Audit Detailed Report

June 2006

Report in the Public Interest

Good Hope Hospital NHS Trust

Audit 2005-2006

External audit is an essential element in the process of accountability for public money and makes an important contribution to the stewardship of public resources and the corporate governance of public services.

Audit in the public sector is underpinned by three fundamental principles:

- auditors are appointed independently from the bodies being audited;
- the scope of auditors' work is extended to cover not only the audit of financial statements but also value for money and the conduct of public business; and
- auditors may report aspects of their work widely to the public and other key stakeholders.

The duties and powers of auditors appointed by the Audit Commission are set out in the Audit Commission Act 1998 and the Commission's statutory Code of Audit Practice. Under the Code of Audit Practice, appointed auditors are also required to comply with the current professional standards issued by the independent Auditing Practices Board.

Appointed auditors act quite separately from the Commission and in meeting their statutory responsibilities are required to exercise their professional judgement independently of both the Commission and the audited body.

Status of our reports to the Trust

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director or officer in their individual capacity; or
- any third party.

Copies of this report

If you require further copies of this report, or a copy in large print, in Braille, on tape, or in a language other than English, please call 0845 056 0566.

For further information on the work of the Commission please contact:
Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ
Tel: 020 7828 1212 Fax: 020 7976 6187 Textphone (minicom): 020 7630 0421
www.audit-commission.gov.uk

Contents

Summary report

Introduction

1 This report in the public interest concerns the financial standing of Good Hope NHS Trust (the Trust). The report forms part of our 2005/06 audit work and is issued under section 8 of the Audit Commission Act 1998. This section of the Act requires the external auditor to consider whether, in the public interest, there should be a report on any significant matter coming to his or her attention.

2 This report also constitutes a referral to the secretary of state under section 19 of the Audit Commission Act. This section of the Act requires the external auditor to make a referral to the Secretary of State where an NHS body has made, or is about to make, decisions involving potentially unlawful expenditure or if they take, or are about to take, potentially unlawful action likely to cause a loss or deficiency.

3 Although this report concerns only Good Hope, the circumstances should be understood within the context of the health economy within which the Trust operates. Decisions made by one body in the health economy may have significant effects upon others. Similarly, while financial standing problems in one organisation may be a result of failings within that organisation they may also add to or be compounded by financial pressure within the local health economy as a whole.

4 We outline our audit approach in Appendix 1.

Background

5 Good Hope is an acute general hospital with a turnover of £112.9 million (2005/06). Income from primary care trusts (PCTs) is £99.4 million. The Trust's main commissioner is North Birmingham PCT. Other significant commissioners are Burntwood, Lichfield and Tamworth PCT, and Eastern Birmingham PCT. These three PCTs provide approximately 85 to 90 per cent of Good Hope's income.

6 The Trust was awarded a 'zero-star' rating in 2002/03 and a 'one-star' rating in 2003/04. In 2004/05, the Trust was rated by the Healthcare Commission as:

- achieving all seven clinical key performance indicators;
- significantly failing the key performance indicator on retaining financial balance; and
- being in the middle band of performance in three assessment categories under the 'balanced scorecard' assessment part of the ratings system.

7 The combination of these scores resulted in a 'one-star' rating for 2004/05.

Financial performance

8 The Board is accountable for financial control and for ensuring that the Trust meets its statutory duty to breakeven. Section 10(1) of the NHS and Community Care Act 1990 states that:

> *'Every trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account'.*

9 This is known as the 'breakeven duty'. NHS trusts should normally plan to meet this duty by achieving a balanced position on their Income and Expenditure account each year. The breakeven duty, however, includes the phrase 'taking one financial year with another'. This provides some flexibility and following extensive discussions between the Department of Health, HM Treasury and the Audit Commission, agreement has been reached that it will be assumed that the duty has been met if expenditure is covered by income over a rolling three-year period. This may in exceptional circumstances and with the agreement of the local Strategic Health Authority, be extended to five.

10 The Trust's has operated at a financial deficit for the past four financial years. The table below sets out its financial performance, and the forecast deficit in 2005/06. On this basis, as at 31 March 2006 the Trust has a cumulative deficit of £15.097 million.

Table 1 Performance against the breakeven duty

	2002/03 (£m)*	2003/04 (£m)*	2004/05 (£m)*	2005/06 (£m) **
Accumulated surplus/(deficit) brought forward	0.332	(0.507)	(5.521)	(9.097)
Surplus/(deficit) for the year	(0.839)	(5.014)	(3.576)	(6.000)
Accumulated surplus/(deficit) carried forward	(0.507)	(5.521)	(9.097)	(15.097)

** Based on note 23.1 of the 2004/05 financial statement*

*** Unaudited 2005/06 accounts*

11 At its May 2006 Board the Trust considered its budget for 2006/07. Subject to the agreement of a savings plan the Trust is forecasting a deficit of £3.0 million. This includes the repayment of £1.1 million of the deficit it incurred in 2005/06.

12 The Trust has discussed this issue with the Birmingham and the Black Country Strategic Health Authority (SHA) and agreed a loan for 2006/07 of £3.0 million from the West Midlands Cluster Bank. This will result in the Trust breaking even in 2006/07.

13 The Trust's cumulative deficit (excluding loans) would fall to £14.0 million as at 31 March 2007. Including loans the cumulative deficit will be £20 million.

Main conclusions

Financial position

14 The Trust has operated under significant financial pressures for several years, reporting a deficit position in 2002/03, 2003/04, 2004/05, and 2005/06. Its funding, savings programmes and non-recurrent support have been insufficient to secure financial balance. Its accumulated deficit as at 31 March 2006 was £15.1 million.

15 The Trust received financial support of £3 million in 2004/05. Without this financial support its cumulative deficit would be £18.1 million. The financial support is repayable (although no timeframe has been set by the SHA for repayment).

16 To breakeven within the statutory five-year period the Trust would, in 2006/07, need to repay its cumulative deficit and the financial support it has received, a total of £18.1 million. However, at its May 2006 Board meeting the Trust forecast a deficit of £3.0 million for 2006/07. This includes the repayment of £1.1 million of the deficit it incurred in 2005/06.

17 The Trust has discussed this issue with the SHA and agreed a loan for 2006/07 of £3.0 million. This will allow the Trust to breakeven for the year. However, the Trust's cumulative deficit as at 31 March 2007 would, at £14.0 million (excluding £6 million in loans), remain significant. It is clear that the Trust will not meet it statutory duty to breakeven within the five-year period without significant financial support.

18 The Trust also has a significant cashflow shortfall. For the 2005/06 financial year it forecast that by February 2006 it would not have generated sufficient cash from its own activity to continue to trade. It has therefore agreed short-term cash support of £16 million with the SHA. [Note 1] While this will allow the Trust to continue to trade into 2006/07 urgent action is required to identify how the shortfall in cash will be addressed in the long-term.

Note 1

We understand that local SHAs are planning to establish a 'West Midland Cluster Bank' to facilitate loans to enable trusts to manage cashflow shortfalls.

Forecast Financial Performance 2007/08 and 2008/09

19 At its May 2006 Board meeting the Trust also discussed financial forecasts for 2007/08, and 2008/09. These forecasts show that the Trust will have a net operating surplus of:

- £0.26 million in 2007/08; and
- £2.052 million in 2008/09.

20 We welcome the action taken by the Board to return the Trust to net operating surplus, and the action taken by staff in support of the Board.

21 However, during this period the Trust will need to repay the £3 million loan received in 2006/07, and the deficit incurred in 2005/06. This will result in a deficit in each of these years (2007/08 deficit of £3.7 million, 2008/09 deficit of £2.06 million).This will increase the Trust's cumulative deficit to £14.9 million (including the remaining loan the cumulative deficit will be £17.9 million). On this basis it would not be possible for the Trust to return to financial balance without additional financial support from the SHA.

22 In response to the increasing deficit position the Trust is considering a merger with the Heart of England Foundation Trust (HEFT). Traditionally, the route by which this partnership would be achieved would be through a formal merger of the two trusts. However, the Monitor for foundation trusts has recently established a process that requires any Foundation Trust that wishes to merge with another Trust to disestablish itself and to re-apply by submitting a new business case based on the two organisations. HEFT do not wish to go through this process, and together with Good Hope, and the SHA are considering alternative ways to establish a sustainable future for Good Hope. However in the interim Good Hope continues to operate at a significant deficit.

23 Despite these difficulties negotiations between the SHA, Good Hope and HEFT about a potential merger are currently ongoing. We understand that as part of these of negotiations HEFT have requested financial support to enable them to manage the cost of merger and the cumulative deficit. In assessing the options for Good Hope it is important that the Good Hope Board and the SHA secure value for money for the public as well as providing for the clinical future and financial viability of the Trust. We understand that once the various options are appraised that any merger proposal will be subject to a consultation process.

Understanding the deficit

24 The Trust's financial position has emerged over a number of years as successive recovery and financial saving plans have not been delivered. It is the result of a number of decisions both within the Trust and wider health economy. Whilst it is not possible to identify all of the factors that led to this position we consider that funding, and capability and capacity issues have significantly contributed to the Trust's financial difficulties. These are summarised below.

Funding issues

- Funding 2003/04, 2004/05 and 2005/06.
  - In both 2003/04 and 2004/05 the Trust's activity exceeded that agreed with its commissioning PCTs. The Trust received no additional funding for this activity in 2003/04, and only partial funding in 2004/05. The Trust has effectively not been paid in full for some of its activity. Similar risks arose in 2005/06 (although following arbitration by the SHA the Trust has now been paid for the majority of the activity it has undertaken). The Trust has estimated that the cumulative effect of underfunding is in the region of £6 million.
  - PCTs have vociferously challenged the validity of this figure raising concerns with regard to the accuracy of healthcare activity data. This was not upheld in arbitration by the SHA. PCTs have also challenged the health need for some of the activity undertaken by the Trust. This issue remains unresolved, and is a block to joint working and achieving financial stability in the health economy.
  - Funding 2005/06 - Under Department of Health's (DoH) transitional arrangements for Payment by Results (the method by which trusts are paid for the activity they undertake) the Trust is funded at a level below national tariffs. If it (and its commissioning PCTs) had been funded at national tariffs its income would have increased in 2005/06 by £5.916 million. This would have significantly reduced the Trust's deficit. It should be noted however that all trusts nationally are subject to this regime. Note 2

Capability and capacity issues

- Financial and strategic planning - The Trust does not have a good record of strategic and financial planning, and at present does not have a clear strategic plan or medium-term financial strategy. The lack of these strategies has significantly reduced the effectiveness of the Trust in managing and developing its services and finances.
- Strength of the Board - The Trust Board has been subject to significant change in recent years, and did not have a permanent Director of Finance for a considerable period. The level of change and the lack of a permanent Director of Finance has significantly undermined the ability of the Trust to resolve its financial deficit.

Note 2

It should be noted that a number of other Trust's are also subject to, and are managing these transitional arrangements for PbR. Also, the PbR tariffs due are subject to change. There is therefore no certainty that the Trust will achieve this level of increase in income when full PbR is implemented in 2008.

- Franchise arrangement - Following the revision of the 2002 star ratings at the Trust to zero stars a franchise process was established and a private sector company appointed to improve performance at the Trust. The franchise was brought to an end on 31 October 2005. The franchise arrangement, despite significant effort on behalf of the Trust and private sector company, was only partially successful and introduced significant additional costs to the Trust.
- Focus on clinical care - There is evidence to suggest that the primary focus of the Board has been to deliver clinical targets despite the financial position of the Trust. While we acknowledge that ensuring a high standard of clinical performance is a key part of the Board's role we consider that clinical targets have been achieved at the cost of financial balance.
- Financial recovery plans - Financial recovery plans have been recognised by all health economy partners to have had limited impact in delivering the required level of savings. Partner organisations consider that Good Hope has not adequately secured the required support from partners in the preparation or implementation of these plans. The Trust also has a poor record in the delivery of its own internal savings plans.
- Use of the Treatment Centre - The Trust opened its new Treatment Centre in July 2005. Since this time it has operated at a significant revenue deficit. The prime cause of the revenue deficit was a numbers of errors and omissions from the Final Business Case (which underestimated the cost of the centre). Partner organisations also indicate that they do not wish to purchase the Healthcare Capacity offered by the Centre. This has increased the financial pressures on the Trust.
- Financial capacity - The Trust has a traditional finance function in terms of its structure and individual roles. There is insufficient capacity within the function to resolve the financial deficit. There are also examples of poor financial planning, for example, errors in the completion of Stage 2 and 3 PbR returns.
- Partner relationships and health economy acute strategy- the financial pressures on the Trust and PCTs have resulted in strained relationships within the Health Economy. The affects of these difficult relationships are significant, and in particular, have affected the health economy's ability to re-design services and manage costs. The Trust and its various partners in the health economy have also failed to develop an agreed and sustainable acute strategy that would deliver a sustainable level of healthcare combined with financial balance to the health economy as a whole. There is some evidence in recent months that relationships have improved. However, both the Trust and PCTs must take their share of responsibility for current financial difficulties within the Trust and Health economy as a whole.

Recommended actions for the Trust Board

	Recommendations
R1	*The Trust should develop a recovery plan with local commissioners and the SHA which repays the Trust's accumulated deficit, delivers financial balance across the health economy, and which the Board is satisfied is robust, realistic and achievable. A realistic timetable should be set for achievement of the plan.*
R2	*A cash strategy should be developed with the SHA to provide cash support to the Trust while it returns to financial balance.*
R3	*The Board should develop a long-term strategic plan that links clearly to service and financial planning. This should be agreed with its commissioners and set out service provision and any necessary service reconfiguration.*
R4	*The Trust should continue to consider how it can return to financial balance in the medium to long term. This may include reconfiguration or changes to services, partnership arrangements with another trust, or merger. The Board and SHA should ensure that, whatever option is chosen, that value for money is provided for the public.*
R5	*The Board should consider its executive management arrangements and whether it has sufficient capacity within the interim management contract and its current executive team to effectively manage the Trust. In particular, it should (where possible) ensure stability at the Director of Finance role and consider the need to appoint to the two currently vacant posts.*
R6	*The Board should establish monitoring procedures to ensure that future budgets and financial recovery plans are delivered. Monitoring needs to be more widely focused than finance, and in particular should include activity against individual SLAs, cash and number of employees.*
R7	*The Board should work with its commissioners and SHA to develop a long term strategy and business and financial plans for the Treatment Centre. The plans should ensure that the Centre operates at financial balance.*
R8	*The Board should strengthen the financial capacity within the finance team.*
R9	*The Board should improve the Trust's working relationships with key partners and stakeholders, particularly NBPCT, in order to ensure that the local health economy as a whole works more effectively.*

25 We will continue to monitor the Trust's progress in delivering sustainable financial balance by the end of its statutory period.

Detailed report

Financial performance 2002/03 to 2004/05

The use of financial support and the underlying financial deficit

26 The Trust incurred a deficit each year between 2002/03 and 2004/05. We have already outlined in Table 1 (above) the Trust's reported financial position and cumulative deficit for this period.

27 The extent of the financial deficit has been mitigated by the use of financial support and non recurrent savings. Trust data shows that it has received a significant level of financial support. If this is excluded the 'underlying' deficit would have been as follows.

Table 2 Financial support

	2002/03 £000's	2003/04 £000's	2004/05 £000's
Cumulative deficit brought forward	332	(3,484)	(9,512)
Reported financial position	(839)	(5,014)	(3,576)
Financial support:			
Non-recurring support – non-repayable	(910)	(400)	
Non-recurring support – repayable			(3,000)
Non-recurrent savings and income:			
Capital to revenue transfers	(900)	0	0
Performance fund	(507)	0	0
Recovery plan	(660)	(614)	(495)
Total support	(2,977)	(1,014)	(3,495)
Underlying in-year position	(3,816)	(6,028)	(7,071)
Underlying deficit carried forward	(3,484)	(9,512)	(16,583)

28 The 'underlying deficits' between 2002/03 and 2004/05 (as highlighted in Table 2) are significant and have increased each year.

Expenditure has been increasing faster than income

29 The Trust has increased its patient activity in recent years. This has been with the aim of achieving the seven key patient-led performance indicators in the Healthcare Commission's star rating assessment. The Trust has been successful in this aim and in 2004/05 met the seven key clinical targets set by the Healthcare Commission. However, the Trust has been unable to meet both patient-led targets and retain financial balance.

30 A review of the Trust's 2004/05 audited accounts and latest 2005/06 financial projections shows that the Trust will have received an additional £23.9 millon income in the last three years. This has been offset by an increase in expenditure over the same period of £29.7 million. A substantial element of the expenditure increase in 2004/05 and 2005/06 relates to payroll costs which increased costs by £8.6 million in 2004/05 and is expected to increase by a further by £6.9 million in 2005/06.

31 Pay costs have increased partially due to increases in headcount but also because of national pay reforms. The increases that have placed pressure on the Trust's finances include:

- employer's superannuation costs;
- the consultant contract;
- agenda for change; and
- European working time directive.

32 The Trust asserts that expenditure has exceeded income because the increase in the Trust’s activity levels and costs to meet the national standards and fund national pay reforms has not been matched by a similar increase in income. Its commissioning PCTs consider that expenditure has not been adequately controlled.

33 There is evidence to support both views and we discuss this later under 'understanding the deficit position'.

Previous financial recovery plans have not been adequate

34 Previous financial recovery plans (2002/03 to 2004/05) have been recognised by all health economy partners to have had limited impact in delivering the required level of savings. These included The North Birmingham and South Staffordshire Review, and The Save, Earn and Modernise programme. Partner organisations have commented that Good Hope has not adequately secured the required support from partners in the preparation or implementation of these plans.

35 The Trust also has a poor record in the delivery of its internal savings plans. For example, at the start of 2004/05 the Trust had a recovery plan of £7 million to achieve breakeven. The Trust delivered 51 per cent of the required savings target and had a deficit of £3.576 million. We have previously reported to the Board on the weaknesses in this recovery plan. These included delays in setting the budget, and ownership of the financial recovery plan.

36 PCTs also point to a consistent lack of will to see through internal redesign to limit costs to met income. For example, the Trust continued to deliver Neonatal Intensive Care Unit Services despite PCT concerns that there was neither the physical environment nor staffing capacity to operate at this level.

37 In 2005, various health economy working groups have recognised the need for a health economy solution and service reconfiguration to deliver financial balance. A 'LETS DO' strategy has been drafted in partnership with North and East Birmingham PCTs and sets out to achieve health economy service reconfiguration leading to financial balance. However, the LET'S DO strategy at present fails to provide a clear statement of how the vision will be achieved, and does not bridge the full financial shortfall in the health economy. It is critical that the next stage of the process, developing and implementing action plans, is completed quickly if the required savings for 2006/07 are to be delivered.

In-year 2005/06 position, repayment of accumulated deficits and cash

38 The reported *(unaudited)* deficit for 2005/06 is £6.0 million. The key areas contributing to the deficit are as follows.

- Costs in excess of budgets with no saving plans identified £4.5 million.
- Saving plans not delivered £1.5 million.

39 In addition, for much of the financial year there was a significant risk that the Trust would not be able to recover £4.7 million in income from its PCTs. This risk has now been resolved but we provide details of this below.

40 As a result of the cumulative deficits the Trust's cash position has also been poor during 2005/06. By February 2006 the Trust had not generated sufficient cash from its own activity to continue to trade. As a short term measure (to allow it to continue to trade) the Trust agreed short-term cash support of £16 million with the SHA. However, urgent action is required to identify how the shortfall in cash will be addressed in the long-term.

41 We provide details of this below.

Areas contributing to the deficit

42 At the start of 2005/06 the Trust faced a potential financial deficit of £11.6 million. Therefore, as part of the 2005/06 budget setting process, it identified a savings target of £6.6 million subject to the receipt of additional £5 million support from the SHA.

43 In April 2005, the Director of Finance (acting as Chief Executive) and the interim Finance Director (seconded from the SHA) submitted a financial recovery plan proposal which sought to achieve financial balance in the medium-term. The proposed solutions required significant changes to the current financial regime for NHS Trusts and sought to move forward through the:

- write-off of all historical debt and brokerage incurred up the end of 2004/05;
- availability of non-recurrent and non-repayable transitional support equivalent to the difference between actual funding and national average under Payment by Results (PbR); and
- a reset of the statutory financial period to the transitional period of PbR.

44 This was a deliberate action taken to raise the Board's awareness of the workings of the current and future NHS financial regimes and their impact on the Trust's financial position. We also understand that the Trust was in discussion with the Strategic Health Authority on this matter. This proposal was not successful and the Trust was required to revisit its proposals.

45 We consider that the following issues delayed the identification of a full year savings plan, resulted in a more back-loaded financial recovery plan, and increased the financial pressure on the Trust:

- there was a general reluctance on the part of most budget holders to engage with further savings following their substantial efforts in 2004/05;
- a significant full-year effect of developments in 2004/05 had not been properly provided for but emerged in the budget setting process;
- there was a perceived lack of strategy and limited planning upon which to base financial plans;
- there was a perceived lack of clarity and agreement about the real scale of the underlying deficit;
- the interim arrangements throughout budget setting, with effectively three Directors of Finance having a role, caused fragmentation of knowledge and effort;
- there were inadequate resources in the finance department, not least due to the interim arrangements;
- discussions over the original financial recovery plan proposal resulted in some delay.

46 Between April and June 2005 the following also occurred.

- In April 2005 the Trust requested from, and considers that it provisionally agreed with, the SHA financial support of £5 million. This resulted in a revised savings target of £6.6 million (from £11.6 million). The SHA considers that it provided provisional authorisation for the Trust to incur a deficit of £5 million but did not agree any financial support.
- Between 3 March and early May the Director of Finance and Performance acted as Chief Executive. This placed additional pressure on the finance directorate, and insufficient progress was made on the recovery plan. On the Director's return additional resources were then input into the development of the recovery plan. By the end of June, approximately £5.5 million of the original £6.6 million savings plan had been identified
- In June 2005, the SHA clarified that no financial support was available and also withdrew its provisional authorisation for the deficit plan leading to a revised cost recovery target of £11.6 million to achieve in-year breakeven. The confusion over whether provisional authorisation was given by the SHA was unfortunate and resulted in significant pressure on the Trust Board.

47 In August 2005, a revised savings plan was presented to the Trust Board. This plan did not result in the Trust achieving an in-year breakeven position. The plan identified £7.1 million of savings but left a further £4.5 million of savings unidentified. The September Board decided that £4.5 million of savings would not be pursued, and effectively agreed that the Trust should overspend by £4.5 million. We understand that Board took this decision on the basis of the need to ensure clinical safety.

48 Of the £7.1 million of savings identified the Trust was able to deliver £5.6 million. The remaining £1.5 million (added to the unidentified savings of £4.5 million) resulted in the in-year deficit of £6 million in 2005/06.

Other risks in 2005/06

49 In addition to the risks highlighted above the Trust faced a number of other risks during the year. We have detailed these below.

Income risk (£4.2 million)

50 The Trust forecast that it would receive an additional £9.8 million of income from PCTs above that originally contracted. This is due to the Trust undertaking additional healthcare activity above that contracted. The forecast over-performance relates mainly to North Birmingham PCT, Burntwood, Litchfield and Tamworth (BLT) PCT and Eastern Birmingham PCT.

51 Under Payment by Results PCTs are required to pay for all activity delivered at full tariff. However, PCTs disputed £4.2 million of income for the following reasons:

- PCTs consider that activity was not necessary to meet national targets, or in line with their strategic priorities;
- PCTs have not had the financial resources to meet the costs of the over-performance, and may overspend as a result; and
- there have been concerns expressed over the robustness of the Trust's activity data.

52 These disputes have now been arbitrated by the SHA and the majority of the additional income has been paid.

Cost risk (£670,000)

53 With the approval of the SHA the Trust signed an interim management contract with the Heart of England Foundation Trust (HEFT) in November 2005. The aim of the contract is to provide Executive Management to the Trust for the period to 31 March 2006, and to draft a recovery plan to return the Trust to financial balance. The cost of this contract for the five-month period was £600,000 plus an allowance of £70,000 for consultancy fees.

54 The contract cost is included in the outturn overspend position of £6 million.

The Trust’s cash position is serious

55 The Trust forecast throughout 2005/06 that it would not have sufficient cash to continue to trade after February 2006. This is the cumulative effect of previous years' deficits. To resolve this issue for 2005/06 the Trust:

- received £5 million cash against its temporary borrowing limit and an early SLA payment of £2 million from Eastern Birmingham PCT; and
- requested cash support of £19.7 million from the SHA in July 2005.

56 The SHA has confirmed £16 million in cash support which ensured that the Trust could continue to trade into 2006/07. The Trust is also considering how it can manage its cashflows internally.

57 However, this requirement for cash support will continue to grow unless the Trust can contain its expenditure within the level of income it receives.

Budget 2006/07

58 At its May 2006 Board the Trust considered its budget for 2006/07. Subject to the agreement of a savings plan the Trust is forecasting a deficit of £3.0 million. This includes the repayment of £1.1 million of the deficit it incurred in 2005/06.

59 The Trust has discussed this issue with the SHA and agreed a loan for 2006/07 of £3.0 million (from the West Midlands cluster bank). This would result in the Trust breaking even in 2006/07. The Trust's cumulative deficit (excluding loans) would fall to £14.0 million as at 31 March 2007. Including loans the cumulative deficit would be £20 million.

60 The Birmingham and Black Country SHA (SHA) formally granted the Trust an extended breakeven period of five years. The breakeven period for Good Hope Hospital NHS Trust is from 2002/03 to 2006/07. The Trust has forecast that its cumulative deficit as at 31 March 2007 will be £14 million. As such, it will not be able to meet its statutory 'breakeven' duty by the end of 2006/07.

Financial position 2007/08 and 2008/09

61 At its May Board meeting the Trust also discussed financial forecasts for 2007/08, and 2008/09. These forecasts show that the Trust will have a net operating surplus of:

- £0.26 million in 2007/08; and
- £2.052 million in 2008/09.

62 We welcome the action taken by the Board to return the Trust to net operating surplus, and the action taken by staff in support of the Board.

63 However, during this period the Trust will need to repay the £3 million loan received in 2006/07, and the deficit incurred in 2005/06. This will result in a deficit in each of these years (2007/08 deficit of £3.7 million, 2008/09 deficit of £2.06 million), and will increase the Trust's cumulative deficit to £14.9 million (including the remaining loan the cumulative deficit will be £17.9 million). On this basis it would not be possible for the Trust to return to financial balance without additional financial support from the SHA.

64 In response to the increasing deficit position the Trust is considering a merger with the Heart of England Foundation Trust (HEFT). Traditionally, the route by which this partnership would be achieved would be through a formal merger of the two trusts. However, the Monitor for foundation trusts has recently established a process that requires any Foundation Trust that wishes to merge with another Trust to disestablish itself and to re-apply by submitting a new business case based on the two organisations. HEFT do not wish to go through this process, and together with Good Hope, and the SHA are considering alternative ways to establish a sustainable future for Good Hope. However in the interim Good Hope continues to operate at a significant deficit.

65 Despite these difficulties negotiations between the SHA, Good Hope and HEFT about a potential merger are currently ongoing. We understand that as part of these of negotiations HEFT have requested financial support to enable them to manage the cost of merger and the cumulative deficit. In assessing the options for Good Hope it is important that the Good Hope Board and the SHA secure value for money for the public as well as providing for the clinical future and financial viability of the Trust. We understand that once the various options are appraised that any merger proposal will be subject to a consultation process.

Understanding the deficit position

66 The Trust's financial position has emerged over a number of years as successive recovery and financial saving plans have not been delivered. It is the result of a number of decisions both within the Trust and wider health economy. Whilst it is not possible to identify all of the factors that led to this position we consider that funding, and capability and capacity have significantly contributed to the Trust's financial difficulties. These are summarised below.

Funding 2003/04, 2004/05 and 2005/06

67 Actual activity has exceeded planned activity in each of the past three years. For example, in 2005/06 PCTs planned for a reduction of 1 per cent in emergency activity. Actual activity increased by 8 per cent. Given that actual activity has exceeded planned activity contract agreement mechanisms, or demand management activity by the PCTs, appear to have been inadequate.

68 The Trust has requested payment each year for the additional activity. The Trust received no additional funding in 2003/04. In 2004/05 the Trust's claim for payment resulted in partial payment from North Birmingham and Eastern Birmingham PCTs through negotiated settlement and arbitration by the SHA in March 2005. No additional funding was received from Burntwood, Litchfield and Tamworth PCT (as the Shropshire and Staffordshire Strategic Health Authority arbitrated against Good Hope). The additional payments did not cover the Trust's costs and were not sufficient to return the Trust to financial balance.

69 As outlined earlier the Trust was successful in its arbitration claims for 2005/06.

70 In addition, the Trust considers that additional payments should also have been made for additional activity under block contracts. Again, this is disputed by its commissioning PCTs. No payments were made for additional activity under these contracts in 2003/04. Settlement was agreed at 50 per cent of marginal cost with two PCTs in 2004/05. These contracts have now been placed on a cost and volume basis on 2005/06.

71 The Trust also maintains that it was not fully funded for the costs of the new consultant contract. For 2004/05 the Trust considers that its funding shortfall was £1.075 million for these contracts.

72 The Trust has estimated that the cumulative effect of this under-funding could be in the region of £6 million by March 2006.

73 It should be noted that PCTs have vociferously challenged the validity of this figure raising concerns with regard to the accuracy of activity data. This was not upheld by the SHA in arbitration. PCTs have also challenged the health need for some of the activity undertaken by the Trust. This issue remains unresolved, and is a block to joint working and achieving financial stability in the health economy.

74 PCTs have also stated that errors were made by the Trust in the completion of Stage 2 and 3 PbR activity returns. This resulted in reduced income from the DoH for the PCTs to pay for additional activity undertaken by the Trust. This is disputed by the Trust.

Funding 2004/05 and 2005/06 (Payment by Results)

75 The NHS is introducing a new payment mechanism, Payment by Results (PbR), which pays trusts for the activity they undertake for PCTs. The Trust has calculated that in 2004/05, based on the agreed service level agreements (SLAs), its income was 92 per cent of the amount that it would have received if it had been funded at the national tariff, which is being implemented in the NHS over the medium term from 2005/06. While this is similar to a number of Trust's nationally, funding at 100 per cent would have returned the Trust to financial balance.

76 For 2005/06, initial calculations under the PbR showed that the Trust would gain:

- £4.87 million for non-elective activity. However, subsequent DoH guidance (rather than a commissioning decisions) delayed the introduction of PbR for non-elective activity. The Trust therefore had no gain; and
- £6.23 million for elective activity. However, subsequent DoH guidance, limited this gain to only £314,000 for the Trust.

77 If the Trust had received funding at full tariff in 2005/06 it would have received additional income of £11.1 million.

78 However, it should be noted that all Trust's are subject to, and are managing these transitional arrangements for PbR. Also, the PbR tariffs due are subject to change. There is therefore no certainty that the Trust will achieve this level of increase in income when full PbR is implemented in 2008.

Financial and strategic planning

79 The Trust does not have a documented strategic plan, or a clear view with regard to its future service provision. The lack of strategic direction has hampered the Trust in developing its service and financial planning, and in managing its financial deficit.

80 There are other constraints that have affected the Trust's performance.

- The strategic objectives for 2004/05 and 2005/06 are high-level, and do not detail a comprehensive strategy in line with local needs.
- The Director of Strategy and Development left in July 2005 and this post was not re-appointed to due to the financial constraints. There is therefore limited capacity to develop a strategic plan.
- Business and service planning is limited.
- There is no medium-term financial strategy.
- A joint strategy is required with its commissioning PCTs if the health economy is to return to financial balance. We note that in recent months a 'LETS DO' strategy has been developed in partnership with the PCTs. However, this has not yet delivered significant change.

81 The Trust has recently begun to consider its future direction, and is currently in the process of reviewing targets and issues for 2006/07. Additional support is also being made available as part of an interim management support contract (with Heart of England Foundation Trust). However, significant and continued action is required to ensure that business planning processes are fit for purpose.

Strength of the Board

82 The Trust Board has been subject to significant change in recent years. Key changes have included the following.

- The Director of Finance position was covered by five short-term appointments from September 2003 to mid-January 2005. This is the result of difficulties encountered by the Trust in appointing a permanent Director of Finance. A permanent Director of Finance and Performance (DFP) was appointed in mid-January 2005. However, on appointment the DFP identified a number of significant competing time pressures that have taken time to resolve, these include:
  - no financial plans were in place for 2005/06;
  - no progress had been made with budget setting for 2005/06;
  - there were significant unresolved disputes over payment for 2004/05 with the PCTs;
  - the Trust was implementing a new financial system which was taking more resources than anticipated to introduce.

- The Director of Finance and Performance has a dual portfolio as Deputy Chief Executive. Since appointment there have been prolonged periods where the post holder has 'acted' as Chief Executive, for example from 3 March to May 2005. This has again left the responsibility for Finance with less experienced staff. We consider that this has resulted in a lack of clarity around the financial performance and direction of the Trust. There has also been confusion for staff within the finance directorate due to the varying management styles of the six temporary appointments.
- The post of the Director of Human Resources was deleted by the Board, and a new role, of Director of Organisational Development established. This resulted in the redundancy of the Director of Human Resources. Due to financial pressures no appointment has been made to the new post.
- A post of the Director of Planning and Strategy was established but the post holder left in July 2005, and has not yet been replaced.

83 We consider that the changes within the Executive Management Team have allowed key skills to be recruited to the Trust. In particular, the arrival of the current Director of Finance and Performance has led to an increased awareness of the full extent of the financial position by the Trust Board. Due to the size of the underlying financial deficit, the Director of Finance and Performance has not been able to offer short-term solutions to return the Trust to financial balance. However, the information provided to the Board should now enable it to determine appropriate medium and long-term actions.

84 In November 2005, the Board let a contract for the provision of interim executive management support to the Heart of England Foundation Trust (HEFT). The key aim of this contract is the provision of a Chief Executive and the assessment of the actions necessary by the Trust to achieve Foundation Trust status. It is hoped that this will provide the Trust with a medium to long-term strategy and financial plan that will return it to financial balance.

85 In the interim, there remain two vacancies at executive director level. The Trust will need to consider the longer-term impact of additional pressure on other directors and the lack of management capacity regarding skills and experience within the management team.

86 Overall, we consider that the delay in appointing a permanent Director of Finance significantly weakened the Trust's management of its finance, and the changes in other posts and current vacancies weakened the Trust's ability to develop coherent long-term plans.

Franchise arrangement

87 Following the revision of the 2002 star ratings at the Trust to zero stars a franchise process was established to appoint a new chief executive and improve performance at the Trust. In September 2003, the post of Chief Executive was franchised to Secta Group Ltd, a private sector company. Nine interventions were agreed as part of the contract. Substantial improvements in performance were

required as part of the franchise arrangements with the Trust planning to move from zero-star status to a three-star status over a period of three years.

88 The purpose of the franchise arrangement was to provide a step change in the standards of healthcare service provided by the Trust and to achieve certain key outcomes, as follows.

- Develop a vision and future strategic direction for healthcare services in the area consistent with the local delivery plans (strategic direction).
- Create a Trust management structure based on the appointment of experienced and effective senior administrative healthcare managers to the vacant post(s) (effective management).
- Create an established and effective culture of team-working (effective management).
- Develop positive and robust relationships between the Trust and Trust employees (both clinical and non-clinical, including senior consultants, doctors and nurses) (effective management).
- Improve the standards of healthcare, based on achievement of the targets (improving performance).

89 The franchise was brought to an end on 31 October 2005 with the resignation of the Chief Executive supplied by Secta Group Ltd. This is approximately 12 months earlier than envisaged in the original contract. Other work undertaken under the franchise will end by 31 December 2005. The franchise agreement was ended with the mutual consent of both the Trust and Secta Group Ltd.

90 During the period of the franchise, the cost of the Chief Executive to the Trust was £225,000 per annum. This is approximately £60,000 to £80,000 more than would be paid for a direct appointment. In addition, in excess of £1 million has been spent on interventions during the contract period.

91 Given the current financial position of the Trust and some of the other issues outlined above, we consider that the franchise arrangement, despite significant effort on behalf of the Trust and Secta, was only partially successful. It also introduced significant additional costs to the Trust which otherwise would not have incurred. Again, these added to the other financial pressures on the Trust.

Focus on clinical care

92 The Trust has made progress during the last few years against NHS Plan clinical targets and is now achieving all of its key clinical targets. Performance against the balanced scorecard is also mainly at or above a satisfactory level.

93 Given the Trust's financial position, and based on discussions with executives, there is evidence to suggest that the primary focus of the Board has been to deliver clinical targets despite the financial position of the Trust. While we acknowledge that this should be the primary focus of the Board we consider that clinical targets have been achieved at the cost of financial balance.

94 Also, management attention until recently has continued to focus on the retention of current services, and there has been limited assessment of service reconfiguration or ward closures. This has been hindered by the lack of an agreed health economy strategy for future service provision.

95 More recently we have seen a refocusing to both clinical and financial priorities. Key actions include:

- the Trust has reported back to the Board on the services which are considered 'loss-making' in financial terms. Clinical reviews have also been undertaken to assess whether the costs of ‘loss-making’ services can be reduced; and
- the Trust has also carried out an internal review of waiting list management looking at how this can be improved.

96 The Trust will need to continue to focus on both clinical and financial balance.

Financial recovery plans

97 As outlined earlier, previous financial recovery plans (2002/03 to 2004/05) have been recognised by all health economy partners to have had limited impact in delivering the required level of savings. PCTs have also commented that there was little support for the 2005/06 recovery plan. The Trust also has a poor record in the delivery of its internal savings plans.

98 We consider that failure to deliver against these plans on a recurrent basis has allowed the underlying deficit of the Trust to grow to its current level.

Use of the Treatment Centre

99 In 1999, the Trust began the procurement and building of a Treatment Centre. The target date for the Centre to be brought into operational use was spring 2005. However, delays in the contract resulted in the final handover occurring in July 2005.

100 The Treatment Centre has operated at a revenue deficit (£0.86 million) since being brought into operational use in July 2005. The deficit is likely to increase in future years (£1.7 million in 2006/07). The Trust is considering how it can attract additional patient activity to cover the significant operational costs. However, we understand that its commissioning PCTs have informed the Trust that they would be reluctant to purchase additional capacity to deliver accelerated targets or provide additional healthcare services through the Treatment Centre. This remains a financial risk for the Trust in 2005/06 and 2006/07.

101 The prime cause of the revenue deficit was a numbers of errors and omissions from the Final Business Case. These have only recently been identified and the consequence is a significant revenue shortfall. In addition, the Trust did not monitor changes to the assumptions and the operating environment during the building of the Treatment Centre and was not in a position to assess and respond to the financial impact of those changes. Continued action is necessary by the Board to ensure that the Treatment Centre operates at breakeven.

102 The Trust has incurred significant additional capital costs in the building of the Treatment (over £4.5 million). The Trust is currently in negotiation with various parties with regard to the recovery of these costs.

103 We have reported separately our recommendations to the Trust.

The Trust has limited financial capacity

104 The Trust has a traditional finance function in terms of its structure and individual roles. Finance staff work within their areas of responsibility and do not always actively seek to share information or understand the wider picture. In particular:

- resources for financial planning are not adequate resulting in no Medium Term Financial Strategy, and late budget setting;
- financial expertise is limited in certain areas such as PbR. For example, in its initial budget the Trust misinterpreted guidance around transitional arrangements under PbR. This resulted in £1.8 million of income being double-counted. The impact of this was to increase the savings target from £11.6 million to £13.4 million further increasing the financial pressures on the Trust;
- the role of the clinical group accountants was not wholly linked to the rest of the finance function (this has recently been changed to ensure they report directly to the Deputy Director of Finance);
- control and co-ordination of the financial recovery plan requires strengthening. For example:
  - some finance staff had limited understanding of how their work linked into the overall financial recovery plan;
  - not all ‘invest to save’ schemes were realistic. In particular, the vacancy freeze on recruitment of nurses means that agency staff are hired to provide cover for these posts. This is often at a higher cost than direct recruitment; and
- until recently there has been limited assessment of the costs and income generated by each service or benchmarking, reducing the Trust's ability to target cost saving programmes, or reducing high-cost services.

105 The new Director and Deputy Director of Finance have strengthened the team since their appointment. However, their ability to make significant changes has been restricted by restrictions on recruitment. We consider that insufficient financial capacity exists within the Trust to support it during this period of financial instability.

The Trust has a difficult relationship with its key partners

106 The Board recognises the importance of working with key partners in the local health economy. However, the financial pressures on the Trust and PCTs have resulted in strained relationships with commissioning PCTs. These difficulties have been exacerbated by the lack of a consistent Trust management team which has delayed the resolution of disagreements with commissioners.

107 The effect of these difficult relationships are significant, and include:

- over-performance against activity has been disputed by PCTs. Whilst it is usual to have these disputes relationships have meant that the Trust and its Partners have not been able to resolve issues via negotiation. Rather disputes have been referred to the SHA for arbitration;
- service level agreements, which set out the patientcare activity that the Trust will provide have not been agreed on a timely basis. For example, in 2005/06 10 of the Trust's 22 commissioners (representing 95 per cent of its income) did not sign SLAs until the final quarter of 2005/06. The SLA with BLT PCT remains unsigned; and
- discussions over service redesign, for example, to reduce accident and emergency activity or delayed discharge have not reached agreement.

108 Both the Trust and PCT must take their share of responsibility for current financial difficulties within the Trust and Health economy as a whole.

109 The various partners in the health economy have also failed to develop an agreed and sustainable acute strategy. The result has been *a* series of joint and Trust specific financial recovery plans that have failed to deliver financial balance to the health economy as a whole.

110 In recent months some progress has been made in improving relationships. The 'Future Search Event' held in June 2005 brought together leaders from the Trust and its three main commissioners as well as being supported by other key partners. The aim of the group was to develop a strategy for the future configuration of health services. Part of this event included identifying issues around financial balance at Good Hope Hospital, the role partners had to play as well as identifying the way forward.

111 Key messages that were accepted by the PCTs included:

- Good Hope Hospital has been historically under-funded;
- there is a need to sharpen investment strategies - thinking strategically of where to invest or divest;
- long-term planning was weak;
- there is a lack of primary care capacity and the ability to get things done quickly;
- involvement/partnership working is slow but beginning to happen; and
- there is a blame culture and a lack of taking responsibility by all bodies in the Health Economy.

112 We consider acceptance of these key messages to be a positive step, and a follow up meeting has been arranged in May 2006. However, the Trust has not yet formally ratified or adopted the strategy. Also continued and significant action is necessary to improve the Trust's working relationships with key partners and stakeholders, particularly North Birmingham PCT. Given the scale of the Trust's financial difficulties, solutions will need to involve major changes to the way in which the Trust delivers its services. There is also need for clarity with regard to the services and volume of activity that the PCTs are willing to commission and, most importantly pay for.

113 Effective leadership, communication, engagement with and working with partners are all critical to the successful delivery of the proposals.

Appendix 1 – Audit approach

1 The audit approach was achieved by:

- reviewing financial reports to the Trust's Board, finance sub-committee, and financial returns to the SHA;
- reviewing the financial recovery plan, noting the progress in their delivery, and forming a judgement on the risk of delivery;
- interviews with members of the Trust Board and key finance staff; and
- reviewing ad-hoc papers presented to health economy meetings by the Trust, eg Director of Finance (DoF) meetings and Tripartite Performance Group meetings between the Trust and North and East Birmingham PCTs.

2 This report has not considered the quality of the clinical care provided by the Trust.