)	-1.3%	(12)	-0.3%
South West (inc AGW)	(10)	-0.2%	(13)	-0.2%	(49)	-0.8%	(36)	-0.6%
NATIONAL TOTAL	73	0.1%	(221)	-0.4%	(512)	-0.8%	(291)	-0.4%

The biggest financial problems are concentrated in the South and East of England.

The East of England SHA had the largest deficit in absolute terms (£214 million) and in percentage terms (3.3% of turnover).

Concentration of financial problems

The majority of the deficit is in a minority of organisations – 70% of the gross deficit is in 11% of the organisations. The concentration of the deficits is shown in the table below.

Concentration of deficits

Cumulative % of gross deficit	Gross deficit £m	Number of organisations	% of all NHS organisations
50	639	35	6
60	772	48	9
70	896	63	11
80	1,025	83	15
90	1,150	109	19
100	1,277	174	31

The majority of organisations are delivering substantial service improvements and living within their budget.

Causes of the deficits

There is no single cause of financial problems. The provisional analysis shows that there is very little correlation between the size of deficits and any of the factors relating to funding – including allocations per head, and increases in allocation.

Similarly, the analysis suggests there is no trade-off between managing within the budget and improving the quality of patient care. There appears to be no significant relationship between deficits and the Healthcare Commission ratings, and there is no evidence that organisations need to overspend to deliver improved access.

The concentration of deficits is largely in organisations that overspent in the previous year – see table below.

Organisations in deficit in 2003-04 to 2005-06

	2005/06 Deficit	
	£m	Number of Organisations
All organisations in deficit in 2005–06	(1,277)	174
Organisations in Deficit 2004–05 and 2005–06	(1,006)	116
Organisations in Deficit 2003–04 and 2005–06	(571)	54

This reflects the fact that organisations that get into financial difficulties, and do not address these immediately, find it increasingly difficult to pull back the position as they face income reductions to recover prior-year deficits.

Action to improve the financial position

Just as there is no simple single cause of the deficits, there is no single simple solution. We are therefore approaching the resolution of the problems at a number of levels, as follows:

- *Within the Department of Health* we are improving the costing of key policy changes. We also continue to identify savings opportunities, particularly in the area of procurement.
- *Improving incentives* through, for example, the extension of practice based commissioning, payment by results, NHS Foundation Trusts and changes to the Healthcare Commission ratings.
- *Increasing transparency of financial performance.* It is clear that where we have financial problems these have not suddenly appeared but have been allowed to build up below the surface over a number of years until they reached a point

where they became unmanageable. More transparent financial reporting could have led to these problems being addressed sooner.

- *Giving organisations the space to recover.* As shown earlier in this report the biggest challenge we face is recovering those organisations that have built up problems over a number of years and are in a vicious circle of deficit followed by income reduction followed by bigger deficit. By giving SHAs the power to create local reserves they can offset the reductions in income caused by over-spending in 2005-06 and allow the organisations with the biggest problems to focus initially on in-year balance.
- *Getting the financial regime right.* Sir Michael Lyons and the Audit Commission are reviewing the NHS financial regime and will make recommendations designed to ensure that it supports a sound NHS financial system.
- *Supporting the identification and take up of best practice.* This includes the Integrated Service Improvement Programme, the Productive Time Programme, the publication of an agreed set of productivity metrics – covering clinical productivity, finance, workforce, prescribing and procurement – encouraging all organisations to benchmark performance; and publication and promulgation of best practice identified by the turnaround teams.

- *Providing support for those organisations with the most significant financial problems.* The Department of Health commissioned an independent baseline assessment by KPMG of 98¹ organisations with significant deficits, and in need of turnaround. Following the assessment, the organisations were categorised as follows:
 - Category 1: Immediate priority. Urgent intervention required to drive turnaround
 - Category 2: Additional expertise/resource needed to support turnaround
 - Category 3: Drive/focus. Maintain high priority of actions
 - Category 4: Encourage to share what works and deliver easy wins

Following the initial assessment, a National Programme Office (NPO) for turnaround was set up in February 2006. The role of the NPO is to provide co-ordination, review, monitoring and scrutiny of all turnaround projects within the cohort.

The turnaround organisations are now receiving tailored and specific support, as appropriate to their requirements.

¹ There are 102 (48 Trusts and 54 PCTs) statutory organisations within the Turnaround cohort but Ipswich PCT and Suffolk Coastal are under joint management and are treated as one organisation, as are Fareham & Gosport PCT and East Hampshire PCT, and three Cumbrian PCTs.



© Crown copyright 2006
275258 Ip 1k June 06 (CWP)
Produced by COI for the Department of Health

If you require further copies of this title quote 275258/Chief Executive's Report to the NHS and contact:

DH Publications Orderline
PO Box 777, London SE1 6XH
Email: dh@prolog.uk.com

Tel: 08701 555 455
Fax: 01623 724 524
Textphone: 08700 102 870 (8am to 6pm Monday to Friday)

www.dh.gov.uk/publications