Royal College of Nursing
Policy Unit – Room 209

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Introduction

This series of briefings on the source and impact of financial deficits in the NHS is designed to inform and engage all members working in environments where financial deficits are prompting changes to the configuration of services or employment.

If you have any comments on this guidance or further questions, you should feedback to your Regional Office in the first instance or contact us via email at deficits@rcn.org.uk.

Financial instability: The national picture

A number of sources have contributed to painting a picture of the NHS which shows well over a quarter of NHS organisations in England (including a third of Acute Trusts) have failed to break even at the end of the financial year 04/05.

For the financial year 05/06, RCN does not believe that this is improving and estimates 27% of all NHS Trusts (and approximately half of Foundation Trusts) will report an end of year deficit.

Our own review of public reporting of financial deficits by NHS organisations to RCN representatives shows an overall deficit of around **£840m in Acute Trusts, £48m in Foundation Trusts and £358m in PCTs – a total of £1.2bn**.

Alongside the financial picture, we have received details of a **reported loss approaching 4000 WTE posts from the NHS** - this figure does not include jobs which may be lost as a result of the changes described in RCN Policy Briefing 02/2005: Commissioning a Patient led NHS.

Across the UK, each country has experienced differing levels of growth in funding and expenditure but all have experienced significant increases. Figure 1 below show an outline comparison of each country's experience of increases in resource allocations over the last 7 years.

In terms of the experience of financial deficits, this is quite different from country to country as the rules governing expenditure are very different; vels 2nbDsorJf-0.n -1tur.0uk

Figure 1: Funding growth comparison for period 1999/2000 - 2006/7[1]

Country	*1999/00*	*2003/4*	*2005/6*	*2006/7*
England	£33.04bn	£61.3bn	£74.3bn	£83.8bn
N Ireland	£1.8bn	£2.9bn	£3.3bn	£3.75bn
Scotland	£5.16bn	£7.10bn	£8.62bn	£9.33bn
Wales	£2.98bn	£4.1bn	£4.87bn	£5.14bn

In Wales some Trusts and Local Health Boards are reporting deficits although total spending on health care will increase to £5bn in 2006/07 – this compares with the £2.98bn health budget which the Assembly inherited in 1999.

Several NHS Boards in Scotland are forecasting deficits for the current financial year. Audit Scotland produced a report called "Following the Public Pound" in December 2005 predicting a cumulative overspend of £91m with funding gaps in excess of £183m anticipated for 2006/7[2]. Boards are now required to produce savings plans to fill these gaps in funding and reduce expenditure.

In Northern Ireland the levels of deficit remain relatively small in comparison to England and tend to be short-term rather than structural, being managed through the manipulation of year-on-year budgets and through occasional financial assistance from the DHSSPS. There is an increasing shift in emphasis towards value for money in reviewing services which is impacting the distribution and organisation of services.

Whilst there are different experiences in each country, there is an overall trend which can be summarised as follows[3];

- There are marked increases in funding allocations to each country from 1999-2006
- The rate of increase will probably level out over 2007/8 – 2008/9 but to different degrees as some countries have historically received insufficient allocations

[1] Figures for each country for the period 2006/7 detail planned growth. Figures for Wales & NI detail allocations for social care and health
[2] Audit Scotland (2005). Following the Public Pound. Accounts Commission, Edinburgh. ISBN 1 904651 98 4
[3] Kings Fund (2005). 'An Independent Audit of the NHS Under Labour (1997-2005)'. Kings Fund, London

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- Each country health department will increasingly expect evidence of efficiency in spending and evidence of improved outcomes in return for increased investment. This is particularly true for England where a series of reforms have placed increasing emphasis on strict financial management and performance reporting.

Key facts: Sources of financial pressure

The following is a brief summary of some of the issues impacting upon NHS Trusts ability to break even. It is not true to say that the reason most Trusts are in deficit is down to poor management. Similarly, whilst it is true that the NHS has enjoyed record rises in funding, it has not all come directly to Trusts and front line services.

1. Many NHS organisations already have historical deficits to repay on top of those caused 'in year'. For some, this can amount to millions of pounds. This can arise from previous poor management of resources but can also result, for example, from the changes in the way the PCTs pay money to acute trusts under Payment by Results (see glossary of terms), or the way in which funding formulae have changed over time

2. The current average cost of providing each service is a legacy of past decisions by NHS organisations – hence the term legacy costs (see glossary of terms). The actual costs of some services may be well above or well below the average cost per unit of activity for the NHS as a whole. Unless the services are completely redesigned or stopped altogether, this legacy of high costs will impact for the life of the service. In reality it is very difficult to do this[4]. In England as PbR rolls out, these legacy costs will become more apparent and force Trusts to consider the viability of these higher than average cost services.

3. Across the UK, Health ministers have required substantial increases in activity from the NHS as a whole in order to address waiting lists and A&E waiting times. The additional activity when coupled with pressures on expenditure from other areas of reform has created cost pressures above and beyond the level of additional funding provided. According to the NHS Confederation, in England only 20% of the new money was spent on providing new services[5] and only part has gone to addressing decades of chronic under funding.

4 Palmer, K. (2005). 'How should we deal with hospital failure? Facing the challenges of the new NHS market'. Kings Fund, London.
5 NHS Confederation, (2005). 'Money in the NHS: the facts'. NHS Confederation Briefing (122), Sept 2005. London

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4. In terms of any overspends related to staffing costs, the RCN has found that there is no significant correlation between financial deficits and the implementation of AfC. In fact some of the Trusts with the worst deficits have not even implemented AfC yet so we do not believe AfC is a key cause of deficits. There is evidence to suggest however that the substantially larger sums involved in delivering on Consultant contracts and GP contracts were not properly costed and this has had an impact on many Trusts financial stability.

5. Alongside increases in activity there have also been net increases in staff numbers in certain areas to meet demand – estimated to have cost around £2bn. There has been an increase of approximately 89,000 more clinical staff employed in the NHS since 1999; 67,880 of which are nurses/midwives/health visitors[6]. besaC is 1nd

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RCN general policy position

The actual level of deficit when compared to the total NHS budget appears to be quite small but this is only half the picture. Locally, the impact of even a small percentage change in deficits can be disproportionate, particularly when considered alongside other costs pressures where organisations are already operating on very small margins.

The RCN has been carefully tracking the deficits picture across the UK through reports from activists and Regional staff; reviewing Trust, SHA, and Board governance papers; and monitoring national and local media. We have noticed a general trend in how NHS organisations are progressively responding to financial instability as follows:

- In the first instance, many organisations have instigated blanket bans on the usage of temporary staff – this places immense pressure on existing clinical staff to increase activity without a corresponding increase in resources.
- This is often followed by vacancy freezes (with vacancies being eventually removed from establishment to provide financial break even picture). This coupled with freezes on temporary staff usage, and reductions in the funding of professional development and education, can damage staff morale and recruitment and retention.
- Latterly we have seen limitations on service provision (particularly specialist services such as health visiting). For example, changing opening hours and reducing the scope of the service.
- This can be followed by more permanent mergers of departments and directorates coupled with reductions in management and support services. In some cases, NHS organisations have decided to 'disinvest' or close a service completely.
- At the start of this year, we have received numerous reports of many NHS organisations are actively considering redundancies in response to their worsening financial situation.
- At the end of this financial year 2005/06, our activists and staff have reported back on a large number of NHS organisations predicted deficits for the end of year 2005/06 based on projected expenditure. Whilst a proportion of the deficit may be recovered, the extent of this recovery will depend on radical recovery plans which we believe will impact upon patient services and our members' employment.

In response to what we believe to be a worsening financial situation across the UK but particularly in England, the RCN is making a series of recommendations to enhance financial stability, protect services and prevent unnecessary loss of employment.

We believe that the steps detailed below would provide an environment in which staff can be both productive and feel valued; achieve greater improvements in service delivery; and generate value for money without being made to make hasty decisions against unrealistic central targets.

Across the UK, we are calling for the following principles to apply to all developments in funding the NHS

Trust

Providers and commissioners of services should inspire public confidence and faith in their services through their clinical effectiveness, financial management and public engagement.

Partnership

Service providers and commissioners should demonstrate how they are actively and meaningfully engaging the public they serve and other stakeholders (such as staff and their representative bodies) in the design, delivery and evaluation of services, regardless of the financial pressures present.

Transparency

Service providers and commissioners should be open to scrutiny and questioning regarding the operation of their business. NHS services are funded by public money and as such restrictions on information should be the exception rather than the norm. Providers and commissioners should adhere **not just** to the relevant legislation in respect of freedom of information and consultation **but also** adhere to best practice.

Sustainability

Services should be commissioned and provided in a manner which provides for immediate needs without impacting adversely upon the needs of future generations. This relates to both structures of services in terms of being robust and lasting but also in terms of organisational behaviours e.g. environmentally sensitive procurement, good governance of resources, use of local produce, etc. There should be comprehensive workforce planning arrangements ensuring an appropriate future workforce.

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RCN policy position: NHS England

Background

Over the period of the five year settlement announced in the 2002 Budget (2002-03 to 2007-08), expenditure in the NHS is rising at an average of 7.3 per cent each year in real terms, bringing total annual expenditure to £76 billion in 2005-06 and reaching £105.6 billion by 2007-08, making healthcare the fastest growing area of public expenditure[9].

The joint report by the National Audit Office (NAO) and the Audit Commission[10] stated that 12% of Trusts failed to achieve in-year financial balance; 14% of PCT's failed to keep within their revenue resource limits; and 7 SHA's reported an aggregate over spend for the year 2003/4. Current estimates suggest 2005/06 is going to show deterioration on this position.

For the coming years, it is estimated that the NHS will receive much less than previous years. It has been suggested that this could amount to less than 4% as compared to the 5%-6% recommended by the Wanless report.

The Director of Finance and Investment for the NHS, Richard Douglas, recently announced an uplift of around £5.4bn for PCT's (9.2%) and 6.5% for acute Trusts through adjustments to the national tariff prices. However this has to be set against a requirement to return 2.5% in efficiency savings and against an effective drop of 2.5% in the baseline for the tariff – in other words this leaves only a 1.5% increase in funding for acute trusts.

Dealing with deficits – RCN policy response

NHS England has a particularly challenging financial environment which is causing severe pressure upon NHS Trusts. The RCN is actively lobbying for the following key actions to be delivered for the coming financial year:

1. To prevent instability in service provision, Trusts should be allowed to operate within a more flexible financial regime. We believe that short-term cost cutting can seriously impact medium and long term improvement in service provision.

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[9] Financial Management in the NHS: NHS (England) Summarised Accounts 2003/4. Joint Report of the NAO and Audit Commission, June 2005
[10] The NAO scrutinises public expenditure on behalf of Parliament; The Audit

believe that significant progress has been made in addressing historic low staffing levels and any attempt to turn back this progress is counter productive.

Guidance for RCN activists – What can you do?

If you are aware that your employer is taking steps to address local deficits but not already discussing recovery plans locally as part of staff side or a staff reference group, you should contact your lead steward or your regional officer to find out if there is already work being done on this issues. If not, the ideal response is one that engages all unions in a debate about the most appropriate method of tackling financial deficits and one which minimises loss of employment and continues to provide high quality services to the public.

Together, you may wish to consider arranging a special meeting with the Director of Nursing and Human Resources or Finance to discuss your concerns about how they are dealing with the deficit situation locally. Again, this should be as part of a briefing or special meeting of the local

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you should inform your Regional / Board Office as soon as possible to arrange additional support in approaching your employer.

If you have press enquiries or are aware that the local pr