NHS LONDON

BRENT TEACHING PRIMARY CARE TRUST

Independent Management Review:

Financial Management and Corporate Governance

Michael Taylor, Independent Investigator
February 2008

FOREWORD

NHS London commissioned this independent management Review into issues within Brent Teaching Primary Care Trust. The Review was undertaken during July and August 2007.

Interviews with existing and former PCT personnel together with representatives of other stakeholder organisations formed the basis of the work. Analysis of formal records and correspondence supplemented the oral testimony provided.

I can confirm that the findings arise from weighing the available oral testimony and documentary evidence. I have not been subject to inappropriate influence from any person or organisation in stating my findings and opinions.

The Review has found that the PCT was subject to serious and serial failings in its leadership until 2007/08. The senior executive management also lacked cohesion. Worryingly, the Review has revealed a PCT Board that took pride in innovation yet was unable to reconcile this with finite finances and the effective monitoring of performance.

The scrutiny exercised by the Non-Executive arm of the PCT Board was superficial. The PCT Board also failed to heed early warnings from Auditors about deficient practices and inadequate controls.

These factors meant that the financial and governance failings of 2006/07 were inevitable because they had their genesis much earlier. The reportedly solid financial position was built on sand.

Critically, the relationship between the PCT HQ, its Primary Care contractors and its Community Care field personnel requires a significant overhaul and improvement. A schism was found at the time of the Review.

The challenges facing the new PCT Chair, together with the new Non-Executive Director team, the incoming Chief Executive and the team of Executive Directors are considerable.

Despite feeling badly let down by the former PCT leadership, loyalty to the diverse population of Brent and commitment to delivering high quality Patient care was very evident from the oral testimony provided by many interviewees.

The overall aim of this type of Review is to identify causes and responsibility; then to assist the healing and learning process. Despite some difficult messages, I hope this report is of help to the PCT in moving forward for the benefit of the population it exists to serve.

ACKNOWLEDGEMENTS

I am indebted to all persons who assisted the furtherance of this Review. I am also very appreciative of those interviewees who willingly undertook research into past events and provided additional documentary evidence.

I am grateful to Mr S Bundred (Chief Executive, Audit Commission) for allowing Ms L Sparks, (Senior Manager, Audit Commission) to attend interviews and undertake research into various technical issues.

Finally, I am very appreciative of the work undertaken by Ms S Little (Brent PCT) who performed with an exemplary degree of efficiency and tact in facilitating the progression of the Review. I wish to record my thanks to Ms M Saunders (PCT Chair) and Mr I Wilson (PCT Interim Chief Executive) for making Ms Little's services available to me.

REVIEW TIMELINE

May 2007 – Initial Briefings.

June 2007 – Collation and reading of documentary evidence.

July – early August 2007 – Interviews with 69 persons who assisted the Review.

End August 2007 – Submission to NHS London of Draft Report.

September 2007 – February 2008 – NHS London's Solicitor's two-stage process to obtain views from certain persons named in the Draft Report.

February 2008 – Submission to NHS London of Final Report.

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THE TERMS OF REFERENCE AND CONTEXT FOR THE INDEPENDENT REVIEW

"Terms of Reference

Independent Review into the Corporate Governance and Financial Management Arrangements at Brent Primary Care Trust

INTRODUCTION:

In May 2006, Brent PCT submitted a FIMS Month 12 report and draft annual accounts to the NWLSHA and DH indicating a surplus of £2.8m.

During the course of the external audit undertaken by Price WaterhouseCoopers a number of significant concerns were raised regarding the financial position of the PCT. This included late arrival of invoices from the London Borough of Brent for Continuing Care amounting to approx £3m for which no accrual had been made. In addition, an under accrual in the range of £6/7M for commissioning activity in acute and other services also came to light.

The final accounts were signed off by external audit in late September over two months after the DH deadline, showing a 2005/6 outturn of £0.4 m surplus.

In March 2006 the PCT agreed a financial plan for the 2006/7 Financial Year which identified a break even position including a savings target of £16/17m. During the 2006/7 Financial Year, monthly FIMS returns up to the end of Month 5 identified a break even position for the PCT in 2006/7.

Subsequent iterations of the Local Delivery Plan for the PCT in 2006/7 continued to indicate a break even position.

In the Month 6 FIMS return, the PCT identified a forecast outturn of £3m deficit. This has increased to £8.5m at Month 7, £17.6m at Month 9 and £24m at Month 12.

PURPOSE

In the light of the position above and the implied reporting deficiencies which allowed the PCT's financial position to be under reported in submissions to the SHA and DH, NHS London has commissioned a review into the corporate governance and financial management arrangements at the PCT. The Terms of Reference are shown below.

1. Taking into account existing work, in particular, that undertaken by the Internal and External Audit, to identify the reasons why the PCT's financial position deteriorated significantly at the end of 2005/06 and during 2006/07, and the causes of implied misinterpretation and under-reporting in returns to NWLSHA, LSHA and the DH.

2. To assess the PCT's corporate governance arrangements, financial management, financial control and reporting that contributed to this situation including the governance issues in respect of the areas of concern raised during the external audit.

3. To identify the extent to which internal and external audit had reviewed the corporate governance and financial reporting processes in the PCT prior to the events of 2006/07 occurring.

4. To make recommendations to secure sound financial management and corporate governance arrangements in the future.

5. To identify and review the involvement of individual members of the PCT Board, the Management Team and senior staff in regards to the facts associated with the deteriorating financial situation for 2005/06 and 2006/07. This will include reviewing documentation, correspondence and reports available within the PCT's Corporate Governance framework.

6. To highlight the lessons that can be learnt from the apparent corporate governance and financial failure in the PCT and to make recommendations of good practice to avoid similar situations in the future.

7. The Review will need to take account of the provisions of the DH's Code of Conduct for NHS Managers and similar codes of good practice.

8. The overall aim of the Review is to assist the PCT in moving forward and to make recommendations for improvement.

The outcome of the Review and any recommendations will be considered by the PCT Board and NHS London and the intention is that a summary of the Report and its full recommendations be made public.

Paul Baumann
Director of Finance and Performance
NHS London"

Local context:

1. In meeting the Terms of Reference provided by Mr P Baumann (Director of Finance and Performance) NHS London I have endeavoured to establish the reasons for the major failing in public accountability which occurred during the NHS financial years 2005/06 and 2006/07 at Brent Teaching PCT. This report identifies the principal and contributory causes based on the evidence made available to me.

2. I have sought to identify if the series of events in 2005/06 and 2006/07 were presaged by an absence of controls, an absence of sensible managerial practice and an absence of reasonable level of managerial foresight in previous years. Equally, I have sought to identify any mitigating factors to the problems.

3. A number of key senior personnel in these matters have moved on. The PCT is now under the relatively new leadership of Ms M Saunders (PCT Chair) and an entirely fresh Non-Executive arm of the Trust Board.

4. I have also addressed issues that remain of concern, to many of the interviewees, in order that this Review is more than a retrospective analysis.

5. Initiatives to strengthen the managerial skills and accountability within the PCT are being introduced at a fast pace by the new PCT Chair and the new PCT Board. An internal managerial restructuring exercise has recently commenced together with a review of governance arrangements. These initiatives may well mean that certain concerns identified during this Review have already been identified and put right.

National context for Code of Conduct Reviews:

6. In October 2002, the Department of Health published the "Code of Conduct for NHS Managers." NHS employers were required to issue copies of the Code to its senior managers. Managers were required to indicate that they had read the provisions of the Code and understood that it constituted part of their Terms and Conditions of employment.

7. I have been advised by the PCT's HR service that the PCT did not comply with the Secretary of State's Directions as stated on page 10 of the Code. It was confirmed to me that Contracts of Employment for the PCT's most senior managers were not amended to reflect the provisions of the Code. This error was also in contravention of the PCT's own Standing Orders issued in July 2004. Appendix 3 of the PCT's 2004 Standing Orders stated: *"The code applies to all managers and should be incorporated into the contracts of senior managers."* The PCT Chair and the PCT's Chief Executive, as the formal Accountable Officer, had a duty to ensure

compliance. The Code is a national document which is a recognised reference point for standards of professional conduct by senior managers within the NHS.

8. More positively, I have been advised that recent Contracts of Employment and local policies about acceptable standards of professional behaviour do incorporate and reflect the requirements of this national Code.

9. It is important that the new procedure be applied retrospectively to current permanent and interim post-holders by checking the terms of individual Contracts of Employment or letters of appointment.

10. In relation to the responsibility of individual managers, the Code states:

- *"…I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer."* [1]

- *"…I will accept responsibility for my own work and the proper performance of the people I manage."* [2]

11. For external investigations, into possible breaches of the Code, the document states:

- *"Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problem. "* [3]

12. On appointment to a NHS Board, Non-Executive Directors and Chairs receive a copy of the "Code of Accountability in the NHS – Code of Conduct for NHS Boards" originally issued by the Department of Health in April 1994 and subsequently adopted by the Appointments Commission.

13. This document states:

- *"Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts."* [4]

- "*The role of an NHS Board is to: be collectively responsible for adding value to the organisation…by directing and supervising the organisation's affairs…provide active leadership of the*

[1] Code of Conduct for NHS Managers: paragraph 3, page 4.
[2] Code of Conduct for NHS Managers: paragraph 4, page 5.
[3] Code of Conduct for NHS Managers: paragraph 4, page 8.
[4] Code of Conduct for NHS Boards (Second revision July 2004): page 2.

organisation within a framework of prudent and effective controls which enable risk to be assessed and managed…" [5]

14. I was unable to establish whether the PCT, at its inception, took action to ensure that all Board members were aware of the provisions of this particular national Code of Accountability. The PCT Board now includes a new team of Non-Executive Directors. A check should be made to ensure they are aware of the appropriate national codes in addition to local policies.

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15. This report provides my opinion on the matters covered by the Terms of Reference after weighing the available evidence. I have also offered Recommendations for consideration by the appropriate bodies.

[5] Code of Accountability for NHS Boards (Second revision July 2004): page 4.

SUMMARY OF FINDINGS

Financial Management within the PCT – Overarching Issues:

16. The PCT Board failed, over a number of years, to exercise a competent oversight role in respect of the organisation's financial affairs.

17. Until late 2006, the PCT Board was pre-disposed to blaming external factors for its financial ills.

18. The PCT Board failed to ensure that balance existed between its developmental work and executive grip.

19. The scrutiny of Finance Reports by the PCT Board was inadequate.

20. The former Chair of the PCT Audit Committee was expected to undertake other onerous financial duties.

21. The PCT Board did not have any successful experience, or process to call upon, when faced with a major savings programme in the 2006/07 financial year.

22. The PCT's initial 2006/07 savings programme of £16.5m was: a) insufficient: b) did not have the advantage of contributions from previous year savings initiatives: c) was initially led by an inexperienced manager in this field: and d) achieved no significant quantum of savings until Quarter 4.

23. The quality and content of the Finance Reports received by the PCT Board failed to provide the full actual and underlying financial picture.

24. The potential 2006/07 deficit was grossly understated to the PCT Board; until late 2006.

25. The PCT never felt obliged to construct a real and meaningful Financial Recovery Plan; until mid 2006.

26. The absence of a rolling Recovery and Savings Plan, allied with a poor record of accomplishment in securing in-year revenue savings meant that when reality began to hit home, at the start of Quarter 3 in 2006/07, the level of short-term savings and cost containment required was extremely high. The corollary being that the short-term consequences for many Patient services were severe.

27. Disputed invoices over Continuing Care, disputed invoices with NHS Trusts and the late submission of the Final Accounts were three problem

areas that existed before 2006/07. The PCT Board had received assurance from Dr Llewellyn, Mr Parker and Mr Patel that corrective action had been taken to prevent recurrence in these matters.

28. Action to reduce the PCT's inherited underlying deficit was unsuccessful.

29. There existed a longstanding simplistic belief, throughout the PCT, that Mr Patel would always be able to secure financial balance via end-of-year accountancy adjustments, use of unallocated earmarked funds, income from sold capital assets and reserves.

30. Mr Patel was not involved in high level commissioning decisions and delegated this key area of the PCT's activity to subordinates.

31. Non-alignment existed between decisions to commit financial resources and available finances.

32. Poor technical accounting practices persisted, despite advice from Auditors.

33. Forward financial planning and in-year financial monitoring groups were ineffective.

34. The Non-Executive arm of the PCT Board was culpable of failing to monitor agreed action by members of the Executive Team.

35. Various parties believed that the financial difficulties only arose because of new pressures in 2006/07. This ignored the overspending budgets of 2005/06 and the issues associated with the need to adjust the 2005/06 Final Accounts due to liabilities that were not processed.

Financial Management within the PCT – Specific Issues:

36. Early warnings, about the significantly worse than expected financial outturn for 2005/06, were ignored by Mr Patel and Mr Parker. The PCT Board was not made aware of this major issue until July 2006.

37. The PCT's internal reconciliation and payment arrangements were so slipshod that some outstanding invoices went back years.

38. The Deputy Director of Finance (Ms I Patel) strove, against resistance and apathy, to describe the true financial position.

39. The PCT failed to heed early warnings about the need to have improved basic systems in relation to its payments systems.

40. The working relationships and communications between the Finance and Commissioning Directorates were poor.

41. The application of a large sum for Contingent Liabilities was used to demonstrate a favourable end-of-year financial position, i.e. £6.9m for 2005/06 made up of NHS and LA creditors.

42. The PCT under accrued for Prescribing Expenditure for a number of years in contravention of national guidance.

43. The accounting treatment in respect of Prescribing accruals and Contingent Liabilities remains an area of disquiet.

44. In September 2006, the EMT chose to support a more optimistic forecast about the financial position for 2006/07, despite an Operating Cost Statement showing a potentially dire financial position.

45. Mr Patel adjusted this Operating Cost Statement to show a more favourable financial position to the PCT Board; although he did indicate in his final Finance Report that a potential deficit of £9m existed. Given that he was known to be leaving the PCT, it seems likely this prognosis was overlooked in favour of the more optimistic one.

46. As the initial savings package agreed by the PCT Board in May 2006 was insufficient, it was faced with having to agree a number of supplementary saving packages that were vague.

47. A key part of the PCT's 2006/07 savings programme was its Demand Management initiative. This was reported as being unsuccessful until late 2006.

48. Regular Risk Assessment of the early savings packages, agreed by the PCT Board, resulted in a downsizing of the anticipated returns.

49. Mr Patel was not a qualified accountant. His accepted success had been in leading the financial affairs of a NHS provider organisation.

50. Mr Patel was uncomfortable with the financial aspects of leading a complex commissioning organisation. In the early years of the PCT's history, he had access to a range of easy manoeuvres to achieve financial balance.

51. Mr Patel worked very closely with a small cadre of trusted finance colleagues, to the exclusion of others, and kept a very close personal control of the PCT's accounts.

52. Mr Patel, during the latter stages of 2005/06 and the early stages of 2006/07, regularly raised the issue of high financial risk at PCT Board meetings.

53. Budgetary planning, budgetary control and budgetary information throughout the PCT, were particularly weak.

54. Many of the PCT's Budget Managers did not own their budgets and accountability was, ad hoc, at best.

55. A number of PCT Finance personnel expressed disquiet about some financial practices they had been expected to perform e.g. write-offs, regular and late adjustment of journals, reversal of journals and the arrangements for financial ledger entries.

56. Whilst the PCT had comparatively high overall management costs, the resources within the Finance Directorate were thin, e.g. a very limited Management Accountancy resource.

57. The link and information contained in Finance Reports to the PCT Board, the FIMS returns and their associated commentaries was erratic and erroneous during parts of the 2005/06 and 2006/07 financial years.

58. The oversight and spot-checking, of the FIMS data and other financial information, exercised by the former North West London SHA, could have been better.

59. Mr Patel and Mr Parker made a series of serious misjudgements in respect of initiating corrective action and in reporting the true financial position for 2005/06 and 2006/07.

Executive Management within the PCT – Overarching Issues:

60. Members of the Executive Management Team cared greatly about the needs of the Brent population and wished to develop and augment service standards.

61. The senior management culture of the PCT was predisposed to development and innovation at the expense of measured performance and financial control.

62. Over many years, most of the Executive Directorates worked in "silos." There existed a fair amount of negative rivalry together with an absence of joined-up or matrix working.

63. There was a lack of decisive follow-up by the EMT to early warnings that the 2005/06 financial outturn would be jeopardised through overspending and the failure of the 2005/06 savings programme.

64. The effects of the tactics used to achieve financial balance were not analysed by the PCT Board or the EMT. Early warnings by Auditors, about the cumulative negative effects of these tactics, also tended to be ignored.

65. The PCT Board and the EMT failed to recognise that the overspendings and other issues, affecting the outturn of 2005/06, had all to do with a lack of in-year control and preceded the new pressures of 2006/07.

66. The lessons concerning the 2005/06 outturn were ignored until it was too late and a somewhat naïve belief persisted, until late 2006, that the financial deficit was overstated.

67. The EMT and PCT Board were not attuned to the changes required by the introduction of Payment By Results.

Wider Issues that need to be Addressed:

68. The Review has revealed a number of very serious concerns held by existing and former PCT personnel, Staff Representatives and Trades Union officials regarding the internal operation of the organisation.

69. Human Resources and Organisational Development were not perceived as being a priority.

70. It was felt, by PCT interviewees, that professional HR advice had been regularly ignored.

71. Several examples of poor HR practice were provided by PCT personnel.

72. Extreme anger was felt by many PCT interviewees about the 2005/06 Management Restructuring exercise initiated by Dr Llewellyn. Concerns were expressed that the present reorganisation would repeat past errors and delays.

73. Much criticism was forthcoming from PCT interviewees about perceived favouritism and cliques operating under the previous PCT leadership. There was considerable anxiety that this would reassert itself.

74. There was a strong belief that certain EDs had been excluded from the real decision-making and that many key executive decisions had been taken outside the meetings of the EMT.

75. There existed considerable frustration that poor performance within the Commissioning Directorate had never been corrected.

76. The PCT Board, under the leadership of Mrs Gaffin, was perceived as intolerant of dissent and being averse to any bad news about the operation of the PCT.

77. Alleged bullying and harassment incidents within the PCT HQ and in the localities have not been sufficiently recognised by the EMT or PCT Board.

78. A Board level seminar, attended by a leading organisation on workplace harassment, held in 2006, was not felt to have resulted in any action plan.

79. Concern was expressed about the confidentiality that could be expected if PCT personnel resorted to the PCT's Whistle blowing and Bullying and Harassment Policies.

80. The key messages from formal Staff Opinion Surveys were perceived as not being addressed.

81. Strategic Planning was based on a far-sighted Service Strategy written in 2003. It was stated that this had not been updated to reflect the changing NHS world. The corollary was that many assumptions were inappropriate.

82. The Service Strategy was not linked to a Workforce, Skills and Financial Resource Plan.

83. A significant amount of criticism was reserved for the capital led emphasis of the Service Strategy. This had resulted in a number of new, large and under utilised facilities.

84. The philosophy underpinning the Care Pathway approach was widely welcomed.

85. Severe criticism was forthcoming about the lack of thought given to the actual working and delivery of the Care Pathways. These concerns included; clinical safety, other governance matters, cost effectiveness, referral routes and basic administrative matters.

86. Many interviewees cited the Care Pathways as symptomatic of the PCT's problems i.e. good on the big picture; poor on delivery and detail.

87. Many concerns were expressed about the operation of the PCT's estate.

88. GPs and other Primary and Community Care personnel were heavily critical of the PCT's leadership, coordination and management of Primary Care services. It was felt that a serious dislocation existed between the PCT HQ, Primary and Community Care services at the sharp-end.

89. Conversely, certain PCT interviewees felt that the PCT had tried its best to support Primary Care. On occasions, this had been rebuffed.

90. A widespread perception existed across Primary Care that the PCT, until recently, was not in favour of Practice Based Commissioning because it eroded the power and influence of the PCT HQ.

91. Serious criticism was forthcoming about the proliferation of PCT working groups that were talking shops.

92. The relationships with LB Brent are fragile at the most senior political and executive levels due to current disputes over the Turnaround Plan, Continuing Care and Section 28a responsibilities.

93. The Borough is concerned to ensure that these disputes do not adversely affect the good relationships and day-to-day liaison between professionals delivering care.

94. The Borough believes that the Turnaround process was unilateral and could harm top-level relationships for some time.

95. Equally, the Borough feels that the PCT should have had a basic grip on its accounts to allow corrective action to be taken in a planned way. In so doing, this could have ameliorated some of the worst effects of the Turnaround Plan, which was imposed with a very short timetable.

96. The Borough found it a total surprise that the financial deficit was so large because the PCT Board had not signalled any financial difficulties whatsoever; until late 2006.

97. The collaborative joint working was felt to be satisfactory and it was hoped that eventually, the PCT would become more actively involved with the Borough's Social Inclusion and Regeneration agendas.

98. The Borough considered that the PCT misunderstood the pivotal role of the local Health Select Committee (Overview and Scrutiny role) was one of community representation; as distinct from dealing with pressures faced by the NHS organisations.

Corporate Governance within the PCT:

99. The PCT's Clinical and Corporate Governance Committee had very thorough debates about Clinical Governance matters. It did not exercise an effective oversight role of other aspects of Corporate Governance including financial risk and financial standards.

100. The "Standards for Better Health" Declaration, submitted to the Healthcare Commission in 2007, shows that considerable work is now underway to achieve compliance with the Governance standard. The 2007 Declaration is a most thorough, objective and competent piece of work.

101. In 2005 and 2006, the PCT indicated that it was Fully Compliant in the area of governance. These were erroneous Declarations.

102. Financial Risks did not feature in overall reports produced by the Clinical and Corporate Governance Committee; until December 2006.

103. All aspects of Financial Risk and associated operational aspects of Financial Governance were vested in Mr Patel.

104. The PCT's Audit Committee was viewed as the custodian for overseeing all matters relating to Financial Governance.

105. Considerable support existed for Ms Atkinson in relation to the progression of Clinical Governance and for Ms Afolabi in relation to the overall co-ordination of the Risk, Assurance and Governance agendas.

106. The new PCT leadership has initiated a wholesale review of the PCT's governance machinery.

107. The movement towards Integrated Governance has been slow. This will accelerate as part of the aforementioned ongoing internal review.

108. Financial Risk was not regarded as a priority until mid-2006.

109. The EMT did not regularly review the Risk Register until 2006.

110. The PCT's Audit Committee considered many matters in fine detail. This resulted in time being unavailable to ensure that follow-up action to Audit Reports had been properly carried through by the executive members of the Committee.

111. Similarly, the Audit Committee did not drill-down, with regularity, into the underlying financial health of the PCT.

112. The Chairman of the Audit Committee had a meticulous approach and was let down by the actions of his Executive colleagues.

113. Auditors found the Audit Committee frustrating because fundamental problems kept reappearing.

114. The Annual Reports of the Audit Committee dealt with process and not substance.

115. Until 2007/08 the Audit Committee was so mired in detail that it was unable to "see the wood for the trees" at critical times.

116. The standard of Internal and External Audit Reports was good.

117. The Auditors were far too patient with the delays and tardy responses provided by the PCT to many of their Reports.

118. From 2003/04, Auditors had highlighted problems to the PCT about financial systems and processes together with the eventual consequences of relying on end-of-year adjustments and other non-recurrent measures to achieve financial balance.

119. I wholly disagree with the assertion by a number of interviewees that Auditors were slow to identify problems.

120. The Internal Auditor was over generous in various Assurance Rankings until late 2006. It is accepted that these rankings are guided by established criteria. The PCT Board relied on these rankings; more weight should have been given to issues of non-compliance or delay by the PCT to previous Audit Reports.

121. Given the highly critical content of successive Annual Audit Letters, the External Auditor might usefully have escalated his concerns.

122. Corporate Objectives for the PCT and individual high-level annual objectives were regularly set for EDs. The collegiate attainment of annual objectives across Directorates was a hurdle.

123. Appraisal of NEDs was regular and comprehensive. Appraisal of EDs was a more problematical area, with the majority indicating that this task was at best ad hoc.

124. Job Descriptions for EDs were out of date, could not be found, or never provided.

125. A number of PCT interviewees who, as part of their duties, required being familiar with the PCT's SFIs and SOs, professed to be unaware of them.

126. The PCT has now revised its outdated SFIs, SOs and Scheme of Delegations.

Overall Opinion:

127. The principal causes for the financial position deteriorating in 2005/06 and 2006/07 were:

- Poor budgetary control.
- No linkage between activity and costs for both commissioning and service developments.
- Failure to achieve planned savings.
- Reliance on accountancy adjustments and one-off savings.
- Weak financial management and accounting systems.
- Absence of a performance culture.
- Weak scrutiny by the PCT Board.
- A divided senior executive team.
- An inexperienced PCT level Chief Executive during 2006.
- Failure to heed early warnings from Auditors.

128. Appointees to the PCT Board, before November 2006, were responsible for grave failings in the following areas:

- Inadequate oversight of the financial affairs of the PCT.
- Inadequate scrutiny of Executive Reports relating to Finance and Performance.
- Inadequate oversight of the senior Executive Team and its responsibility to ensure that a sensible balance existed between development and grip.
- Inadequate Corporate Governance machinery.

129. I hold concerns about the legitimacy of the PCT's reported final financial position for 2004/05 and 2005/06.

130. The current PCT leadership has taken steps to ensure sound financial practice, budgetary management and accurate financial reporting; both internally and externally.

131. I am of the opinion that Mr Parker and Mr Patel breached certain Principles within the Department of Health's "Code of Conduct for NHS Managers." Despite the PCT being in breach of its own Standing Orders by not incorporating the provisions of the Code into the Contracts of Employment the document is a nationally recognised point of reference for standards of professional conduct.

132. On the advice of Mrs Gaffin, Mr Parker received an increase to his original Acting-Up allowance as Acting Chief Executive to reflect his duties as the PCT's Accountable Officer. I do not consider that Mr Parker fully understood his responsibilities in respect of the overall stewardship of public funds.

133. I hold concerns about laxity in certain areas of financial practice and procedures; until recent improvements.

134. Mrs Gaffin had a distinguished record of Public Service and was exemplary in her ambassadorial and community representative roles. I hold the opinion that Mrs Gaffin was ineffective in ensuring that the PCT Board acted with balance.

135. I believe Mrs Gaffin, as leader of the PCT Board was in breach of certain provisions within the "Code of Accountability for NHS Boards" which relate to the duties of the Chair.

136. Many PCT personnel feel badly let down by their previous leadership.

137. Loyalty and a determination to continue providing services to the people of Brent was a hallmark of the resilience of many interviewees; who represent the PCT's greatest asset.

138. In spite of many difficulties, the PCT has much to celebrate, across a wide range of service excellence.

RECOMMENDATIONS

139. In providing these Recommendations for consideration, I am aware that the new PCT leadership has recently initiated many areas of improved practice. Consequently, certain of these Recommendations may well have been overtaken by improvements now embedded or being planned.

Context:

140. The PCT Chair and Chief Executive should ensure that NEDs are familiar with the provisions of the "Code of Conduct and Code of Accountability for NHS Boards" along with local Policies relating to expected professional standards of behaviour. A similar exercise should be undertaken to ensure both the understanding and incorporation into Contracts of Employment, for senior managers and EDs, the provisions of the "Code of Conduct for NHS Managers."

Financial Management within the PCT – Overarching Issues:

141. The PCT Board should consider the merits of establishing a Resources Sub-Committee to ensure that forward planning is appropriately linked to strategic service developments.

142. The PCT is in possession of many findings from Internal and External Audit Reports, Healthcare Commission Assessments, Benchmarking Exercises and this Review, which relate to Financial Management and Corporate Governance matters. To reduce the risk of duplicated effort a consolidated Action Plan should be considered; allied to clarity as to who is leading what.

143. Account should be taken of various national reports relating to financial management e.g. "Delivering Excellence in Financial Governance" issued by the DH in 2003; "The Role of the Finance Director in a Patient Led NHS" issued by the DH in 2006; "Review of the NHS Financial Management and Accounting Regime" and "Learning the Lessons of Financial failure in the NHS" both issued by the Audit Commission in 2006.

144. Care should be taken to ensure that the clarity of Finance Reports now presented to the PCT Board and senior managers is maintained as interim personnel move on. The opacity and conflicting messages in previous Finance Reports should not be tolerated.

145. A clear link between Finance Reports and Performance Reports is essential.

146. Although the Turnaround process has probably already inculcated this in the mindset of relevant PCT personnel, the idea – Finance is everybody's business – should be emphasised.

147. The PCT Board should demand that Executive Reports display clarity of content and clarity about options for discussion and decision.

148. It is assumed that the Turnaround Plan will evolve into a formal Financial Recovery Plan. Therefore, the PCT Board and the senior Executive Team will need continuing clarity and accountability for scheduled tasks and executive leadership. In other words, a checking and tracking system to ensure that things happen.

149. As time and resources allow, consideration might usefully be given to ensuring that PCT HQ personnel have time at "each others desks" and have time away from the HQ to experience the delivery of Patient services.

150. The Management Accountancy resource requires reinforcement.

151. Budgetary accountability should be made crystal-clear to individual budget holders.

152. Budget preparation timetables should be followed.

153. Budget holders should be provided with timely and accurate information.

154. Variances and requests for budgetary virement should be subject to clear discussion between budget holders and their linked Management Accountant or more senior Finance personnel.

Financial Management within the PCT – Specific Issues:

155. If not already implemented, a watertight logging and tracking system for invoices is essential. The practice of invoices being received by different parts of the organisation should be stopped.

156. The application of Contingent Liabilities should be fully understood by relevant Finance personnel as this is a sore point. A number of staff have felt uncomfortable with various accounting and financial practices they have previously been asked to follow.

157. A decision is required by the PCT and NHS London as to whether my concerns about the legitimacy of the Final Accounts and associated formal declarations, in respect of 2005/06 and 2006/07, in view of the high level of Contingent Liabilities should be followed-up.

158. A similar decision is required in relation to issues over the accounting treatment for Prescribing Expenditure by the PCT.

159. The PCT Board should consider some form of oral or written acknowledgement to junior and middle ranking Finance (and other) personnel that it has recognised the pressures and anxieties they have borne.

160. The PCT Board should consider forwarding a letter of thanks to Ms I Patel and an apology. This being in respect of the difficulties she faced in trying to disclose the true financial position of the PCT during 2006.

161. Consideration should be given to procedures followed by PCT personnel responsible for making payments. The overall Income and Debtor function should be examined to ensure compliance with best practice.

162. The FIMS returns and similar reports should dovetail, as far as different reporting timetables allow, with the financial information considered by the PCT Board. The free text Commentary might usefully be considered as an Appendix to the regular Finance Report to the PCT Board and to meetings of the senior management team.

163. The PCT Chair and Chief Executive should be aware that they are expected to know the main messages within the FIMS Returns before submission.

Executive Management within the PCT – Overarching Issues:

164. Echoing the views of many existing PCT interviewees, cohesive working between all Executive Directorates should become the hallmark standard.

165. The mainline decisions taken by the senior management team should be communicated regularly across the PCT. The residual view that decisions are taken in secret, by a small group of individuals, should be emphatically dispelled.

Wider Issues that need to be addressed:

166. Investment in a modern HR resource is a priority.

167. Basic HR processes, from employment services to monitoring of sickness absence are in need of overhaul.

168. A systematic but affordable profile for OD and individual professional training should be considered. The residual perception that investment in training has been for the favoured few should be dispelled in favour of an acceptance that training is provided on merit and need.

169. A fundamental new approach to formal staff liaison and consultation should be considered by the PCT Board. This should include half-yearly focused discussion with professional officers from Trade Unions and Professional Associations.

170. The PCT Board should consider asking the previously used Andrea Adams Trust, or similar organisation, to provide advice on identifying and dealing with systemic worries, among PCT personnel, about the level of harassment and bullying within the PCT HQ and in the localities. This has been a longstanding issue and personnel believe that senior management is not interested in resolving it.

171. Reassurance should be provided to PCT personnel that confidentiality would be respected if any person has legitimate recourse to the provisions of the PCT's Whistle-blowing and Bullying and Harassment Policies.

172. The PCT's Service Strategy should be updated, at an appropriate time, and incorporate a Resource Plan covering skills, workforce and financial considerations. As with the 2003 Service Strategy, the revision should involve stakeholders. This engagement should be ongoing and not a one off academic exercise.

173. Concerns about the management of the PCT's Estate should be taken seriously and consideration given to a programme of Audit and other specialist inquiries in the areas mentioned within the main body of this Report.

174. A new working concordat is required between the PCT and Primary Care professionals in relation to: a) a deeper understanding of Primary Care's challenges: b) the support provided by the Integrated Delivery Directorate: and c) the approach to Practice Based Commissioning.

175. Similarly, more effective liaison is required between the leaders of the PEC, the PCT Medical Director and the PCT's other clinical advisors.

176. The new PCT leadership will already know the main areas of concern held by their own personnel working within Primary and Community Care. They will also be aware of the main concerns among Independent Contractors within General Practice. This is perhaps the largest challenge facing the PCT.

177. As with Primary Care, a new working and relationship concordat is urgently required between the PCT and LB Brent.

178. Once the dust has settled over the extant disputes, the PCT will need to make clear its priorities for joint working and listen to LB Brent in respect of becoming engaged with the Regeneration and Social Inclusion agendas.

Corporate Governance within the PCT:

179. The ongoing governance review should promote the concept and application of Integrated Governance.

180. It will be important that consideration be given to the appropriate training of personnel directly involved with the process of governance, especially in the areas of Risk Awareness and Risk Management.

181. Equally, clarity will be required about the precise duties and responsibilities of the personnel responsible for overseeing and coordinating the Risk and overarching Governance agenda.

182. Emphasis should be given to ensuring that certain areas of the PCT have increased awareness of Risk issues in particular, the Integrated Delivery arm. Similarly, these specialist areas need to be overseen by a competent individual e.g. Health and Safety.

183. Some of the foundation policies and procedures require, as time allows, updating e.g. the Risk Strategy.

184. The new Audit Committee has a focused work agenda. It will also be important for the Audit Committee to develop a new understanding with its Auditors about timelines for the consideration, acceptance and implementation of Audit recommendations.

185. A consolidated Action Plan is required, if not already prepared, to identify those historic Audit recommendations which still require implementation.

186. The Audit Committee and the PCT Board need to be comfortable with, and understand the principles of Audit undertaken on their behalf. Whilst this predominantly comes from a mutually trusting relationship, a

useful refresher is provided within the Audit Commission's *"Statement of Responsibilities of Auditors and of Audited Bodies."*

187. The Audit Committee should consider inclusion, within the annual Audit Plan, time for an assessment of procedures connected with the PCT's Commissioning process, estates management, payments to creditors (in fact the whole area of Income and Debtors.)

188. A consistent approach is required to the setting and monitoring of annual objectives for members of the senior management team.

189. The PCT should ensure that relevant personnel have access to, and knowledge of, SFIs and SOs.

190. These bedrock policies should be regularly assessed to ensure compliance with the latest framework issued by the Department of Health.

METHODOLOGY

191. The first briefing for this Review was provided on 25 May 2007 by Ms H Cameron (Head of PCT Finance and Performance, NHS London,) Ms M Saunders (PCT Chair) and Mr I Wilson (Interim PCT Chief Executive.) At a second briefing, held on 14 June 2007, it was confirmed that the Review was to proceed, on the original lines proposed by NHS London, in the interests of public accountability and good governance within a public body.

192. A list of documentary evidence was prepared, together with a list of required interviewees. The PCT assembled the documentary evidence and arrangements were made to access email correspondence for various PCT personnel relating to relevant search words.

193. Following assessment of the documentary evidence, semi-structured interviews were held during July and early August 2007. A draft Report was submitted to NHS London at the end of August 2007. There then followed a two stage process undertaken by the Solicitors to NHS London, between September 2007 and February 2008, to obtain the views of persons named in the draft Report. The final Report was submitted to NHS London in February 2008. **Appendix 1** provides details of the 69 persons who aided this Review by giving oral testimony and, in some cases, supplying additional documentary evidence. Interviews took place with persons who were considered to possess relevant knowledge of the matters under scrutiny. They were held with a cross-section of personnel from various professional backgrounds, levels of seniority and different organisations who I felt could assist in establishing the truth.

194. A few interviews were conducted by telephone; almost all the remaining interviews were taped and one copy provided to the interviewee at the conclusion of the interview. Interviews were held on a non-attributable basis, except those with the most senior personnel. As shown in **Appendix 1** four interviewees held the surname Patel. The text of this Report refers to Mr Mahendra Patel (former PCT Director of Finance) or Ms Indira Patel (former PCT Deputy Director of Finance.)

195. The high majority of interviewees felt that the Review was necessary in order to understand the reasons for the PCT's financial failing in 2006/07. They also felt that it was essential for the PCT to learn from any past mistakes and weaknesses especially in the following areas:

- Internal communications.
- Transparency of executive decisions.

- Converting good ideas into cost-effective practice.

- External communications and relationship with GPs, Community and Primary Care based personnel.

- Financial management systems.

- Accountability within the PCT.

- Commissioning.

- Valuing of loyal PCT personnel.

196. A small number of interviewees felt that the Review was unnecessary because:

- Those responsible had left the PCT.

- New arrangements had replaced discredited systems and processes, especially in the areas of financial management and commissioning.

- It was a "witch-hunt" required by NHS London.

197. Mr A Parker (former Acting Chief Executive) and Dr L Llewellyn (former Chief Executive) declined the invitation to be interviewed and submitted a written response together with written answers to various supplementary questions, which I forwarded to them.

198. KPMG, who performed the first Turnaround plan, indicated that whilst they would be prepared to meet, they required a list of conditions to be met. **Appendix 2** details these requirements. I took the decision that the conditions were overly onerous and totally out of line with the co-operation extended by other leading Management Consultancies in this area of work.

199. Interviewees were advised, at the commencement of their interview, about the goals of the Review:

- To establish the truth based on the available evidence in relation to the Terms of Reference.

- To identify persons and/or systems at fault for any inappropriate and/or weak practices.

- To assist the healing process by identifying good practices and offering constructive recommendations for consideration.

200. Interviewees answered the questions most comprehensively and volunteered additional information, which they considered relevant. Some provided supplementary documentary evidence during and following their interview, whilst others willingly undertook further research into specific matters.

201. It was clear to me that the high majority of interviewees had thought very seriously about the matters under scrutiny and how they could assist me in striving for the truth.

202. I would like to record my appreciation to all those who made themselves available for their high degree of co-operation and openness; especially as some sensitive issues were necessarily addressed. I am particularly grateful to personnel no longer working at the PCT, those on maternity leave and to those who had retired.

FINANCIAL MANAGEMENT WITHIN THE PCT: OVERARCHING ISSUES

203. Based upon the oral testimony and documentary evidence, I consider the following matters to be especially significant in relation to the sudden deterioration in the PCT's financial position in 2005/06 and 2006/07:

- **Early warnings.**
- **Scrutiny by the PCT Board.** (PCT Board refers to full members i.e. Chairman, Non-Executive Directors and Executive Directors.)
- **Meetings of the Forward Financial Planning Group and its Strategic Steering Committee.**
- **Finance and associated papers received by the PCT Board.**

Early warnings.

Level of Corroboration – Documentary Evidence:

Level of awareness before April 2006:

204. The PCT Board received a number of early warnings that control and planning mechanisms were in need of improvement.

205. As early as November 2004, the External Auditor was providing very clear messages that basic systems were awry. In one of the most forceful and critical Annual Audit Letters I have seen during the course of similar NHS Reviews the 2003/04 Audit Letter stated quite unequivocally that the PCT should: *"…seek to find a long-term solution to the underlying financial problems, which may include an assessment of the level of service that the PCT can sustain in the long-term given the resources at its disposal."* [6] The PCT Board was also left in no doubt that, improvements were required in the following areas:

- Meeting the national timetable for the submission of the PCT's annual accounts.
- Addressing inappropriate capitalisation of revenue expenditure.
- Improving weak budgetary control procedures.

[6] Brent Teaching PCT: 2003/04 Audit Letter – PwC – November 2004 – Page 21.

- Dealing with the inadequate financial review of Continuing Care expenditure.

- Dealing with inadequate arrangements to reconcile balances with other NHS bodies.

206. The Minutes of the November 2004 PCT Board meeting, at which the Audit Letter was discussed, are somewhat ambiguous about the seriousness of the messages in the Audit Letter. The External Auditor is attributed with saying that: *"He was sure that the tPCT had a sound financial plan…Otherwise he believed that there were no major accounting or technical issues."* Similarly, Mr Boucher (NED) observed that: *"…with reference to internal control, that no areas or issues of concern had been found."* [7]

207. Frankly, this is a paradox and the Minute does not reflect the content of the Audit Letter. However, in fairness to the PCT Board, the External Auditor, in presenting his first Annual Audit Letter to this particular PCT Board, was presumably content with the tone of the discussion and the reassurances provided.

208. Regrettably, many of these issues were re-stated as problems in the Annual Audit Letter issued in the following year.[8] Of particular importance is the fact this Audit Letter re-states: *"…that the PCT takes steps to identify a clear medium term plan to meet its financial objectives that does not rely upon slippage and other non-recurrent solutions."* [9]

209. The 2004/05 Audit Letter also presaged issues that were to reappear, with a vengeance, at the end of 2005/06 relating to the reconciliation of balances. For example: *"Accounting Issues - The PCT experienced difficulties in identifying and reconciling its year end balances with other NHS bodies. Eventually the PCT adjusted its year end balances as allowed for in the manual of accounts…The resolution of this issue would have been much simpler had the PCT adopted a more proactive approach to monitoring balances…This will also help to reduce any uncertainty regarding debtor and creditor balances at the year-end."* [10]

The 2004/05 Financial Year:

210. In 2004/05, the need for savings had been recognised. The Finance Report presented to the PCT Board in November 2004 stated that: *"The financial position of the tPCT does not look healthy. However, the*

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[7] PCT Board: 25 November 2004 – Minute 550.
[8] Brent Teaching PCT: Audit Letter 2004/05 – PwC – October 2005.
[9] Brent Teaching PCT: Audit Letter 2004/05 – PwC – October 2005 – Page 15.
[10] Brent Teaching PCT: Audit Letter 2004/05 – PwC – October 2005 – Pages 7 and 8.

breakeven position would be achieved from slippages, and savings, which need to be agreed and generated…ATOS KPMG Consulting had submitted their proposal to implement savings. However, the cost of achieving the savings would be around 40% for a minimum savings of £1,068,000 and 20% for a maximum savings of £2,119,000. It was agreed by both the EMT and the Recovery Board that this does not represent value for money and alternatives are being considered." [11]

211. The paper went on to forecast a small surplus, which would be dependent on £6.615m of slippages and savings being achieved in the remaining four months of the financial year. The slippages and savings were not described in any detail whatsoever.

212. Dr L Llewellyn (Chief Executive) advised me: *"…it was agreed that repayment of the remaining debt would be over 3 years (commencing 2004) with a finance recovery group set up to manage and oversee projects set up to deliver savings. The decision to set up a deficit budget in 2005/06 was taken explicitly with the deficit being underpinned by sale of land at Willesden and slippage in other budgets. It should be noted that 20 months ago when these conversations were taking place the necessity was for PCTs to deliver one year plans and it was commonplace to do this using recurrent and non recurrent means."*

The 2005/06 Financial Year:

213. From the beginning of 2005/06, the PCT Board knowingly entered a high-risk financial programme of investments. This is confirmed by the acceptance of a £4.4m deficit at the PCT Board meeting of March 2005 when Dr Llewellyn stated: *"…that realistic savings plans were being developed to address this. A two year savings plan was being developed."* [12]

214. At the September 2005 meeting of the PCT Board the financial position was reported to be heading for a potential deficit of around £5m based on rolled forward commitments from 2004/05 and in-year overspending. It is interesting that Mr Boucher, NED and Chair of the Audit Committee is reported to have stated: *"…at this stage it was too early to quantify the financial risk. He believed, though there would be key discussions at the November meeting of the Board."* [13] Moreover, in reporting the establishment of a Forward Financial Planning Group the PCT Board accepted that its target was: *"…to review the current level of spending to generate savings in excess of £1m."* [14] There appears to be no

[11] PCT Finance Report – 25 November 2004 – Paragraphs 5 and 6.
[12] PCT Board: 17 March 2005 – Minute 643.
[13] PCT Board: 22 September 2005 – Minute 767.
[14] PCT Board: 22 September 2005 – Finance Report – Paragraph 15.

correlation with the original savings programme of £4.8m as shown in **Appendix 3** or, that it was significantly under achieving.

215. From the Minutes of the November 2005 PCT Board meeting, key discussions about the overspending budgets and the attainment of the savings programme did not take place. Mr Mahendra Patel (Director of Finance) stated that: *"…he anticipated at this stage that the tPCT would be able to meet its targets at the end of the year."* [15]

216. As shown by **Appendix 3** the savings plans for 2005/06 were also largely unsuccessful. A surplus was dependent on the sale of land at Willesden. The underlying deficit and overspending budgets remained very significant matters.

217. The financial picture presented to the final PCT Board meeting in March 2006 was also upbeat with Mr Patel stating: *"He felt that overall the financial position was healthy…there continued to be risks associated with Continuing Care and the SLAs."* [16]

218. This meeting, I consider, was important for three other reasons:

- The Operating Cost Statement shows that the projected surplus of £2.8m, to meet the PCT's Control Total agreed with NWLSHA, was based on a deficit operating position of £7.016m reconciled with positive *"Potential slippages and savings"* of £9.816m; of which £4.9m was to be achieved from the sale of land at Willesden.

- The Financial Plan for the financial year 2006/07 was received and supported. This showed that a savings programme of £21.715m was required. This was to tackle underlying cost pressures from previous years of £5.203m and additionally, recognised that: *"… financial breakeven will only be achieved if the budgets are reduced by £16,512k."* This included: *"…underlying cost pressures of £5,203k in 2005/06."* [17]

And crucially -

- The section on *Risks* categorically stated: *"The tPCT has not implemented any major cost savings plan."* [18]

219. These basic issues and inconsistencies do not appear to have alarmed the PCT Board. They were, however, to become a significant portent of later unfortunate events. It is also clear that the first year of the two year savings programme entered into in 2005/06 was largely

[15] PCT Board: 24 November 2005 – Minute 803.
[16] PCT Board: 23 March 2006 – Minute 889.
[17] PCT Board: 23 March 2006 – Financial Plan 2006/07 – Paragraphs 4.3 and 5.1.
[18] PCT Board: 23 March 2006 – Financial Plan 2006/07 – Paragraph 6.

unsuccessful and that the sale of the Willesden land had not, in fact, contributed to reducing the inherited underlying deficit.

Scrutiny by the PCT Board in 2006/07.

220. The PCT Board met in Public Session and Private Session on the following dates in the 2006/07 financial year: 25 May, 20 July, 28 September, 23 November 2006, 25 January and 22 March 2007. Private Part 2 meetings were held on these dates followed by a Private Part 3 meeting on certain dates, usually attended by the voting Non-Executive and Executive Board members. Additionally, the Board met informally at seminars on various occasions and were briefed on Financial and other matters.

Level of Corroboration - Documentary Evidence:

221. The Finance Reports and resultant Board Minutes, for the financial year 2006/07, have been examined in relation to the ongoing financial position. What I consider apposite points from PCT Board discussions about the 2006/07 financial position are **quoted thus**:

222. PCT Board meeting – 25 May 2006:

Financial Savings Plan - 2006/07: *"It was noted that in the March paper that there was an additional underlying cost pressure of £5.2m in 2005/06, making a total requirement of £21.7m. However measures have been implemented to manage this hence the savings target required against budget is £16.5 million…with two months of the year already completed, it is now urgent that the Board agrees proposals to be implemented…"*

Board Minute – 914: *"The Teaching Primary Care Trust unanimously agreed the proposal…"*

Finance Report – Year ending 31 March 2006: *"…there was* **(a)** *net surplus of £2.8m."*

Board Minute – 924: *"Mr Boucher recognised that the figures had not yet been audited…The Director of Finance explained that it was anticipated that a number of outstanding invoices would remain…"*

223. PCT Board meeting – 20 July 2006:

Minute 958 - Financial Statements 2005/06: *"…some issues had arisen from capitalisation of the assets, so that the surplus had reduced by*

around £400,000; and also that that an adjustment of approximately £2.2million was required in terms of accruals as a consequence of the late arrival and reassessment of some NHS and non-NHS invoices…Mr Boucher recalled that the tPCT had been late in submitting its accounts on a former occasion."

Financial Report and Delivery of the Savings Plan Report: *"The tPCT is reporting a deficit of £1.5 million at month 2…the savings plan results in increasing savings during the year, so this gap should reduce…There are risks to the savings plan between £2m and £6m…"*

Minute 959: *"The Teaching Primary Care Trust approved the further schemes to achieve the overall savings plan amount of £16.5 million."*

224. PCT Board meeting – 28 September 2006:

Financial Statements 2005/06: **"***Net surplus as per audited Financial statements = £430,000…The auditors issued an unqualified audit report to the Directors of the Board…However, the auditors qualified their conclusion on arrangements for securing economy, effecting* **(efficiency)** *and effectiveness in the use of resources."*

Minute 995: *"The Teaching Primary Care Trust ratified the Financial Statements 2005/06."*

Financial Savings Plan – Risk Assessment and Recovery Plan: *"The PCT needs to develop a further recovery plan of at least £6m to cover the high risk of not delivering all the savings at this stage…the PCT would benefit from Phase 1 of* **(an)** *external Turnaround resource, which would further test the robustness of the current plan and recovery plans and recommend further action on recovery."*

Minute 996: *"The Teaching Primary Care Trust noted the risk assessment and risk management actions and agreed the recovery plan."*

Finance Report: *"The tPCT will require a further savings plan and actions to reduce the overspending so that the projected deficit of £9m can be reduced."*

Minute 1000: *"Mr Boucher asked the Director of Finance what he felt to be the main areas of concern at this stage. The Director of Finance believed that the key issue was achieving savings in the area of commissioning and ensuring that demand management initiatives were effective…The Teaching Primary Care Trust discussed the report."*

225. PCT Board meeting – 23 November 2006:

Minute 1034 - Turnaround Plan: *"…none of the new proposals were yet agreed, but it was imperative to make the required level of savings…The 94 savings proposals included in the plan had been drawn proportionately from all areas of the tPCT…the longer the delay in working towards the savings the more difficult they would be to achieve."*

Minute 1035 – Finance Report: *"The Interim Director of Finance…focussing particularly on the Income and Expenditure table, which showed a month 6 overspend variance of £15.9million…She also referred to the forecast of performance to* **(the)** *end of the financial year which demonstrated that the tPCT would be £25.1 million overspent without the impact of the turnaround plan…Mr Boucher complimented the Interim Director of Finance and her team on the new format of the paper. He asked how much of the £14.2 million savings target had been achieved to date. The Turnaround Director replied that this was £2.3 million approximately…The Teaching Primary Care Trust discussed and noted the report."*

226. PCT Board meeting – 25 January 2007:

Minute 1054: *"…The Chair…wanted to state to the public the deep regret of the Board for the weakness of financial control that had happened in the past…The Chair stressed that the savings must be made, the tPCT must balance its books over the next 18 months…she advised that there will be pain on the way but she particularly welcomed the ongoing partnership working with the Council…"*

Minute 1058 – Turnaround/Savings Plan Report: *"…the Turnaround Director… highlighted that it is now clear that the £14m target will not be achieved by the end of March 2007, it will achieve approximately £9m and for 2007/08 achievement will be somewhere in the region of £21m."*

Finance Report: *"Deficit against Resource Limit - £21.2m…The main reason why the deficit has increased from the £16.5m reported for the end of November to £21.5m at the end of December is because £10m is now included for 2005/06 issues, compared to £5m last month…By the end of December, gross savings of £4.4m had been achieved compared to the target of £6.9m in the turnaround plan."*

227. PCT Board meeting – 22 March 2007:

Finance Report: **"Expenditure to the end of February is £26.5m over budget which is an increase of £4.3m on the deficit reported at the end of January and the year end forecast outturn has been revised to £25m."**

Minute 6 – Turnaround Report – February 2007: *"The PCT would exit this financial year overdrawn by £25m. The PCT was now, for the first time in at least 18 months, only spending what it earned."*

Meetings of the Forward Financial Planning Group and its Strategic Steering Committee.

228. In association with discussion at meetings of the PCT Board, the PCT's most senior managers met at a separate meeting known as the Forward Financial Planning Group (FFPG.) Additionally, the FFPG had a Strategic Steering Committee (SSCFFP) with the NED Chair of the PCT Audit Committee (Mr Boucher) chairing the SSCFFP meetings.

Meetings in 2005/06:

229. These two Groups, **Appendix 4** were established in July 2005 and created inter alia:

- *"…to explore and identify solutions to reduce the financial deficit…*
- *to produce a 6 month project plan for reviewing costs and making recommendations of cost reduction schemes…*
- *to review financial control and governance processes to ensure these are at a high standard."* [19]

230. At the meeting of the SSCFFP held on 7 November 2005 a list of potential savings schemes were discussed; also within **Appendix 4.** Interestingly, this shows that heavy reliance was being placed on the sale of the Willesden land and the sale receipt expected matched precisely, at £2.8m, the PCT's Control Total set by the SHA for 2005/06. Additionally, the redundancy costs of the ongoing management re-structuring do not appear to have been factored into the target saving against the two year planned savings target of £1.5m. The Minutes (Item 1) of this meeting also show that the SLA with North West London Hospitals Trust (NWLHT) was subject to conflict over coding of Patient episodes, whether the PCT

[19] **FFPG – 4 July 2005 – Attachment A.**

should follow the national Secondary Uses Service (SUS) guidance as being adopted by NWLHT and that Q1 Patient activity had yet to be signed-off.

231. In addition, at this meeting, concerns were raised about two aspects of the Estates and Facilities Management Service Level Agreement (SLA):

- That expected annual costs of £1m had risen to £1.6m.

- *"There appears to be a lack of clarity and control at K&C as invoices are being raised for costs that sit outside the service level agreement."* [20]

232. At the FFPG meeting held on 5 December 2005 a key area of discussion was the number of filled but unfunded posts within the PCT, which compromised the ability to meet planned management cost savings.

233. A particularly important meeting of the SSCFFP occurred on 9 January 2006 **Appendix 5.** Extracts from the Minutes show that extensive concerns existed about the 20005/06 financial position:

- *"AP* (Mr Parker) *stressed that the 2005/06 overall commissioning out-turn would influence the 2006/07 LDP…*

- *AP also stressed that the Tribal sector* (Secta) *report on Continuing Care (on behalf of NWLSHA) exposes Brent as being a high cost PCT compared to the national average…*

- *PB* (Mr P Beal) *reported that the management restructuring was now complete, however redundancy costs still need to be assessed, and could be between £0.5m to £1.5m…It is not likely that there will be any generation of savings during 2005/06, as most staff are on 3 months notice…*

- *PB stressed that there were savings generated compared to 2004/05 agency costs but not as high as anticipated…*

- *IP* (Ms Patel) *shared with* (the) *committee savings plans from other sector wide PCTs. It was agreed that for 2006/07 the PCT needs to be a lot more robust in setting schemes and monitoring the position against these…*

- *AP asked the committee to review PCT LIFT commitments, in light of the present financial climate, and also the provider functions, capital assets, and to look at ways of doing things differently."* [21]

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[20] SSCFFP – 7 November 2005 – Note 2.
[21] SSCFFP – 9 January 2006 – Notes 1, 4, 5, 6, 7 and 11.

234. The SSCFFP on 6 March 2006 received a paper **Appendix 6** from Mr Patel *"Savings Target – 2006/07."* Although proposing to end the 2005/06 financial year by meeting its Control Total of £2.8m surplus, the paper shows that an actual overspending of £5.203m had occurred due: *"…to cost pressures resulting in overspending in the current year…The first step we need to take is to plan to reduce the overspend of £5.2m in 2006/07."* The total savings target for 2006/07 was projected in Mr Patel's paper as being £20.141m.

235. At the same meeting, in March 2006, Mr Patel presented the *"Financial Plan 2006/07"* this projected a lower savings target amount of £17.455m for 2006/07 as EDs had agreed to find additional savings and stay within their budgets. This figure is reflected in the Minutes of this meeting; no mention is made of the former paper and the higher figure.

236. The Minutes also show that: *"It was agreed that the Executive Directors should now focus on drawing up a savings plan…"* [22]

237. As shown previously, Mr Patel, in his approved "Finance Plan - 2006/07" to the March 2006 meeting of the PCT Board stated that: *"The tPCT has not implemented any major cost savings plan."*

238. An anomaly, in respect of 2005/06, is shown in **Appendix 3 – Part B.** These are Financial Commentaries produced by Mr Patel in respect of Months 6 and 7. They show that the PCT had a Savings Scheme Target for the year of £4.8m and an admission that actual annual savings would only total £1m at Month 6. The projected outcome was revised upwards to £1.8m at Month 7.

239. These documents were produced at the same time that the FFPG and SSCFFP were considering savings schemes for 2005/06 and subsequent years. These Groups did not appear to be monitoring the accomplishment of a definitive Savings Plan, for 2005/06, anywhere near the original £4.8m target as shown in the Commentaries. In any event, if they had done so, the Commentaries, **Appendix 3 – Part B,** clearly show that the expected actual level of savings for the year would be significantly less than the target figure.

Meetings in 2006/07:

240. Come the FFPG meeting of 3 April 2006 the savings target for 2006/07 was back to £21.7m. In respect of 2005/06 Mr Patel: *"…stressed concerns regarding the acute service level agreement over performance."* [23]

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[22] SSCFFP – 6 March 2006 – Note 6.
[23] FFPG – 3 April 2006 – Note 2.

241. At the SSCFFP meeting of 8 May 2006 the savings target was, once again, at the lower figure of £16m: *"AP highlighted that currently there was a gap against the savings target of £16m as the PCT had identified schemes totalling £10.6m…CB stressed that the PCT should not lose sight of the need to continue to deliver safe services to patients as well as meet* (the) *savings target. AP added that if the PCT did not deliver safe services and the savings target, it would not be fit for purpose."* [24]

242. By the FFPG meeting of 5 June 2006, budgets for 2006/07 had still to be issued. The key debate was around how the Savings Plan was to be structured and measured. From early May, a Director of Business Improvement (Mr M Hellier) had been appointed, via a secondment, whose key tasks included driving forward the 2006/07 savings programme.

243. The actual accrual of meaningful savings had yet to start; as the PCT Board only approved the first savings package, of £16.5m, at the end of May 2006. No information was provided to the PCT Board about any accumulated benefit from the savings programmes of previous years. In other words, the PCT was not benefiting from the rolling addition of savings produced by programmes that had commenced in previous financial years. Similarly, no detailed explanation was provided to the PCT Board as to how the savings plan had been successfully reduced from £21+m to £16.5m.

244. At the SSCFFP meeting, held on 3 July 2006, Mr Patel advocated the need for a further £3m savings programme as the profiled savings for the first two months of 2006/07 had not been achieved. The Pay Tracker information, **Appendix 6**, demonstrated that at an overspending against budget of £0.781m for the first two months of 2006/07 occurred. The messages of tackling the cost pressures from 2005/06, given at various meetings in Quarter 4 of 2005/06 by Mr Patel, were clearly not being followed through.

245. By the FFPG meeting of 7 August the forecast end of year outturn, for 2006/07, was a deficit of £3.9m with the year to date deficit standing at £0.953m. With regard to the 2006/07 savings plan: *"…MP highlighted the need to draw up project plans for further savings, and AP emphasised the need to increase the controls and monitoring, e.g. around commissioning…"* [25]

246. The final Minutes made available to me were from a meeting of the SSCFFP held on 4 September 2006, **Appendix 6**. By this time the PCT was about to: a) enter the initial stage of Turnaround undertaken by KPMG: b) was projecting a deficit of £4m, at Month 4, with an under recovery in its planned savings: and c) brainstorming a raft of new savings ideas consequent to meeting its share of a further a further London-wide levy.

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[24] SSCFFP – 8 May 2006 – Note 2.
[25] FFPG – 7 August 2006 – Note 7.

Finance and associated papers received by the PCT Board.

247. Clear and focused Finance Reports were received by the PCT Board from the end of 2006. My examination of the finance papers submitted to the PCT Board in the two years, prior to the end of 2006, showed a number of basic technical and presentational deficiencies:

- During 2005/06, the Finance Reports were rather thin on detail and limited discussion about sizeable funding gaps appeared to have been undertaken by the PCT Board. For example, in May 2005 the "Draft Budgets – 2005/06" were approved with acceptance that the: *"… gap in funding £4.4m as agreed by the Board in March 2005. It is intended that this would be funded from savings and slippages."* [26]

- I have not been provided with any documentary evidence to show that any systematic or successful process was in place to compile, monitor or evaluate in-year savings programmes before the middle of 2006/07.

- Allied with this matter is increasing concern, at the PCT Board during 2005/06, about the Local Delivery Plan (LDP) funding gap that, in May 2005, totalled £2.5m. This was impeding finalisation of certain Service Level Agreements (SLAs.) It was recognised: *"… that it would be necessary to change some of these commitments. One way of doing this might be to consider recycling existing resources."* [27] Such levels of imprecise reporting are continued throughout the year in respect of achieving financial balance.

- The Finance Reports had limited correlation with the Monthly Performance Reports. For example, the Performance Report presented to the May 2006 meeting of the PCT Board showed that in respect of the acute SLAs: *"Overall over-performance for the year 2005/06 is approximately £6.5m."* [28] At the same meeting, a healthy picture was presented about the achievement of a financial surplus in 2005/06.

- The Performance Report presented to the next PCT Board meeting, in July 2006, signally omitted any follow-up to the reported £6.5m deficit within the previous Performance Report. Indeed this particular Performance Report is so full of indigestible detail that NEDs would have struggled to ascertain the key messages.

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[26] PCT Board – 12 May 2005: Draft Budgets 2005/06 – Paragraph 7.
[27] PCT Board – 12 May 2005: Minute 686.
[28] PCT Board - 25 May 2006: Performance Report – Acute SLA Performance Monitoring.

- Until mid-2006/07, the Finance Reports were opaque as to the actual decisions expected from the PCT Board. The opening page did ask Members to discuss and note the Report but did not point the way towards key items for discussion and decision.

- Until the March 2006 meeting, of the PCT Board, Finance Reports omitted Balance Sheet information.

- The Finance Reports did contain a comprehensive Operating Cost Statement. This however, appeared to use the Potential Slippages and Savings section as a convenient "balancing house" to show the achievement of a satisfactory projected financial outturn.

- Emphasis was placed on risks, forecasts and assumptions. This approach covered both savings and income. There was little definitive information provided about the actual achievement of savings or, for that matter, the difficulties of achieving savings. Little information was provided about income.

248. Additionally, large assumptions were made without any real foundation. Probably the most disturbing related to the "massaging-out" of the £5.2m underlying cost pressures within the Financial Savings Plan presented to the PCT Board in May 2006. This joint paper by Mr Patel and Mr Hellier stated: *"It was noted in the March paper that there was an additional underlying cost pressure of £5.2m in 2005/06, making a total savings requirement of £21.7 million. However, measures have been implemented to manage this. Hence the savings target required against budget is £16.5 million."* [29]

249. These measures were not described and the recollections of Mr Parker and Mr Patel are interesting. Mr Parker advised me: *"I think the £5.2million reported in the savings plan report was intended to reflect the budget over-commitment from 05/06 that had been covered non-recurrently through the receipt of the sale of Willesden and other slippage."*

250. Mr Patel advised me: *"In preparing the plan there was recognition of underlying cost pressures of £3-£5m in 2005-06. However, it was agreed at some point in time that this would not be incorporated in the savings plan and instead each Director will ensure that the expenditure was within budget."*

251. The recollections of both Mr Parker and Mr Patel demonstrate that in reality the savings package that the PCT Board should have been asked to support in May 2006 was in the order of £21.7m and not at the reduced sum of £16.5m. This was because of the recurrent budget overspendings,

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[29] PCT Board: 25 May 2006 – Financial Savings Plan – Summary.

from 2005/06, were to be contained within the normal 2006/07 Directorate budgets and be additional to the new wave of savings totalling £16.5m.

252. A more detailed and expert commentary of the Finance Reports is provided at **Appendix 7.**

Level of Corroboration – Oral Testimony:

253. A high number of interviewees told me that detailed scrutiny of the Finance Reports presented to the PCT Board did not occur until late 2006. This standpoint was echoed by certain former NEDs. Furthermore, I was told by one existing Board Member that: *"Jean* (Mrs Gaffin) *would look to Charles Boucher and if he appeared content we moved on."* Mrs Gaffin disagreed with this viewpoint. The Minutes of PCT Board meetings, until late 2006, do show that the recorded contributions to discussion about financial matters by NEDs were almost all attributed to Mr Boucher.

254. The following observations, made to me, by various interviewees who attended PCT Board meetings exemplify the situation in relation to consideration given to financial issues:

- *"Finance was not a priority for the Board because we had always balanced the books."*

- *"…we looked at what was needed not what could be afforded and I remember regularly being told that land sales would cover funding."*

- *"The Board and the senior managers desperately wanted to improve things for our deprived population…I cannot with any honesty say we pored over every plan to check if it could be funded."*

- *"I had faith in Mahendra* (Patel) *and I or the Board had no reason to feel otherwise."*

255. Recipients of this Report possessing a longstanding knowledge of how the former PCT Board operated, in relation to the consideration given to financial matters until late 2006, will be able to confirm, or otherwise, whether such comments are a truthful reflection.

256. Many interviewees said that they found the language used in certain Finance Reports confusing. I was provided with examples by a number of interviewees who could not understand how various issues were reconciled. A selection is provided here:

- *Example One:* The reconciliation of sizeable differences between the monthly Operating Cost Statements, presented to EMT, and the final version presented to the PCT Board as part of the Finance Report was not understood.

- *Example Two:* The "Savings Target - 2006/07" paper presented to the FFPG in March 2006 was found confusing, because, on page one it confirmed that a surplus for 2005/06 had been achieved. It then stated that the net overspend on budgets was £3.8m but that this would be £5.2m if under-spending in certain budgets was omitted.

- *Example Three:* Confusion over how the term "slippage" could be used so flexibly. In some finance papers, it was a good thing – when applied to funds not required for the original purpose and thereby available to offset overspending elsewhere. In other papers, the term being used to convey bad news, in respect of planned savings not being achieved.

257. The right or wrong interpretation of these financial management and accountancy niceties is not the point. Many PCT interviewees stated that they had been confused on the one hand, yet on the other hand, re-assured, because the PCT was viewed as being financially successful. For example; through being in balance and loaning out capital as brokerage.

OPINION:

258. After considering the documentary evidence and oral testimony, I am of the firm opinion that the PCT Board failed, over a number of years, to exercise a competent role in overseeing the financial affairs of the organisation. The events of 2006/07 were, in my view, inevitable and an accident waiting to happen.

259. To blame wholly poor financial leadership and poor financial management would be the convenient explanation. This, in my view, would be both incorrect and unjust. A PCT Board works to the principle of collective responsibility. I believe there are a number of factors, which show that the PCT Board failed, as a collective whole, to provide adequate stewardship of public funds. The main factors are described below:

Brent PCT feeling that it was the victim:

260. The PCT, in 2006, tended to blame its ills on the imposition of London-wide top slicing, Purchaser Parity levies and other developments such as Payment By Results. What appears to have been conveniently

forgotten is that the 2005/06 budgetary overspendings and the financial outturn problems preceded most, if not all, of these 2006/07 pressures.

261. I hold the unequivocal opinion that the PCT Board and its most senior managers believed that end-of-year accountancy adjustments and the utilisation of, for example, land sale income would continue to assuage operational financial pressures. This faith was, I believe, wholly based on Mr Patel's proven ability to deliver financial balance in successive years. Throughout this Review, the term: *"Mahendra's back pocket"* was used by a fair number of PCT interviewees of all levels of seniority.

262. For whatever reason the PCT Board did not anticipate, or plan, for the inevitability of a changing NHS financial world until it was far too late. Indeed, the "penny did not drop" about the NHS financial world having fundamentally changed until the start of 2006/07. Furthermore, the EMT, nor the full PCT Board, appeared to have used the well-published findings of crises in some other London PCTs as a toolkit to forearm themselves in any comprehensive way. I do accept that Dr Llewellyn did initiate some safeguards following her secondment to a troubled PCT in 2005 and prior to her departure from Brent at the end of 2005.

263. I find it inexplicable that Mrs Gaffin, accompanied by Mr Parker in October 2006, advised the Brent Health Select Committee (the local title for the Overview and Scrutiny function): *"…that the Brent tPCT Savings Programme 2006/07 was the result of steps taken by the Department of Health (DoH) to make savings rather than the result of any deficit in PCT funds."* [30]

264. Admittedly, Mrs Gaffin partially retracted this remarkable statement at the next meeting: *"…it had been asserted that the Savings Plan had been implemented as a result of Department of Health (DoH) requirements to make savings rather than any deficit in PCT funds. However, it was now acknowledged that the situation was more complex, with the PCT itself being responsible for some of the current financial problems."* [31]

265. As noted previously, Mrs Gaffin also apologised on behalf of the Board at the January 2007 PCT Board meeting: *"…for the weakness of financial control that had happened in the past."*

266. Immediately before doing so; the PCT Board Minutes record that Mrs Gaffin stated: *"…that on looking at the debt some of it was out of the PCT's control through "topslicing of budgets" by the London Strategic*

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[30] Health Select Committee – 4 October 2006: Minute 6.
[31] Health Select Committee – 6 December 2006: Minute 4.

Health Authority and some new technical adjustments such as Payment by Results payments that had to be made." [32]

267. My concern is on two counts:

- That in October 2006 Mrs Gaffin still believed, presumably after briefing by members of the Executive Team, that the PCT was immune from any responsibility for the financial problems. This was despite: a) the 2005/06 Accounts having to be re-opened and adjusted: b) the early exit of Mr Patel: c) that KPMG were re-profiling and extending the Board's own savings programme: d) the PCT Board was advised at its September meeting, by Mr Patel, there was a potential deficit of £9m: and e) the PCT Board had received numerous early warnings from Auditors about its financial management systems and the parlous state of its underlying financial health.

- At the January 2007 PCT Board meeting, the ills of the PCT were still only being laid at the door of inadequate financial management.

268. I hold the unequivocal opinion that the PCT Board was blind to very deep-seated weaknesses in its overall senior managerial infrastructure, from its inception until comparatively recently.

269. Moreover, I consider, that the PCT Board had a most immature and amateurish approach to dealing with in-year financial pressures. Essentially, it relied on convenient end-of-year financial manoeuvres e.g. income from land sales and technical adjustments. Additionally, the PCT's methods for financial planning and budgetary control were wholly ineffective.

Inadequate scrutiny of executive reports:

270. The documentary evidence and oral testimony shows that little searching scrutiny was exercised of the regular Finance Reports and other financial information presented to the Board; until mid-2006.

271. I believe that it was a fundamental error for Mr Boucher to be expected to undertake the role of Audit Committee Chair and provide the NED input to the SSCFFP. I consider this to have been unfair on Mr Boucher. I fully understand that, among the NEDs, Mr Boucher was seen as the financial expert, but equally, as Audit Chair he had to be a "critical friend." It has also been shown previously that Mr Boucher provided the

[32] **PCT Board: 25 January 2007 – Minute 1054.**

regular, and usually sole, questioning of financial papers at PCT Board meetings.

Historic approach to savings programmes:

272. Until May 2006 there was little analysis by the PCT Board of proposed savings programmes. The PCT was faced, at the start of 2006/07, with a huge challenge to affect savings and it had no successful experience to call upon.

273. Ostensibly, the PCT had embarked on annual savings programmes previously. They were poorly planned and not particularly successful. For example, the 2005/06 Management Restructuring was intended to save £1.5m over two years. This did not materialise and basic issues such as associated redundancy costs were not factored into the savings forecast. Taken together, all of this is evidence that the PCT Board did not effectively monitor the in-year achievement of its savings programmes.

The original 2006/07 savings programme:

274. The PCT Board gave considerable thought to the range, health impact and financial impact of the original savings programme of some £16.5m, agreed at the May 2006 meeting. The evidence unfortunately shows:

- That £16.5m was too low a sum.
- The planning was not carried out early enough.
- Almost all the savings were from a standing start, i.e. savings initiatives did not roll forward from previous years.
- An inexperienced manager in this field was appointed by Mrs Gaffin, Mr Boucher and Mr Parker to co-ordinate and progress the largest savings programme in the history of the PCT.
- Many new savings areas had to be constructed from Quarter 3.
- No significant quantum of savings materialised until the start of Quarter 4.
- The PCT Board and some of its most senior managers believed, until well into Quarter 3, that the financial challenges were manageable.

Quality of Finance Reports:

275. The regular Finance Reports presented to the PCT Board, until recently were, in my view, amateurish and failed to provide the full picture of the prevailing resource situation. This view was also shared by the PCT Board at its November 2006 meeting; regrettably too late to alter the scale of the emerging financial problems.

276. Specifically, I am very concerned that the Finance Reports routinely stated that a high level of risk existed, but then proceeded to provide a bullish forecast about the eventual year-end outturn being in balance. That is, until Mr Patel's final Board meeting in September 2006, when he advised that the potential deficit could be £9m (this was undermined through an unprofessional act by Mr Patel, which is addressed later.) As we know now, this was a gross under-estimation; but higher than the deficit suggested by Mr Parker and Mr Hellier.

277. A shortcoming was that the PCT Board never felt obliged to construct an early Financial Recovery Plan, simply because, until mid-2006/07, it did not consider that it was in need of one.

278. The absence of a rolling Recovery and Savings Plan, allied with a poor record of achieving in-year revenue savings, meant that when reality began to hit home, at the start of Quarter 3 of 2006/07, the level of short-term savings and cost containment required was extremely high. The corollary being that the short-term consequences for many Patient services were severe.

Awareness of long standing financial issues and financial tactics to achieve balance:

279. Disputed invoices over Continuing Care, disputed invoices with NHS Trusts, late submission of the Final Accounts are three problem areas that existed well before 2006/07. The PCT Board had received assurance, on numerous occasions, that measures to avoid repetition of these problems had been initiated. As we know these issues became very problematical again from mid-2006.

280. Equally, the PCT Board was aware that financial balance in 2005/06 had been dependent on income from a major land sale. Mrs Gaffin described the position thus: *"…given the expectation that the sale of land in Willesden would cover any deficit, and the expectation that the issue of disputed invoices would not be an issue again, I felt confident towards the end of the financial year that Brent tPCT would not have a deficit."*

281. The historic underlying financial deficit was also known about and its eradication was an aim; although Mr Patel and certain other senior PCT

interviewees felt that it was not viewed as a priority. Conversely, Dr Llewellyn and Mr Parker indicated that the PCT was committed to removing the inherited underlying deficit over a three to four year period commencing in 2004/05.

282. Mr Parker described the position as: *"This was very much down to Mahendra* (Mr Patel)*…Previous years recurrent deficits were funded through phasing of growth expenditure through the year and through the use of non recurrent funds. Recurrent overspends had been a feature of the PCT since its inception and the plan was to reduce these down over the 06/07, 07/08 periods at which point NHS growth would reduce. Mahendra was used to managing in year pressures, I know that many in year pressure*(s) *were addressed to him over the years as they had been in his Parkside Trust days."*

283. All of this is indicative of a Board that relied on regular assurances; yet failed to drill down into the reality of the assurances received.

284. I am therefore forced to the opinion, that until Quarter 3 of 2006/07, the simplistic belief persisted among EDs and NEDs that, as in previous years, the financial problem would be sorted out by Mr Patel. One former PCT Board Member described the situation thus: *"We were regularly told that we were at high risk but at the end of the day we met our statutory requirements."*

285. In 2006/07, the sands of time ran out. The avenue of financial adjustments and adroit use of growth funds was closed-down because of continued internal overspending, unfunded cost pressures, the impact of London-wide levies and having no systematic approach for the achievement of savings.

Reasons for the Financial Deficit:

286. I consider the following to be the main reasons for the financial deficits that occurred:

Financial Management Reasons:

- The former Director of Finance was not involved with high level commissioning. Despite this being a main function of the PCT.

- Non-alignment between decisions to commit resources and affordability.

- Poor technical accounting practices e.g. no standard practice in relation to financial journals, inadequate invoice logging and reconciliation systems and limited segregation of duties in the area of income and debtors.

- Financial management processes not being attuned to operating in a commissioning organisation.

- Savings programmes not being closely monitored and failing to deliver, until Quarter 4 of 2006/07.

- A poor track record of achieving savings year-on-year.

- A failure to understand the impact of the underlying historic deficit and the cumulative negative effect on affordable service planning.

- Regular and significant use of Balance Sheet "raids" and other accountancy adjustments to manage the end-of-year position and thereby restrict the options available in the succeeding year.

- Finance Reports presented to the PCT Board that included significant assumptions and risk analyses. They did not include objectively based forecasts and targets about the end of year position.

- Budget setting that was not rigorous and was based on the roll-forward of outturn budgets. No sanctions existed for poor budgetary management or rewards for good budgetary management.

- Budgets that were not owned and proactively managed by budget holders.

- A weak Management Accountancy resource to support budget holders.

- Routine budgetary information to budget holders that was not held in high esteem as it did not reflect changes and was, at times, late.

Other Management Reasons:

- A management team that was out of its depth in respect of progressing major savings programmes.

- Ineffective forward financial planning and financial monitoring groups.

- An inexperienced PCT level Chief Executive in 2006.

- A former PCT Chair who was dedicated to the well being of the PCT but who eschewed conflict and criticism of the PCT and relied heavily on others in relation to financial scrutiny.

- Rivalries and poor communication between certain Directorates.

- A PCT that was motivated by innovation and development with limited appreciation of a performance orientated management culture.

- Weak secondary care commissioning.

- A Board that was committed to enhancing services and representing the Brent population but which had limited financial and commercial expertise.

- A Board that failed to drill down into vague and opaque reports.

- Inadequate linkage between financial and activity information.

Summation:

287. I wholeheartedly recognise that the PCT Board endeavoured to develop services for the people of Brent and that both arms of the Board worked hard to achieve this. I further recognise that Mrs Gaffin and certain other NEDs, in particular Mr Boucher, worked well beyond the "call of duty."

288. I also recognise that Mrs Gaffin issued an apology at the public meeting of the PCT Board in January 2007 in respect of financial mismanagement and a lack of financial control.

289. I do not believe that this apology was comprehensive enough. I am firmly of the opinion that the apology should have included reference to the inadequate internal working arrangements of the senior management team and the weak oversight exercised by the PCT Board.

290. The PCT Board, in my view, did not:

- Provide effective governance.

- Provide effective financial control; which is one the limited statutory duties of a PCT Board.

- Appraise the performance of its Executive Directors with sufficient rigour.

- Anticipate and plan for emerging service and financial pressures.

291. These failings have resulted in the need for a Turnaround Plan that, by its very nature, demands short-term and very painful adverse effects

on Patient services, personnel and Patient Care facilities. If the PCT's senior management activity had been more cohesive and more balance had existed between development and grip, then a planned approach, rather than a crisis reaction, to financial pressures may well have been possible.

292. I totally reject the arguments put forward by certain parties that the severe financial problems only arose in 2006/07 and were, largely, not of the PCT's making.

293. The 2005/06 Final Accounts debacle was caused by longstanding internal incompetence. Equally, the overspendings in 2005/06 had nothing to do with the new pressures of 2006/07.

294. The financial crisis of 2006/07 had much to do with the legacy from 2005/06 and the slow management response to kick starting a meaningful savings programme. Planning of savings should have commenced much earlier. Equally, Mr Parker should have had a competitive process to appoint a proven manager, to drive forward the savings programme and tighter internal budgetary controls in early 2006.

295. Overall:

- The PCT Board failed to ask the right questions.
- The Finance Department operated poor systems.
- The Director of Finance was out of his depth.
- The Accountable Officers were ineffective in the area of financial stewardship in 2005/06 and 2006/07.
- The EMT was slow in commencing corrective action even though it knew, in early 2006, that financial plans for 2005/06 were badly awry and would seriously affect 2006/07.

296. I am of the unequivocal opinion that all full members of the PCT Board, holding office in 2005/06 and 2006/07 and before November 2006, were culpable of corporate failings in the oversight of the PCT's financial affairs.

FINANCIAL MANAGEMENT WITHIN THE PCT: SPECIFIC ISSUES

297. During the course of this Review, various matters have become known from examining the documentary evidence. Other issues have been drawn to my attention by interviewees who, in some cases, undertook further research and were able to provide supportive information.

298. I have addressed the following issues because I considered them particularly pertinent:

- **The 2005/06 financial outturn.**
- **Financial Report and Savings Plan Report to the PCT Board meeting in September 2006.**
- **The accrual for Prescribing Payments.**
- **The professional leadership of the PCT's Finance function.**

The 2005/06 financial outturn:

Part 1 - January to May 2006:

299. The Control Total for the PCT set by the former NWLSHA was a surplus of £2.8m. The Finance Reports received by the PCT Board stated that this target would be achieved. They also expressed confidence that all the PCT's financial statutory duties would be met. The Finance Report received by the PCT Board at its May 2006 meeting stated: *"The operating cost statement shows the total net expenditure of the tPCT for the year. It shows that there was* (a) *net surplus of £2.8m. This is in line with the control total agreed with North West London SHA."* [33]

300. The enclosures, within **Appendix 8** suggest that major concerns existed, about the likely 2005/06 outturn, both at the end of the financial year and shortly thereafter. The emails and analyses of mid-March 2006 show a potential overspend of £15.490m in respect of commissioned services; excluding Continuing Care charges. The emails and analyses of early-May 2006 show a worst-case deficit of £24.998m and a best-case deficit of £6.7m.

[33] **PCT Board: 25 May 2006 – Finance Report – Paragraph 5.**

301. I forwarded these documents to Mr Parker, who denied having seen them previously: *"The papers you have attached are not ones I have any memory of having reviewed before. When we discussed the year end position I was aware that there were pressures, including pressures on SLAs, however Mahendra* (Mr Patel) *was confident that these pressures could be managed through slippage and the use of non-recurrent resources. At no time during this period did Mahendra tell me that he believed he was unable to deliver the control total figure. The main risk we were focused on from 05/06 was associated with achieving the profit on the sale of Willesden. This was achieved."* Mr Parker also confirmed that he had not been involved in any meetings to verify or risk assess the documents within **Appendix 8.**

302. Mr Patel, at interview, stated that the issues within the documents of **Appendix 8** were reconciled at a meeting, in July 2006, attended by Mr Parker, Finance and Commissioning personnel. He did not consider that the large deficits for 2005/06 in these documents were valid when they were originally passed to him by his Deputy, Ms Patel.

303. The views expressed by other PCT Finance and Commissioning interviewees centred on their awareness of financial pressures within the acute SLA in Quarter 4 of 2005/06. They indicated that it was well known, throughout Quarter 4 of 2005/06, that the acute SLA was overheating by a significant degree.

304. One former PCT interviewee, who had held a very senior Commissioning position, stated: *"We all knew that the 05/06 SLA was over-performing greatly and we did little about it…Performance Reports went to the Board, then no response…it was if acute commissioning could not be touched…the Exec Team did not appear to be worried so why should I have been."*

305. The following are a selection of other comments made by both existing and former PCT personnel who held Commissioning or Finance responsibilities:

- *"…my main difficulty was managing the worsening position upwards – there was no regular link between SLA reports and finance reports and I was told that reserves existed to sort out any overspendings."*

- "*No one knew the full picture and Mahendra* (Mr Patel) *and Andrew* (Mr Parker) *did not acknowledge the risk at the end of that financial year."*

- *"There really was no forward planning for the 06/07 SLA and this repeated the position in 05/06…commissioning was not joined up with finance."*

- *"In January we knew the SLAs had big problems….I reported to Indira* (Ms Patel) *that it could be as bad as £8m and she passed it on."*

306. **Appendix 9** includes an exchange of emails between Mr Parker and various PCT personnel, in May 2006, and a letter dated 15 May 2006 from Ms Patel to Mr Patel.

307. In his email, of 24 May 2006, about the 2006/07 Commissioning Gap, Mr Parker makes reference to the 2005/06 outturn position: *"Presumably only a gap if we really believe* (t)*hat the projected 'overperformance' for year end is real and massive – I'm sceptical?"*

308. In Ms Patel's letter of 15 May 2006, she makes reference to a meeting held on 8 May 2006, involving Mr Patel and a second one with Mr Patel and Mr Parker: *"I raised my concerns about the 2005/06 financial health of the PCT, as the year end process identified £18 million proposed expenditure over the Brent control total…Later on that afternoon we both met with Andrew Parker, and we shared with him the year end position and he supported you, in that the tPCT needed to report the position as already stated and projected."*

309. Mr Patel's response to Ms Patel's letter was that: *"She wrote the letter in anger but did not give any details of £18m…She was invited to the meeting on 14 July to raise all the outstanding Commissioning and any other financial matters for 2005/06 accounts."*

310. Along with other material, I forwarded Ms Patel's letter to Mr Parker, who responded thus: *"Clearly the two of them had very different approaches and styles. I was aware that they did not see eye to eye on matters, something I had discussed with the chair and audit chair. Nonetheless, in May I still had a reasonable degree of confidence in Mahendra,* (Mr Patel) *having been very much a 'safe pair of hands' for many years. He had expressed to me that he felt that Indira* (Ms Patel) *was relatively inexperienced and did not have the full picture of the PCT's finances. My perspective would be that this letter emphasises those differences."*

311. I also asked Mr Parker to reaffirm when he first became aware that the 2005/06 outturn was potentially worse than the reported £2.8m surplus. His written reply was: *"…when it brought to my attention towards the end of July by Samih* (Mr Kalakeche) *and Mahendra* (Mr Patel) *that there appeared to be an under-accrual in respect of continuing care invoices."*

312. This appears to be at odds with the notes of the January 2006 SSCFFP meeting, quoted earlier and within **Appendix 5.** It also appears to

be at odds with Mr Parker's email of 24 May 2006 and the meeting held with Mr Patel and Ms Patel on 8 May 2006.

313. I have not been able to find any evidence that Mr Parker or Mr Patel took the potential SLA and Continuing Care over-spending seriously or felt the need to make any deep enquiries about the situation, until July 2006, when the end-of-year Final Accounts reconciliation crisis emerged.

314. One of the most disturbing aspects of **Appendix 8** is the fact it shows that the PCT was aware, in May 2006, that historic invoices existed for Continuing Care from LB Brent going back to 2003/04 - some two years previously.

315. The validity of these very old invoices is not the point, the fact that they were still on the PCT's financial record, in May 2006, as a possible liability is very much the point.

Part 2 – June to September 2006:

316. I was advised by PCT interviewees that more invoices from the LB Brent and NHS Providers started to emerge from April 2006 with the largest batches arriving during late June and in July 2006. Finance interviewees described the situation thus:

- *"We received 560 invoices from the Council and they had been held in our Continuing Care department for weeks…for some reason these invoices went to Continuing Care – all others came straight to Finance."*

- *"Many of the Continuing Care invoices valued at over £4m arrived just as the Final Accounts were about to be signed…Mahendra* (Mr Patel) *was very shocked by this as we had written to managers in March asking them to send us any invoices they had…It then got worse because we were sent lots of hospital invoices as well."*

- *"…some of us had raised the issue of delays to processing these invoices before - because they were sent to Commissioning but nothing happened."*

317. I was also told by various more junior PCT interviewees they had seen many old invoices that had *"HOLD"* written on them. They assumed that as it occurred in previous years, this was normal practice.

318. Some reconciliation meetings about the outstanding invoices occurred prior to a detailed meeting on 14 July 2006 involving Mrs Gaffin, Mr Boucher, Mr Parker and Mr Patel. This was some two months after the

emergence of information of a potentially serious financial impact for 2005/06.

319. It was the meeting, on the 14 July, that was the catalyst for taking the problems seriously. On 17 July Mr Parker and Mr Patel met Mr P Donnelly (former Director of Finance – NWLSHA.) This was to advise him of the emerging position that was likely to have an adverse impact on the, already reported, PCT's compliance with the agreed Control Total of a £2.8m surplus for 2005/06.

320. Mr Donnelly's recollection of the July meeting was that Mr Patel and Mr Parker indicated that the extent of the problem was likely to be in the order of a £2m - £3m, which would reduce the surplus for 2005/06. This situation was a complete surprise to the SHA because, up to that point, the PCT had not reported any financial pressures whatsoever. Following this meeting, the SHA required the PCT to submit fortnightly financial monitoring returns.

321. In respect of meeting the Control Total Mr Patel stated to me that he was: *"…aware of SLAs over-performance, but we still reported a £2.8m surplus to the Board after discussing this with Andrew Parker and Indira Patel and we agreed that once we knew what the definite liability was it would then be put in the books and reported to NWLSHA, Auditors and the Board."*

322. It is clear that the PCT Board acted with extreme diligence and speed following the July PCT Board meeting when it was established that the 2005/06 Accounts would need to be re-examined. The Board appointed a Sub-Committee. It also commissioned the Internal Auditor to carry out a comprehensive review of the outstanding invoices that had been received from various providers.

323. Mrs Gaffin, Mr Boucher, Mr Parker and Mr Patel recognised the seriousness of the problem and worked assiduously in trying to achieve an appropriate solution.

324. The 2005/06 Accounts were eventually agreed in September 2006 and a surplus of £0.43m declared. This, however, was based on a Contingent Liability of £6.9m made up of NHS, LB Brent and other provider creditors.

325. The issue of Contingent Liabilities was of concern to a number of PCT Finance personnel. Three of whom expressed their disquiet as follows:

- *"Contingent Liabilities was a regular tactic used by Mahendra* (Mr Patel) *at year end along with other tactics to show break-even had been achieved."*

- *"This was an area of mine and I was closely involved – but I did struggle to understand the whys at times."*

- *"…a high number for the contingencies…it was a surprise that some of these sums were not accrued for and it was again surprising to me the auditors allowed it."*

326. A great amount of management time was expended, in mid-2006, on these detailed matters. An unfortunate, yet inevitable consequence was aptly described by Mrs Gaffin: *"…I believe that this may have contributed to the financial problems of the following year as the over-performance issues began to surface and took second place to getting the accounts signed off."*

OPINION:

Early information about the 2005/06 financial outturn:

327. I hold the opinion that, for whatever reason, both Mr Parker and Mr Patel chose not to take seriously the early warnings about the significantly worse than expected 2005/06 financial outturn. I am satisfied they received indications that the likely outturn position was much worse than that reported at PCT Board meetings.

328. I believe the evidence within **Appendix 5** clearly demonstrates that both Mr Parker and Mr Patel, along with their ED colleagues and Mr Boucher were fully aware that significant financial pressures existed during 2005/06. Specifically, with: a) the acute SLAs: b) Continuing Care: c) the low achievement of planned cost savings: d) planned reductions in the cost of Agency Staff: and e) capital commitments. They were also aware that the cumulative effect would have an adverse impact on 2006/07.

329. The email sent by Mr Parker on 24 May 2006 is evidence that he was aware, albeit sceptical, of a potentially sizeable gap regarding the acute SLA outturn for 2005/06.

330. I believe Mr Patel chose to ignore the early warning produced by his own staff and chose, instead, to rely on his historic ability to manipulate the end of year position through the judicious use of accountancy adjustments and non-recurrent funds.

331. I am of the opinion that the PCT should have acted more professionally in dealing with these claims for payment. It is also unfathomable to me why two months were lost, from the information being available about a massive potential liability, and the commencement of meaningful action to achieve reconciliation.

332. The fact that Mr Parker and Mr Patel chose to ignore such early warnings was, in my opinion, a grave error of judgement by both of them.

The invoice saga:

333. My main concern about the impact of the invoices from LB Brent and NHS Providers is not the quantum, the lateness or the processes that were undertaken to check whether they should be paid. What I am particularly concerned about is:

- **One -** the problem had been experienced in previous years and the PCT Board had received assurances from Dr Llewellyn, Mr Parker and Mr Patel that corrective action had been taken.

- **Two –** the internal reconciliation and payment arrangements were so slipshod that some of the outstanding invoices went back years.

- **Three –** that no-one at senior level within the Commissioning and Finance Directorates, or at EMT meetings, was talking to each other about known, and very large, potential bills in respect of Continuing, Secondary and Tertiary care.

334. Regrettably, I am forced to the conclusion that delay and obfuscation in this area was a deliberate ploy undertaken at the end of successive financial years. This was to assist the construction of a favourable end-of-year financial position.

335. If a combination of other financial pressures and the determination of Ms Patel to establish the true financial position had not occurred then, I believe, the ploy would have continued.

336. I have been provided with a great amount of detailed information from various parties about how this matter was addressed to show that some aspects concerning the legitimacy of the Continuing Care and other invoices remain unresolved. (These matters have nothing to do with the issue over Contingent Liabilities that I address shortly.) I have taken the decision that it would have been wasteful of time to drill-down into every aspect because the issues have already been pored over; both by the PCT's former and current management teams and more specialist experts than me.

337. To carry out a further detailed examination would not remove the kernel of this matter. This, in my opinion, is that problems would not have arisen if the PCT:

- Had taken cognisance of early-warnings about weaknesses within the Finance Directorate. For example, by systematically following-

up the recommendations within various Audit Reports and having a basic tracking system for invoices.

- Had taken seriously and addressed known problems relating to the poor and immature working relationships between some of its Executive Directorates; especially that between Finance and Commissioning.

338. Mr Patel denied that serious problems existed between the Finance and Commissioning Directorates while Mr Parker acknowledged this was an issue that he had tried to address when he became Acting CE.

339. I am also minded to believe the testimony of many existing and former PCT personnel who were adamant that rivalry (denied by Mr Parker) and a lack of openness was indeed the usual order of things during the tenure of Mr Parker and Mr Patel as the heads of these two Directorates. I was also faced with a significant amount of oral testimony about a very poor working relationship between the PCT's Integrated Health Services and Commissioning Directorates. These issues are addressed later.

340. If not already resolved, what appears particularly important is settlement of the current legal standoff over the general Continuing Care and S28a disputes between the PCT and LB Brent. The underlying problem is very old and persists despite groundbreaking initiatives, such as a local "Umbrella Agreement" brokered a few years ago. The focus of attention should be the avoidance of a lengthy legal dispute where Patients, Carers and the general taxpayer are the eventual losers - with the only winners being lawyers in the form of the fees they receive. I am sure that various parties will argue that this opinion is over simplistic.

341. The high level and composition of Contingent Liabilities as distinct to the accrual of large and known creditor sums within the accounts, not solely in 2005/06 but in previous years, is of considerable concern.

342. I am uneasy that the manoeuvres over Contingent Liabilities may have undermined the legitimacy of the 2005/06 Final Accounts, the formal Letter of Representation and associated declarations, such as the SIC.

343. Grounding definitively, these highly technical matters would require specialist Audit analyses. On the one hand, the cost effectiveness of such enquiries would need to be balanced against the fact that the current PCT senior management team has worked diligently to expose the full legacy of the accumulated financial deficit and is taking decisive action to restore the PCT's financial standing. Additionally, it is well on the way to introducing modern standards of accounting practice and financial management.

344. On the other hand, the PCT ended 2006/07 with a deficit of just under £24m. Much of this was attributable to the laxity of internal financial control in early 2006/07 and previous financial years. As such, there exists the concomitant duty of accountability to the taxpayer in order to explain whether the application of Contingent Liabilities, to achieve financial balance, was correct and in line with conventional NHS accounting practice. This is a decision for the PCT and NHS London to make.

345. I hold the opinion that Mr Patel was principally at fault for these failings and to a lesser degree, Mr Parker as the PCT's Accountable Officer. I further consider that the PCT Board and its Audit Committee was culpable in failing to ensure that promised corrective executive action, prior to 2006, was effective.

346. I consider that Ms I Patel should be commended for her diligence, in the face of resistance and apathy, in trying to describe and disclose the true financial picture.

Financial Report and Savings Plan Report to the PCT Board meeting in September 2006:

347. This PCT Board meeting occurred on 28 September 2006. Previously, on 11 September, the EMT discussed the Financial Operating Cost Statement for the four months ending July 2006 and the Financial Savings Plan. During the EMT meeting: *"Andrew Parker noted the difference between the figure of risk in the turnaround report and that contained in the present report and Mahendra Patel and Mike Hellier agreed to ensure consistency between the reports. Mike Hellier also believed that the future position on commissioning might be in the area of £5 million rather than the quoted £8 million."* [34]

348. The Operating Cost Statement provided by Mr Patel to the EMT meeting is given at **Appendix 10.** A potential deficit at year-end is shown as £11.159m.

349. Following the reconciliation requested by Mr Parker, the Operating Cost Statement provided to the PCT Board, at its meeting on 28 September 2006, (also within **Appendix 10**) as part of the Finance Report gave a reduced forecast deficit of £4.081m.

350. Simple comparison of the two Operating Cost Statements showed that the lower overall forecast deficit figure was achieved by removing certain deficit figures in the first Statement and substituting them as a

[34] EMT: 11 September 2006 – Note 9.

positive figure in the second Statement. Additionally, whole sections in the first Statement are omitted from the second Statement e.g. Joint Working.

351. Even more disturbingly, the PCT Board does not appear to have picked up the fact that the Operating Cost Statement presented at the Board meeting differed in style and content from that presented at previous meetings.

352. The inconsistencies are compounded by the fact that elsewhere in the Finance Report Mr Patel indicated that: *"The tPCT will require a further savings plan and actions to reduce the overspending so that the projected deficit of £9m can be reduced."* [35] Therefore, a glaring anomaly was present in the main text and an Appendix of the very same paper received by the PCT Board!

353. This managerial yo-yoing of savings assumptions and of the forecast deficit figure was to reappear later in 2006.

354. The Financial Savings and Recovery Plan, [36] presented by Mr Hellier, indicated that: *"The key gap is on demand management savings, where, despite some slippage, the key issue is the effectiveness of our schemes."*

355. This document proposed further savings of £2.7m on top of the £16.5m package agreed at the May Board meeting and a second £2.9m package agreed at the July Board meeting. A total of £22.1m.

356. Unfortunately, an error appears to have occurred in the paper's Recovery Plan analysis that does not seem to have been picked up by the Board. If added correctly the analysis would have shown that the savings gap was £6.1m not £3.2m. The further savings target of £6m was based on a £3.2m gap, it is logical therefore that a higher level of additional savings was required.

357. Far more important than these details, is the fact the analysis showed that the original savings package of £16.5m, for 2006/07, had, been reduced to £11.3m after risk assessment. Of which £4.7m was attributed to failures in the demand management initiative at the end of Month 4.

OPINION:

358. I hold the opinion, that this sequence of events, demonstrated that the EMT did not have a grasp of the reality relating to the financial pressures generated by the month on month operation of the SLAs or a

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[35] PCT Board: 28 September 2006 – Finance Report – Paragraph 15.
[36] PCT Board: 28 September 2006 – Financial Savings Plan – Risk Assessment and Recovery Plan – Paragraph 2.

grip on the total savings programme. This has nothing to do with the additional pressures generated by London-wide in-year impositions.

359. It was, I consider, also bizarre that, at the EMT on 11 September, Mr Parker chose to favour Mr Hellier's more optimistic estimate of the likely commissioning deficit. More especially, when it was known that the PCT's Demand Management initiatives were struggling to achieve savings and that the PCT had a long history of overspending in its acute SLAs.

360. Additionally, it was in my view, wholly unprofessional of Mr Patel to adjust the presentation of the Operating Cost Statement, so blatantly, when he clearly was very worried about the financial position. I do accept that he was influenced by Mr Parker's and Mr Hellier's desire to paint a more optimistic financial picture. Nonetheless, and even allowing for the fact that he inserted into the main text of his Finance Report that a potential deficit of £9m existed, this action was plain wrong.

361. The other unfortunate aspect is that at this time, Mr Patel was known to be taking early retirement and the PCT's leadership had become critical of his financial management ability and acumen. I am minded to believe that the PCT Board did not take, too seriously, Mr Patel's prognosis about this higher level of deficit. This would not be altogether unsurprising as it did not match the much lower forecast deficit he provided in the, albeit, revised Operating Cost Statement.

The accrual for Prescribing Payments.

362. This is a complex story. I was advised by former NWLSHA Finance personnel that it was first raised in connection with the 2003/04 Final Accounts. It reappeared as an issue in August 2005 in relation to the Final Accounts for 2004/05. The substantial adverse impact took effect in 2006/07.

363. The information provided to me by former NWLSHA Finance personnel, about 2003/04 and 2004/05, was that: *"…in 03/04 they had basically written back that creditor. It only came to light in 04/05 - we weren't aware at the SHA until 04/05…it was around £3.9m he only claimed two weeks creditors instead of nine and we certainly advised that it was wrong - and the Auditors were going to make a change then they suddenly backtracked at the last minute which we couldn't understand as others in the patch had to change. It was obviously going to come back at another point in time."*

364. The eventual harmful result was on a slow burning fuse. The issue became a sizeable contributor, at £4.7m, to the 2006/07 £24m deficit.

365. The Finance Report to the March 2007 PCT Board meeting provided a most useful synopsis: *"The reason for this deterioration in the deficit is a historical issue which dates back to Brent and Harrow Health Authority. The HA, and subsequently the PCT, has consistently underprovided for the Prescription Pricing Authority (PPA) creditor at year end. Locally approximately 2 weeks' expenditure has been included whereas the recommended level is 7 weeks and the value of this difference is £4.7m. Many PCTs had a similar issue but most corrected this 2 years ago in line with Department of Health advice but this did not happen in Brent."* [37]

366. I have examined the historic records and **Appendix 11** provides a contemporaneous record, produced in August 2005, for Mr Boucher by Ms Patel. This describes events from the perspective of the PCT. It shows that advice was taken from the External Auditor and the former NWLSHA following a query about the 2004/05 Final Accounts by the Department of Health.

367. The Minutes of the October 2005 PCT Audit Committee show that concern existed about the accounting treatment. However, the Annual Audit Letter received in October 2005 stated: *"In line with guidance from the Audit Commission, we reviewed the basis on which prescribing expenditure was accounted for, particularly the accrual included in the accounts for expenditure incurred but not notified to the PCT as at 31 March 2005…We were satisfied that the accrual had been calculated appropriately."* [38] As shown by **Appendix 11** the issue of the accounting treatment placed the PCT in the firing line between the External Auditor, the former NWLSHA and the Department of Health.

368. Whatever the rights and wrongs of the accounting treatment in relation to the Final Accounts, the fact remains that the PCT was under accruing for this area of expenditure. This practice had continued for a number of years. It is this issue, which reappeared and required corrective action by the PCT in Quarter 4 of 2006/07.

OPINION:

369. It is clear that the PCT was in error to operate with a low accrual ratio, as this, in reality, stored up problems that have now materialised. I can only presume that this is an issue around Mr Patel's early lack of awareness of the financial commitments of a commissioning organisation. I can merely speculate that to increase the provision would have reduced Mr Patel's flexibility in the management of the accounts to achieve financial balance; at a time when the scope for exercising flexibility was becoming more restrictive.

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[37] PCT Board: 22 March 2007 – Finance Report – Page 1.
[38] Brent teaching Primary Care Trust – 2004/05 Audit Letter: PwC – Page 9.

370. The External Auditor has maintained a position that the correct advice was given to the PCT. This is a specialist area of Audit and if it is felt that the historic accounting treatment should be disputed, the recipients of this Report will need to commission an independent Audit opinion. This matter, along with my concern about the application of Contingent Liabilities, could cast further doubt on the legitimacy of the Final Accounts for 2004/05 and 2005/06, together with the associated formal declarations, e.g. the SIC.

371. From my perspective, for this Review, the PCT's Interim Director of Finance has taken decisive action to identify the full extent of the problem and the level of liability. Corrective measures have been implemented after discussion with NHS London.

The professional leadership of the PCT's Finance function.

372. Mr Patel was not a qualified accountant. His experience and successful record of accomplishment over many years was a key factor in his appointment as the PCT's Finance Director. It is apparent that he was appointed after thorough checks had been made by Dr Llewellyn with his former NHS employer (Parkside NHS Trust) and KPMG who provided a positive and detailed analysis of his professional competencies. Mr Patel's appointment was via an externally assessed competitive selection process. I was also advised that the views of the former London Regional Office's senior finance personnel were sought prior to Mr Patel's appointment. Due to the elapsed time, I have been unable to establish whether the Appointments Panel, the former SHA or the former London Regional Office obtained a dispensation from the Department of Health to appoint an unqualified accountant as the PCT's Director of Finance. I have been advised by the Department of Health that it has expected such dispensations to be sought, for many years, and well before Mr Patel's appointment to Brent.

373. What does not seem to have been thoroughly checked was Mr Patel's suitability for leading a large organisation with extensive responsibilities for Commissioning.

374. In the early years of the PCT's existence, when financial growth was available, these matters were not problematical. Moreover, the PCT possessed, as one interviewee put it: *"…plenty of low-hanging fruit…"* In other words, a wide range of capital assets and very high comparative management costs that provided easy savings and income. Painless savings which allowed the PCT to achieve financial balance year-on-year.

375. Many interviewees advised me of their professional concerns on four fronts:

- That Mr Patel had a small cadre of former Parkside financial personnel whom he worked with very closely in controlling the PCT's finances.

- Finance personnel, including his Deputies, who did not fit into his traditional style of operating were gradually excluded from the "inner sanctum."

- That it was extremely difficult to obtain a full picture of the PCT's finances.

- Various financial management practices seemed odd.

376. In fairness to Mr Patel, at interview, he confirmed that his was a Provider background and that he largely left commissioning matters to his two Deputies; initially Ms Evans followed by Ms Patel.

377. Mr Patel also confirmed that as financial pressures were not a real issue, until 2006/07, he was able to achieve financial balance through end-of year adjustments use of slippage and non-recurrent funds. Crucially Mr Patel stated, quite forcibly, that the PCT wanted: *"…developments and not hear about the need for a performance culture."* He expressed exasperation that his regular messages about risk to the PCT Board and the EMT went largely unheeded before mid-2006/07. Dr Llewellyn denied that such concerns were made known.

378. He went on to say that in the early part of 2006/07, he was the only Executive Director who was emphasising the level of financial risk. Moreover, that he encouraged Mr Parker to obtain additional skills in the organisation in order to develop and progress the savings programme. On this issue Mr Patel, professed disappointment that he was not involved in the appointment of what was, in effect, the PCT's first Turnaround Director. He believed that Mr Parker, in appointing Mr Hellier, chose someone he knew and someone who, whilst possessing a Performance Management background at SHA level, had no experience of the hands-on delivery of a major savings programme in an operational NHS organisation.

Budgetary Management:

379. It was readily admitted by many PCT Finance and non-Finance interviewees that deep-seated weaknesses were evident in the following areas:

- The annual budgetary planning process.

- Accountability for the effective management of budgets.

- Unreliable, inflexible and often late routine budgetary information.

380. PCT interviewees described the situation thus:

- *"We were given plenty of responsibility but no real authority…if we had a financial issue or bid we were simply told to speak to Mahendra* (Mr Patel)*…everything was so central."*

- *"…support from Management Accountants to help me run and understand my budget was minimal and I have to say grudgingly given."*

- *"He controlled the finances no-one else really knew."*

381. Conversely, some PCT Finance interviewees provided this perspective:

- *"It is easy to criticise Mahendra Patel about the way it all worked then, but you have to remember no-one else was really bothered about the money side."*

- *"I don't remember many managers at my door saying they were unhappy with their budget report."*

- *"…until last year our ways of working were praised by the Board…some Directors were quick to take the credit for what we did."*

Financial practices:

382. A number of PCT Finance personnel expressed to me disquiet about certain practices that they had been asked to perform by their senior manager. They stated to me that these practices were frequent. What particularly concerned them was that they never received an explanation for the action. Issues included:

- Writing-off of balances within certain ledger accounts at year-end e.g. Payments on Account.

- Regular and late adjustment of journals after closure.

- Reversal of journals into the previous financial year. Certain PCT personnel expressed disquiet that so much occurred, in September 2006, to aid the 2005/06 outturn.

- Mr Patel acting as sole arbiter as to what was to be included, or omitted, from the ledger.

383. Of particular concern to certain PCT Finance interviewees was the "closed approach" to how things worked. A number expressed surprise about how things operated and in particular Mr Patel's very tight control of the internal and external reporting mechanism.

384. One senior Finance interviewee stated: *"Mahendra* (Mr Patel) *controlled the Balance Sheets and Mahendra spoke directly to the Financial Controller on issues to do with the Final Accounts."*

385. I was faced with concerns from a number of existing and former PCT Finance personnel that Mr Patel did not seem to appreciate or fully understand the role of a PCT Finance Director; bearing in mind that the majority of budgets were associated with commissioning.

386. A number of Finance interviewees stated that the PCT had achieved financial balance, on the back of applying unused sector wide specific allocations to its own Accounts, at the end of financial years. This practice then engendered a cost pressure in the following year, which on occasions, would be met by a similar tactic. These interviewees expressed concern, albeit without proof, that the PCT had wrongly applied certain dedicated allocations; the London Fund and Healthy Harlesden were two examples given from both the early and later years of the PCT's life.

387. A number of existing and former senior PCT Finance personnel told me that they had worked in the dark. To quote one very senior interviewee about the early years of the PCT: *"What I kept on saying is I cannot see the full picture… I cannot sit here and people believe in my competence when I can't see the whole picture and that's the one thing I kept on saying over and over again to Lise* (Dr Llewellyn) *and some others…that I was worried that I was working in isolation here without seeing everything that was going on…I felt that I would give a false picture if I tried to do the complete budget statement because I didn't know what was going on in some of those budgets."*

388. This professional anxiety was echoed by junior PCT Finance personnel who had held posts more recently. One of whom stated that: *"Mahendra* (Mr Mahendra Patel) *and Manu* (Mr Manu Patel) *had always worked that way it was as though Mahendra did not want any changes."*

389. I was told that both Mr Patel's Deputies were excluded from key Finance discussions and information. The result being that only Mr Patel held the full financial picture. More worryingly, was the concerns expressed to me that Finance personnel were expected to fall in line or risk being marginalised. In addition, even temporary Finance staff had expressed surprise at the opaqueness and method of performing certain financial management and accounting tasks.

Finance Department - skills and staffing resources:

390. The management costs incurred in the PCT have been traditionally high in comparison with similar NHS organisations. In relation to the Finance Department, the paradox is that "engine room" functions appear to have been poorly resourced in terms of hands-on Management Accountancy and Financial Accountancy personnel. I have already mentioned that many of the PCT's general management personnel felt un-supported in relation to their budgetary management responsibilities.

391. The closure of the 2005/06 Accounts was clearly a stressful time for many more junior Finance personnel. Typical of comments received were:

- *"We had to work all the hours including some weekends."*
- *"…the auditors kept returning so I knew we had problems…I did feel uncomfortable having to keep silent about some issues."*

392. This is just one area where Finance personnel felt overstretched. I received other comments, which suggested that the PCT and/or Mr Patel did not feel that investment in additional Finance personnel to cover skill gaps was a priority.

The FIMS Returns:

393. These monthly returns should have a strong correlation to the Finance Reports and other information provided to the Board and other senior managers. The free text commentaries submitted as part of the return to the SHA should also align with the figures submitted. The Director of Finance, Chief Executive and Chair should be aware of the main financial message imparted by the FIMS Return. Examination of the consolidated returns, **Appendix 12,** and associated commentaries for 2005/06 and 2006/07 has shown some glaring anomalies.

FIMS in 2005/06:

394. Whilst the consolidated return shows an increasing level of savings achieved from £0.25m at Month 4 to £2.550m at Month 12 the associated Commentaries stated a wholly different picture.

395. The Month 4 Commentary confirmed that the underlying financial deficit of £4.5m and a further £1m target would be met from slippages and savings. Then matters become unclear. **Appendix 3 – Parts A and B** provides the Commentaries to accompany the FIMS Return for Months 6 and 7. **Part A** is those I received from the SHA and **Part B** those I received from the PCT. The total forecast outturn (**Appendix 12**) was a surplus of

£1.4m in Month 6 and £1.957m in Month 7. The respective totals for the savings achieved were £0.375 for Month 6 and £1.7m for Month 7 out of planned savings programmes totalling £3m. This contrasts quite markedly from the planned savings total of £4.8m and a statement that the estimated achieved sum for the whole year would be between £1m and £1.8m as shown in **Appendix 3 – Part B.** This detailed breakdown does not appear to have been forwarded to the SHA.

396. At Months 9 and 10, the consolidated FIMS Return shows that a surplus of £3.496m was expected and the savings achieved to date stood, respectively, at £1.913m and £2.337m. The Commentaries however indicated that only £1m was likely to be achieved from the savings programme and that the sale of the Willesden land was becoming a pivotal issue.

397. The Month 12 Return showed a surplus of £2.8m with a savings achieved total of £2.5m. The Commentary, however, showed that only £1m savings had been achieved. It also confirmed that the Willesden land sale had been completed. It further stated that the Control Total of a £2.8m surplus would be met, the underlying deficit of £4.5m would be met and that: *"Both the Board and the management Team understand the position and the risks involved."* [39] This was an erroneous statement because the underlying deficit had not been met.

FIMS in 2006/07 - April – October:

398. The Month 4 Return indicated that financial balance was likely with identified savings shown as £12.514m while the Commentary shows that £18.4m had been sanctioned by the PCT Board. The Commentaries for Month 5 and 6 showed, for the first time, that the run-rate was in deficit and not expected to improve until October as savings started to accumulate. For some reason the Returns showed a marked decrease in the level of savings and back to the original plan figure of £9.24m which has little correlation to the savings package of £16.5, previously agreed by the PCT Board, at its May 2006 meeting.

399. Even more importantly, they showed that the forecast outturn was balance at Month 5, a deficit of £3.5m at Month 6 and a deficit of £10.9m at Month 7.

FIMS in 2006/07 – November – March:

400. **Appendix 13** provides the trail of correspondence in respect of the Month 7 financial position and is an exemplar of the fluidity in financial reporting by the PCT. The Appendix also includes Mr Parker's reasoning,

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[39] Brent PCT: Commentary Month 11+ 2005/06 – April 2006 – Paragraph 6.

in an internal email of 8 November 2006, for declaring a forecast deficit of £8.5m at Month 7: *"My view to date is that the 15m 'gap' that has been shared informally with the HA and ourselves is overstated."* A week earlier on 31 October Mr Parker had advised the SHA's Interim Director of Finance (Mr J Wise) that the deficit was likely to be in the order of £11m - £13m. This was confirmed back to Mr Parker by Mr Wise on 7 November; also within **Appendix 13.** This correspondence occurred immediately prior to a Board-to-Board meeting between the PCT and SHA that took place on 9 November 2006.

401. Mr Parker stated that: *"As this was an important judgement, I discussed this with the chair and the audit chair and we collectively agreed that due to the seriousness of the financial position, we should aim to neither under nor over-report and hence we agreed to assume that 50% of the uncertain £5 million liability would be assumed for the purposes of the return."*

402. I was told by certain interviewees that they were surprised by the low submission proposed by Mr Parker. One stated: *"I advised Andrew* (Mr Parker) *to submit the higher figure as it was easier to come down than go-up."* Another commented it: *"…was done because we wanted to be better than Hillingdon and he wanted the CE job and Jean* (Mrs Gaffin) *supported him."* Mr Parker has stated that both comments were untrue.

403. A few days later the FIMS return, following further discussion with the SHA, was amended to show a deficit of £11.5m. In subsequent months, this figure more than doubled as additional issues relating to 2005/06 and the true position for expenditure in 2006/07 emerged.

404. Mr Parker responded fully to my questions in respect of his responsibilities as the Accountable Officer and his awareness of the externally and formally reported financial position: *"Yes - I was aware in principle of the duties as accountable officer. I was not aware that I was required to be aware of the main messages within FIMS returns…I was not involved in the FIMS returns process until Mahendra* (Mr Patel) *left. I assumed that he was making returns in the same way that he had been for previous years and that were consistent with the PCT's position."*

405. A number of interviewees who were former NEDs of the PCT stated that they had felt extremely angry at the Board-to-Board meeting when they heard about the regularly changing deficit figures. One former NED said: *"…we had problems but I was led to believe they were manageable and we had plans to sort it out – I had no idea the deficit was so high."* Another former NED said: *"I thought that we were treated lightly given our performance…"*

406. Conversely, other PCT attendees felt that the SHA intended the meeting as nothing more than a blame session. Both Mrs Gaffin and Mr Parker believed that the PCT had been treated harshly by the SHA.

407. **Appendix 14** is part of the financial briefing material provided by Mr Hellier to the PCT Board attendees. This can best be described as superficial. Despite containing arithmetical errors and mentioning trivial areas of savings, it does state, however, that the risks had increased and: *"The combined effect of these could worsen the position by £10m for 2006/07."*

408. Shortly after the 9 November Board-to-Board meeting Mr Parker reverted to his substantive role as Director of Strategy and Commissioning.

409. From Month 8 onwards, the FIMS returns, were completed by the new Interim Director of Finance (Ms A Anderson) and reflected with accuracy the 2006/07 operational position, additional problems associated with 2005/06 and the progress, of what was in reality, the third Turnaround Plan with the achievement of savings. The combined effect of these issues was that at Month 12 for 2006/07, the forecast deficit was £23.993m and the total of savings achieved was reported as £12.412m.

OPINION:

Financial practices and leadership:

410. I believe that the professional leadership of the PCT's finance function was not geared to the demands of a commissioning organisation. Mr Patel's successful NHS background had been based in a Community Trust with the financial requirements of an NHS Provider organisation. I believe that Mr Patel was out of his professional comfort zone in a commissioning organisation. He was able to show financial achievements in the early years of the PCT's existence because of the availability of growth funds, un-utilised specific funds and major capital assets that could be sold.

411. It was also a major weakness by Mr Patel to allow high-level financial commissioning matters to be delegated to his subordinates.

412. From 2005/06, the NHS financial climate changed and Mr Patel was faced with a new set of challenges that he was unable to deal with. I further believe that Mr Patel had an unfortunate relationship with his two Deputies (Ms Evans followed by Ms Patel) and kept them in the dark over various key issues about the real financial situation.

413. I believe that both Ms Evans and Ms Patel were let down by Mr Patel and the PCT Board.

414. In fairness to Mr Patel, he clearly took great professional pride in his work and the successful achievement of statutory and other financial targets. Equally, he appears to me, to have been the only Executive Director who flagged-up to the PCT Board and the EMT the risks emerging during 2005/06 and that the PCT's history in achieving savings was poor.

415. At the end of the day, however, Mr Patel was the principal finance professional and principal financial advisor to the PCT Board for which he received a substantial remunerative package. Additionally, he was undoubtedly aware of the eventual effects of the tactics used to achieve financial balance since the inception of the PCT.

416. I am of the opinion that Mr Patel failed to discharge his financial duties with the requisite degree of professional competence. Furthermore, that as an experienced NHS Finance professional Mr Patel failed to take appropriate action when the scope for achieving financial balance, by the use of end-of-year manoeuvres, became restricted.

417. I further believe that this failing is mitigated, to a small extent, by the low level of scrutiny exercised by the PCT Board and the pre-disposition to pursuing service developments and other initiatives at the expense of ensuring medium and long-term financial sustainability.

The FIMS returns and liaison with the SHA:

418. Given the inconsistencies, it seems clear that linkage between the FIMS forms and the associated Commentaries did not occur within the PCT's Finance Department. Equally, I consider that the SHA should have been more thorough in checking the reconciliation between the detailed FIMS forms and the associated Commentaries received from the PCT in 2005/06.

419. During 2006/07, I believe that Mr Parker was ill advised to submit a Month 7 return that understated the level of the forecasted deficit. It is unfathomable to me that he should have done so, even after discussing the matter with Mrs Gaffin and Mr Boucher and the uncertainty surrounding a £5m potential liability raised by Ms Patel, because:

- Of the known adverse events associated with the 2005/06 Final Accounts.

- The Finance Report to the September meeting of the PCT Board, albeit Mr Patel's last meeting, indicated a potential deficit of £9m.

- Successive iterations of the Financial Saving Plan recommended the need for further savings and a lack of year-to-date savings.

- The acute SLAs continued to over-perform. Mr Parker had previously advised the EMT, in August 2006, that the PCT's Demand Management initiatives were not having the desired effect and: *"Overall, this indicated that the PCT would probably not meet its £7.2m savings target."* [40] This was a main plank of the 2006/07 Savings Programme.

420. I am of the opinion that Mr Parker, and those who advised him to submit a more optimistic outturn figure, made a serious error of judgement.

421. This, together with the history of imprecise financial reporting undoubtedly, influenced the content and course of the Board-to-Board Meeting held on 9 November 2006. It also influenced the attitude of the SHA to the PCT. It would have been naïve to anticipate otherwise.

[40] **EMT: 21 August 2006 - Note 4.**

EXECUTIVE MANAGEMENT WITHIN THE PCT: OVERARCHING ISSUES

422. I considered a wealth of oral testimony and documentary evidence relating to the internal management of the PCT. This confirmed that many of the specific financial and other management problems, during 2006/07, were caused by:

- **The management culture of the PCT.**
- **The working arrangements of the Executive Directors.**
- **External oversight.**

423. I recognise that 2006/07 posed some considerable challenges to the PCT's management team as it was led by a new Acting Chief Executive and various other senior level Acting-up arrangements were in place. This situation was compounded by the PCT operating within the area of the former NWLSHA, which had a very large health economy wide deficit.

424. The need to become involved with Fitness For Purpose Assessments, responding to central levies and various other financial imperatives, possible London-wide PCT restructuring together with the raft of national and local service targets also posed many challenges for the PCT. Conversely, these challenges were faced by other NHS organisations across London. It is, I believe, also relevant to emphasise that the PCT's senior management team had worked together for many years and comprised experienced NHS managers.

The management culture of the PCT.

Events before 2006 - The integration of personnel into Brent PCT:

Level of Corroboration – Oral Testimony:

425. I was assailed by expressions of concern, from many interviewees, about split camps within the PCT from the date of its inception. Many of these interviewees believed that the split camps still lingered and were concerned that the present re-structuring exercise would not eradicate the problem.

426. Essentially, I was told that former Parkside Trust personnel were at loggerheads with personnel from the former local PCGs and the former Brent and Harrow Health Authority. This rivalry appeared to centre on

perceived advantageous employment terms enjoyed by the former Parkside Trust employees. Of particular concern had been issues relating to "Golden Handcuff" payments made to certain Parkside NHS Trust personnel, prior to the dissolution of that Trust, on condition that they stayed until the dissolution of the Trust. A number of these personnel were then appointed to Director level and other positions at Brent PCT.

427. It was known that this former Trust was particularly commercially orientated and had pioneered non-Whitley employment terms and conditions.

428. In relation to the "Golden Handcuff" payments Dr Llewellyn had the issue externally investigated for its legitimacy with the matter being referred to the Department of Health. Despite the elapsed time, many long-serving PCT personnel asserted, to me, that former Parkside Trust personnel, within the Finance and Integrated Health Services Directorates, had a long history of being favoured and working as a clique.

429. Of concern, to many interviewees, was that the split camp situation resulted in three further problems:

- A gradual worsening in the professional relationship between certain Executive Directors.

This caused -

- A gradual worsening in the degree of liaison between certain PCT Directorates.

This resulted in -

- Newly appointed PCT personnel being expected to show allegiance to the particular camp within their Directorate, or face a degree of ostracism.

430. I was also provided with examples of personnel whom, it was felt, had left the employment of the PCT because of these issues. I interviewed a number of former PCT personnel who confirmed that a contributory factor to their exit was the immature and divisive working atmosphere.

431. The fact that aspects of this situation are history is not the point. It quite clearly represents a long running sore that has not healed and continues to have an adverse effect on working relationships among PCT personnel at both senior and junior levels.

432. Recipients of this Report possessing a far longer knowledge of the PCT than I acquired, during just over two weeks in Brent, can comment

on the veracity and seriousness of these deeply felt and long held concerns by PCT personnel.

Events before 2006 – Leadership:

433. A great attraction stated by many existing and former PCT personnel to working in Brent was the diversity of the population and responding to their associated health needs. Allied to these factors was the developing reputation of the PCT as being one of the most innovative in the country.

434. Characteristic of positive comments from many interviewees was:

- *"…it was an exciting place to work we always seemed to be doing things and others came to see how we did it."*
- *"I came to this PCT because of Lise Llewellyn's national reputation and there was a lot going on in Primary Care."*
- *"This was the first place I had worked in the NHS that was not daunted by its problems…our residents were deprived and we felt that we were making a difference."*

435. Dr Llewellyn was credited by many interviewees for achieving this pre-eminent position. I was provided with numerous examples as to how the PCT had led the field in developing alternative patterns of Patient Care and service delivery.

436. Conversely, I was told by numerous interviewees that Dr Llewellyn led an organisation that was innovative yet:

- Had difficulty in embedding ideas into practice.
- Had favourite areas of managerial activity at the expense of others.
- Had not grasped the need to link plans and strategies to the available and/or future resource envelopes.
- Was reluctant to acknowledge and resolve internal conflict.

437. To quote one long serving PCT employee: *"We have always been very high on good ideas but very low on implementing them."* This view was echoed by many existing and former PCT personnel.

438. Writing in May 2005, as part of the internal managerial re-structuring paper *"Taking Brent Teaching PCT into the future* –

Consultation Document" Dr Llewellyn rightly identified the many successes of the PCT.

439. Dr Llewellyn also identified internal problems: *"…with effective matrix working, where staff from one directorate form part of a team led by another directorate. Sometimes this works well, but we think there is room for improvement. One of the difficulties that we face is managing conflict within the organisation. Where challenges are made within the organisation, they are not always seen as supportive, and sometimes we respond with defensive behaviour. It is often easier to work around conflicts or points of difference then to present a challenge and agree an appropriate way forward."* [41]

440. This was a most honest assessment. One, which, unfortunately, from the evidence provided to me by many existing and former PCT personnel, did not achieve the desired results during the remainder of Dr Llewellyn's tenure and beyond.

441. In relation to the financial climate of the PCT in its early years (and indeed into 2006), the following quotations from interviewees were representative:

- *"Finance was never a factor - we developed plans without linkage with the Finance Directorate."*

- *"… even at Board meetings - let alone the Management Team we joked about Mahendra's* (Mr Patel) *back pocket solving any money matters."*

- *"I sometimes wondered how we did it but we always balanced – in fact we were told that the PCT was seen as good - as we sometimes apparently lent out money – brokerage I think it was called."*

- *"…look you have to realise that we had growth and the Board supported setting deficits and we were told that slippage would happen…I did not feel we were in a financial mess until towards the end of last year…Yes - I do mean the end of 2006."*

Events from 2006 – Leadership:

442. The change of Chief Executive from Dr Llewellyn to Mr Parker in an acting capacity (whose substantive position was Director of Strategy and Commissioning) was a key point at the beginning of 2006. It is clear that

[41] "Taking Brent Teaching PCT into the future – Consultation Document: May 2005 – Paragraphs 4.3 and 4.4.

Mr Parker was viewed as being given a most difficult chalice. Equally, it was believed that his acting appointment would be for approximately three to four months, until a substantive Chief Executive was appointed, because of a London wide reconfiguration of PCTs.

443. Many interviewees felt that Mr Parker was well intentioned and had high integrity. On the other hand, his position was felt to be untenable because; first, Commissioning was not seen as a particularly successful part of the PCT's overall operation. This, I was told, was because acute SLA overspending had never been tackled and when Mr Parker became Acting Chief Executive, he believed that the Integrated Health Services arm of the PCT was able to deliver considerable savings. Secondly, that poor communication and clashes of personality characterised the relationship between Mr Parker and two other Executive Directors i.e. Mr Patel and Mr Arif (Director of Integrated Health Services.)

444. One former ED who attended EMT meetings from the inception of the PCT summarised the position thus: *"…despite some OD type workshops we never really developed as a team. There were two camps Parkside and the rest – there was a lot of mistrust between the team members."*

445. Another existing ED said: *"….Lise* (Dr Llewellyn) *shied away from conflict and the organisation operated in quite distinct compartments…this also went on under Andrew* (Mr Parker) – *you will probably hear the word silo because it was a matter we talked about quite openly."*

446. Representative of comments from interviewees holding senior manager positions; but not members of the EMT was:

- *"…I felt sorry for Andrew* (Mr Parker) *because tensions got worse after Lise's restructuring…people stayed in their own bunkers more."*

- *"These were good people, they worked hard for the PCT but did not gel."*

447. The high majority of existing and former EMT members confirmed that indeed "silo" working was a problem and remains so. More junior PCT personnel and currently in post also expressed some unease about the present management restructuring. Among comments made were the following:

- *"I bet it will effect the staff lower down and those at the top will stay and that's where the problems are – that's what happened with Lise Llewellyn's reorganisation and we felt she deserted us."*

- *"…the Interim I work for now is good - she has opened so many things up – but when she goes who knows – those below her will still be around and old systems will probably come back."*

- *"We really must get some stability at the top – I just hope Marcia* (Ms Saunders) *understands that."*

448. Mr Parker in a written statement said: *"We had acknowledged that we needed to work more effectively as a corporate team, in particular to avoid some of the 'silo working' we had identified both at an executive level and across some of the teams."*

449. Mr Patel and Mr Parker felt that mature relationships existed between themselves and that no clashes of personality or poor communication had existed. I can only report that this view was not shared by other interviewees; examples of comments provided are:

- *"…the tensions happened because nobody really commissioned anything there was no follow–up to commissioning problems."*

- *"Commissioning in this PCT was about posturing and then capitulating - ask Bashir* (Mr Arif) *about how we had to drop everything to set up a Phlebotomy service without funding virtually overnight because Commissioning caved-in to Northwick Park after they withdrew it unilaterally."*

- *"…everything in Finance was tight and closed - we could not get the right info to assist Commissioning decisions – Chris* (Ms Evans) *and then Indira* (Ms Patel) *tried but were always up against it."*

- *"It is true Finance and Commissioning did not get on because they wanted to score points."*

450. Former NEDs, who had been with the PCT since its inception, appeared largely unaware of unease among the most senior managers. One stated: *"…I did not become aware about the tensions until mid-2006 - then again I was unaware Mahendra* (Mr Patel) *was unqualified until recently."*

The working arrangements of the Executive Directors.

Level of Corroboration – Documentary Evidence:

Meetings of the Executive Management Team:

451. I have examined the Notes taken of the Executive Management Team (EMT) meetings from the beginning of 2005 and a rather more

limited set that was available of the Senior Management Team (SMT) meetings also from 2005. The former met on average every four weeks in 2005 and from the end of January 2006, the aim was to meet weekly. The EMT was attended by the most senior Directors. During the period, end of September 2006 to the end of November 2006 formal EMT meetings were superseded by regular sessions with KPMG relating to the composition of the first Turnaround plan.

452. The SMT was attended by EDs plus a wider group of senior managers. No notes were available to me from the end of 2005.

453. It is clear that finance issues formed a part of the EMT agenda. What is patently unclear, from the formal notes, is the effectiveness of follow-up action to the identified problems and challenges. There is also an absence of regular and detailed debate about the PCTs finances. Some pivotal matters about the financial situation occurred as follows:

- No extensive discussion at EMT meetings of the PCT's financial position between 23 May 2005 and 31 October 2005.

- At the EMT meeting of 31 October 2005; under the heading of the CIP Dr Llewellyn: *"…asked that Directors look at their budgets and slip any items that were not crucial. She also explained that this was why the tPCT was taking a firm line with Social Services."* [42] As shown by the letter of 28 October 2005 from LB Brent, within **Appendix 8**, the firm line was reciprocal.

- At Dr Llewellyn's final EMT, meeting on 19 December 2005 each Directorate was asked about current priorities. In relation to the financial position: *"Indira Patel acknowledged that the position was very tight this year. Lise Llewellyn noted that Mahendra Patel was managing to achieve financial balance, but she highlighted the need to be clear about where efficiencies were. Indira Patel highlighted the need for transparent discussions between EMT members in this connection."* [43]

- At the EMT meeting held on 27 February 2006: *"Mahendra Patel noted that there was still much uncertainty, but he believed the tPCT should plan for 7% reduction with 5% for provider services."* **Appendix 15** shows that a range of potential savings was discussed in outline. Specifically, in relation to *"Over Commissioning – measures to be adopted to address this."* [44] Given that acute commissioning was a regular and main area of overspending, one would have anticipated a rather more definitive approach.

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[42] **EMT – 31 October 2005 – Note 6.**
[43] **EMT – 19 December 2005 – Note 8.**
[44] **EMT – 27 February 2006 – Note 4.**

- At the EMT meeting held on 8 May 2006, Mr Parker stated: *"…it would be necessary to come up with savings plans to cover the existing gap. He felt this was a big test for the EMT as a management team."* [45]

- At the EMT meeting held on 31 July 2006 Mr Parker reported that in respect of 2005/06 *"…that the accounts were not yet finalised…He highlighted the need to have systems in place to ensure that such an issue did not arise in the future."* Additionally, In the light of a further top-slice of £700k required by the SHA: *"Andrew Parker invited everyone to think radically about potential areas of savings."* [46]

- At the EMT meeting held on 21 August 2006 it was reported that in connection with the savings target for acute services: *"…that the tPCT's demand management initiatives were not sufficiently reducing attendances at NWLH…Overall, this indicated that the PCT would probably not meet its £7.2m savings target."* [47]

- At the EMT meeting held on 11 September 2006, differences between the reported financial position and the savings plan were discussed. My concerns about this meeting have been stated in an earlier section.

- I received no formal record of the meetings between the end of September and the end of November 2006. However, informal notes were provided to me by an existing ED, for meetings held on 6 and 7 November 2006; immediately prior to the formal Board-to-Board meeting with the SHA. These indicated that the EMT was aware that a potential financial gap of £15m existed.

- In the aftermath of the Board-to-Board meeting, the EMT had regular and structured discussions about the measures required to achieve tangible savings during the remaining four and a half months of the financial year.

Level of Corroboration – Oral Testimony:

454. The overwhelming weight of oral testimony centred on the recognition that the collective meetings of the Executive Directors were characterised by:

- Forceful charismatic leadership under Dr Llewellyn.

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[45] **EMT – 8 May 2006 – Note 9.**
[46] **EMT – 31 July 2006 – Note 3.**
[47] **EMT – 21 August 2006 – Note 4.**

- A more discursive and consensual approach under Mr Parker.
- A "can-do" approach and an emphasis on new approaches and services.
- Limited attention to detail.
- Limited challenge between EDs.
- No systematic follow-up to agreed action.
- Until mid-2006 little emphasis given to financial issues.

455. Typical of comments from interviewees, including existing and former EMT members were:

- *"…the real decisions were not taken at meetings of the Management Team."*
- *"Finance was never a priority and we never made real decisions about priorities – we thought that we could achieve a lot of things and in spite of these events we did do a lot."*
- *"…I put my hands up - there was no performance culture until Turnaround."*
- *"Financial considerations were an add-on consideration, they never got in the way of decisions about what we wanted to do."*
- *"With hindsight Andrew* (Mr Parker) *should have brought in proper Turnaround much earlier – we wasted so much time before that – we had metrics for this and metrics for that but we didn't really deliver much and then the KPMG exercise was an unhappy period."*

456. A fair number of PCT interviewees informed me that the "silo" working between certain Directorates meant that the Finance Directorate and financial issues were somewhat separate from the decision making process. In other words, there existed confidence that, whatever decision was taken, Mr Patel would be able to accommodate the financial impact. Dr Llewellyn stressed that due process was always followed in relation to financial investment decisions.

457. Many interviewees stated that the PCT was not a Commissioning organisation and they believed that this activity was weak. I was faced with a lot of disquiet from PCT personnel who stated that the Commissioning Directorate had been favoured and had not tackled regular overspending SLAs.

458. Examples of comments made to me were:

- *"In preparing for this… I have reviewed the Board papers over the last couple of years or so and the thing that stands out for me is the constant reference to acute overspending and Continuing Care – and those themes were regularly there."*

- *"…one of our key weaknesses was we weren't a commissioning organisation – we were a development organisation doing lots of interesting new things against a background of supposedly financial stability."*

459. The following comment from an existing ED encapsulated the majority view about the working of the senior management structure: *"We were an organisation that cared, we were not very good at stopping things."*

External oversight:

460. Throughout this Review, I was faced with a lot of criticism about the perceived lack of support and awareness shown by the former and present SHA to the PCT.

461. The facts demonstrate that until July 2006 the PCT did not provide any report, or other evidence, to the former NWLSHA that financial balance or the meeting of Control Totals were a difficulty. I also verified this with the three former Finance Directors of the SHA, the former Chair and the former Chief Executive.

462. In essence, the PCT was not on the SHA radar screen as being in any financial trouble whatsoever. As one former SHA Finance Director said: *"Mahendra* (Mr Patel) *always had something up his sleeve."* By early 2006, the NWLSHA held around 25% of the whole NHS operating deficit. SHA interviewees, in post at that time, stated that their attention was focused on retrieving the situation in known "hot-spot" organisations as they were tasked by DH in reducing expenditure by £50m over a very short period.

463. I was told, however, by the former Chief Executive of the NWLSHA that all organisations, in 2005/06 and 2006/07, were regularly apprised of expected standards in financial practice. This was consequent to issues emerging from Public Interest Reports affecting NHS organisations in London.

464. Similarly, I was advised that the PCT Board and its Executive Team had not been regularly and rigorously appraised in 2005/06. This was because the PCT was not viewed as failing on any key financial or service targets.

465. The main concerns held by the SHA, until mid-2006, was the absence of a forward financial plan and the skill mix of the PCT Board, which was felt to be lightweight in terms of business and financial experience. It was, however, viewed as being extremely strong in respect of its local community knowledge and representative roles.

466. Attitudinally, the PCT was viewed as being somewhat elitist by the SHA and I was told, that particularly in its early years, engagement with the senior executive team was at times difficult. On the other hand, Dr Llewellyn was viewed as a strong leader and asked to provide interim cover at a troubled PCT elsewhere in London during 2005.

467. One of the former SHA Directors of Finance advised me that in connection with secondary care commissioning the SHA saw Mr Parker as being the total lead and that Mr Patel was always only in the background. This made the PCT atypical in respect of this key activity.

468. The main difficulty in the early years of the PCT was seen as the confrontational relationship between the PCT and NWLHT. This resulted in arbitrations on commissioning issues. I was advised that a significant one occurred in 2003/04 that found in favour of the PCT. After that, further commissioning disputes occurred and formal or informal arbitration decisions were equally shared.

469. I was further advised that Mrs Gaffin had been a strong advocate of Mr Parker becoming Acting CE. It was thought that Mrs Gaffin would also have advocated Mr Parker's candidature for the substantive CE position after it became clear, in 2006, that the number of London PCTs was not to be reduced.

470. Although not raised formally at the time, SHA Finance personnel did hold some concerns about the PCT's usage of earmarked special allocations, which the PCT held on behalf of the sector, as a contribution to achieving financial balance. The SHA did however, receive assurance from the PCT that such practice would not jeopardise the proper allocation of such funds in the following year.

471. The transitional period between NWLSHA and NHS London was accepted as being difficult for local organisations by personnel from both SHAs.

472. Soon after its establishment NHS London commissioned Deloitte to undertake a LDP External Review Process [48] of all organisations. This showed that the PCT was in Turnaround (the KPMG stage) and that concerns existed about the over-performing SLAs together with a low success rate from Demand Management initiatives. This was one of the

[48] NHS London: LDP External Review Process – Brent PCT – Version 2 – 11 October 2006

prompts for the SHA to observe more closely the standard of financial reporting by the PCT and eventually led to the events of November 2006, which have been previously described.

OPINION:

The management culture and the working arrangements of the EDs:

473. I hold the view that the members of the PCT's Executive Team cared passionately about their areas of responsibility and wished to develop services for the people of Brent. I do not believe, however, that under the executive leadership of Dr Llewellyn and Mr Parker sufficient attention was paid to the necessary balance between developments and their financial sustainability.

474. I further consider that cohesion between certain Executive Directorates was generally poor over a number of years. Regrettably, a significant contributory factor being, I believe, the lack of integration that stemmed from the very foundation of the PCT. In other words, the Parkside Trust personnel versus The Rest wrangle.

475. I am of the opinion that a fundamental problem was, until mid-2006/07, that there was a significant lack of concern about the financial situation. This was compounded by Mr Patel operating in his own "money-box" to control the financial resources of a complex multi-million pound commissioning NHS organisation.

476. This reflected the managerial "silos" problem. As the matter was talked about by many existing and former PCT interviewees I am forced to the conclusion that this was an accepted way of working for far too long.

477. I believe that Mr Patel operated in a somewhat isolationist way for various reasons:

- Mr Patel was comfortable working closely with a small cadre of financial colleagues with whom he had worked for many years prior to his position in Brent.

- Mr Patel was comfortable with managing the detailed finances of a provider orientated NHS organisation; yet uncomfortable with managing the detailed finances of a commissioning orientated NHS organisation. This was compounded by his reluctance to lead from the front on financial commissioning matters.

- Mr Patel was a victim of his own success in delivering ostensible year-on-year financial balance from the inception of the PCT. A financial fragility that went unchallenged, or, more accurately, unnoticed by the PCT Board and the SHA.

- Mr Patel was not part of the PCT's inner-circle. I address this issue later.

478. The meetings of the EMT were both regular and full. When allied to the meetings of the FFPG and the SSCFFP should have provided an effective mechanism for planning and monitoring the financial situation. This mechanism failed spectacularly in 2005/06 and 2006/07. It did so, I believe, due to various factors:

- The Finance groups met immediately after the EMT meetings; therefore, attendees' attention span was stretched.

- The degree of NED scrutiny was inadequate and insufficiently separate from the EDs perspective. I believe that a mistake was made in not establishing a formal Finance Sub-Committee of the PCT Board, simply on the premise that it was unnecessary, because the organisation had always broken-even.

- The EMT did not operate as a mature team. There was little challenge between EDs. They tended to only speak about their own professional territory and robustly defend it. One corollary being that no collegiate understanding and approach to financial pressures existed.

- Factionalism and rivalry between various Directorates militated against a collegiate approach, in 2006/07, and earlier.

- The follow-up to clear indicators of pressure about the financial situation was woefully absent. First, the lack of action, in 2005, to the knowledge that savings plans were awry. This fact was regularly reported to meetings of the FFPG and SSCFFP. Secondly, the lack of follow-up to the many pressure points highlighted at the January 2006 SSCFFP meeting which would have a sizeable bearing on the 2006/07 financial year.

- Mr Patel regularly stated that financial risks were high. I am forced to the opinion that this was seen as "crying wolf" by some of his peers. This, I believe, was because Mr Patel had achieved financial balance over successive years without the imposition of punitive savings schemes or reductions to service development and capital programmes.

- Members of the EMT, if not their subordinates, were largely content with the limited financial and budgetary information provided by the PCT's Finance Department. This was because, until mid 2006/07, they had become almost wholly inured against the need for robust financial planning and monitoring.

- There was limited individual managerial accountability.

- The EMT had no experience of successfully delivering savings programmes.

- The specialist executive support provided to the EMT to deliver the 2006/07 savings programme was both too late and too inexperienced until the start of Quarter 3.

- A failure to appreciate, by both the EMT and the full Board, that the overspendings of 2005/06 had all to do with a lack of in-year control and preceded the new pressures of 2006/07.

- The EMT and PCT Board were not attuned to the changes required by the introduction of Payment By Results and Practice Based Commissioning.

External Oversight:

479. I have commented earlier on the approach to scrutinising FIMS returns by the former NWLSHA. The fact that no PCT personnel expressed concern to the NWLSHA about finance or other performance issues until mid-July 2006 provides confirmation that the SHA had no grounds for unease based on information received from the PCT.

480. It does expose four weaknesses; both then and potentially now, in respect of the SHA trusting the content of formal reports:

- **One –** Did the PCT understand the concept and conjoint responsibilities of having local autonomy based on the truthful reporting of key information to the SHA?

- **Two -** Did the PCT fully understand that it had a responsibility to embed good corporate governance across all of its management activities; including internal checks before data was submitted?

- **Three –** Did the former NWLSHA possess a checking mechanism to ascertain that positive finance reports received from the PCT were conveying the truth?

- **Four –** Did the former NWLSHA and Appointments Commission have adequate ways of assessing and appraising the two arms of the PCT Board, in order to establish their awareness and skills, to cope with a changing NHS agenda?

481. Unfortunately, I believe the answer to these questions is – no.

482. The Terms of Reference for this Review indicated that account should be taken of various Codes of Conduct governing professional behaviour. As an external independent investigator, I am also required to consider possible wider organisational issues that may have contributed to the matters under examination. This is in line with the provisions of the Department of Health's "Code of Conduct for NHS Managers." [49]

483. I regret to report that during this particular NHS Review I have been beset by a number of undercurrents and allegations. Some of these concerned particularly unpalatable issues.

484. In other NHS Reviews, I have tended to discount allegations made by an individual or a small number of interviewees. In this case, I have adopted the same approach but have included some matters where many PCT interviewees raised them; together with certain Staff and Trade Union representatives.

485. It is the responsibility of the recipients of this report, who are much more familiar with the working of the PCT, to take the appropriate corrective action if they believe these matters are sufficiently serious. Likewise, I do recognise that the new PCT leadership has put in train a variety of measures, which may already be well on the way, to rectifying some of these areas of concern. I further recognise that the elapsed time and the movement away of certain personnel may have contributed to improving certain matters.

Human Resources and Organisational Development:

486. The overwhelming view provided by PCT interviewees, below Executive Director level, was that HR and OD had not been viewed as a priority by the PCT Board and the EMT.

487. I was told that the problems had started at the inception of the PCT when, HR at the most senior level, was led by interim post-holders. This situation improved when a substantive appointment was made. It was, however, felt that it was, and still is, easy for sound HR advice to be ignored by senior operational managers. In other words, the advice provided by HR professionals was either not enacted or they were prevented from following it through. Examples given ranged from the delays with the updating of formal HR Policies and Procedures, delays in routine Employment Services, Job Descriptions being out-of-date, delays

[49] Code of Conduct for NHS Managers; Page 8 – Paragraph 4.

in progressing complaints and grievances by PCT personnel. Some concerns were most specific. For example, managers were frustrated that the PCT had no systematic approach to handling increased sickness rates among certain groups of personnel. This was confirmed by the PCT's HR Department, which stated that recent workforce data indicated that frequent sickness absence is now a greater problem within the organisation than previously.

488. PCT middle and junior staff also expressed anger that they had not received appropriate Acting-up payments. It was inferred that EDs and other more senior staff had received enhanced payment when Acting-up.

489. Severe expressions of concern were made about the favoured appointment of relatives of certain senior level PCT staff, including appointments made during periods of vacancy freezes. In some cases, I was advised that such appointments had proceeded in spite of contrary HR advice being given. I was told that, during the early years of the PCT, senior staff who had transferred from the former Parkside NHS Trust had tried to force through up-gradings for other former Parkside personnel who were on lower grades than they had been expecting. I was advised that some of these pressures resulted in inappropriate re-grading. The practice ceased when trained and permanent HR professionals were appointed.

490. I was further informed that due diligence checks had not been carried out into the employment terms and conditions, of certain contracted employees, in some current LIFT capital schemes. The allegations centred on the fact that these personnel had no, or very limited entitlement, to sickness, pension and other statutory employment benefits.

491. A particular area of anger among many PCT interviewees was the delay associated with the 2005/06 internal managerial re-structuring initiated by Dr Llewellyn and delays associated with the Agenda For Change exercise.

492. In relation to the former I was told that, whilst everyone understood that it was needed as a response to a national imperative the internal processes were both long-winded and unfair. Not only, did staff question the cost-effectiveness of the competency based interviewee regime and its adverse affect on morale. They also highlighted the fact that the Reorganisation did not save any real money. More importantly, many current PCT personnel said that the 2005/06 reorganisation had caused maximum turbulence for more middle and junior staff and minimal turbulence, anxiety and change for the most senior PCT employees.

493. In relation to Agenda For Change, I was told that the skills criteria approach had been, on occasions, used flexibly to favour certain

individuals. I was also advised that the appeal process was slow and that some cases remain unresolved.

494. In respect of the current managerial restructuring, I can only report that there exists an undercurrent of feeling, that it will result in some new faces but deeply ingrained poor practices and attitudes will not be removed.

495. One aspect was striking to me. During the interview process for this Review; HR and staff support did not feature as a perceived problem in the testimony provided by the high majority of the PCTs most senior former and existing managerial personnel or, in that provided by former NEDs. One former NED stated, in writing, that the inadequate standard of HR services had been raised regularly by NEDs with Mrs Gaffin.

OPINION:

496. Investment, in a wide-based and modern HR service, is a requirement to overcome a fair amount of cynicism that this area of management is not a priority.

497. I am of the opinion that the PCT has to become much more proactive in the understanding and investigating the reasons for staff attrition and atypically high incidences of sickness absence in some Directorates. Equally, it should consider a more systematic approach to exit interviews being conducted by neutral interviewees. HR procedures and policies need to be regularly updated to reflect local empirical experience, national good practice and statutory requirements.

498. Some stability at the top of the HR service is essential. Together with able support staff in the areas of OD, training, Health and Safety (if this deemed part of the HR service, or elsewhere, if not) and Employment Services.

Favouritism and cliquism:

499. I have already discussed the issue of "silo" working, both between and within certain Executive Directorates. In this section, I have to discuss and reflect the strongly held perceptions and views that the PCT has operated, from its inception, with two senior level cliques. I was surprised by the forcefulness of these feelings from many interviewees who do, or had, worked at the PCT Wembley HQ or in the field. Again, those with a far longer knowledge of the PCT than I possess, can attest, or otherwise, to the legitimacy of these concerns.

500. Of most concern was the belief that, until recently, the PCT had a senior level group that excluded other senior PCT personnel. This inner-circle was said to comprise a number of former PCT Board Members. These were: Mrs Gaffin, Mr Boucher, Dr Llewellyn (until the end of 2005), Mr Parker, the Director of Public Health (Dr J Stanton) and the PEC Chair (Dr A Craig.) It was further alleged by many interviewees that this had resulted in other EDs feeling distant from the real decision-making process, as distinct from the official decision-making process. This situation, it was asserted, contributed to the PCT's Finance and Integrated Health Services Directorates becoming increasingly isolated and senior personnel in these Directorates forming a second clique. These views were strongly denied by Mrs Gaffin, Dr Stanton, Dr Craig, and Dr Llewellyn.

501. I was also faced with considerable annoyance from a number of PCT personnel who insisted that decision-making had been distorted in favour of members of these exclusive groups. Again, these issues were denied by Mrs Gaffin, Dr Craig, Dr Stanton and Dr Llewellyn.

502. Mrs Gaffin and Dr Llewellyn disagreed with the following but I was told that despite a longstanding record of overspending within the Commissioning Directorate savings plans were not enforced. Instead, focus was applied to reducing overspending within the Integrated Health Services functions. More worryingly, was alleged favouritism in cost cutting to areas supported by Mrs Gaffin and certain other EDs e.g. the protection of the Child Care Nursery despite a large operating deficit and the non-renewal of certain NED appointments. Ms N Tewari's non-renewal was cited because it was felt this NED asked difficult questions about pursuing economies (and on other matters) that the inner-circle did not favour.

503. It was a concern to some PCT interviewees that the organisation had tended to shy away from implementing recommendations made by external bodies to achieve improved performance. Two examples were provided; one, the perceived "lip-service" paid to the findings of an ATOS KPMG Benchmarking exercise in 2004/05 and the delay by Mr Parker in obtaining experienced Turnaround support in 2006/07. Dr Llewellyn pointed out that the former was felt to offer poor value for money by three NHS organisations,

504. I was advised that, in respect of the former, the PCT had not advanced improvements to Commissioning and other areas. This was because it relied on the fact that it had a record of achieving financial balance. Moreover, Brent was felt to be subsidising health service costs in Harrow.

505. Regarding the latter, deep disquiet was expressed to me, by a number of PCT interviewees that Mr Parker had appointed, via a

secondment Mr Hellier who was known to be inexperienced in the requisite area. Conversely, Mr Parker, in his written statements to me, commended Mr Hellier for his work in planning and moving forward the 2006/07 savings programme before the arrival of KPMG and the subsequent appointment of a Turnaround Director. Mr Parker also strongly denied any impropriety.

506. It was openly stated to me that, within the PCT, at the time of Dr Llewellyn's departure, Mrs Gaffin favoured Mr Parker to become Acting Chief Executive and the new permanent Chief Executive despite known problems over performance within the Commissioning Directorate. A number of EMT members were critical of the internal process whereby Mr Parker had been made Acting Chief Executive i.e. although expressions of interest were sought from EDs; Mr Parker's appointment was a "coronation" rather than via an objectively based internal selection process. Mrs Gaffin emphasised that, in her view, the process was open and objective.

OPINION:

507. The new PCT leadership has initiated corrective action in some of these areas. It is my opinion, based on what I was told, much still needs to be achieved if the PCT Board is to convince many of its own personnel that objectivity is now the hallmark of executive decision-making.

508. Although now history, some of these issues and events are most serious. I believe that they contributed to the "head-in-sand" attitude adopted by the PCT Board to clear messages, from Auditors, that the PCT's financial health was, itself, "built-on-sand" long before the unfortunate events of 2006/07.

509. I have already commented that I found it inexplicable that Mrs Gaffin and Mr Parker could, as late as October 2006, assert to the local Health Select Committee that the financial problems of the PCT were caused by other parties.

510. I am of the opinion that the most senior management of the PCT had a farsighted approach to a number of service and Patient care initiatives. They undoubtedly deserve credit for these successes. Unfortunately, such far-sightedness in the planning of services was linked to short-sightedness in the area of sustainable financial management.

Bullying and harassment of PCT personnel:

511. This was a most sensitive area and one that many interviewees felt that the PCT Board had acknowledged in theory but had ignored in

practice. I was advised that findings about this problem from formal and informal Staff Opinion Surveys had not been followed-up.

512. Moreover, that in 2006, following a Board seminar attended by the Andrea Adams Trust (one of the country's leading independent advisory agencies in the field of workplace harassment) I was told that little or no action ensued. A number of attendees felt that the attitude of certain Board Members, at this event, bordered on: this is not a problem we want to recognise.

513. This issue has had a long history of concern. One former NED stated in writing that NEDs had regularly raised this issue at PCT Board level and received assurance that they would be addressed by the HR service. Dr Llewellyn advised me that a number of initiatives had been taken and a policy of zero tolerance pursued. Dr Llewellyn further stated that she had believed the concern was within the localities of the PCT and was not evident within the PCT HQ.

514. This was contrary to the views expressed by other interviewees. I was advised that problems had occurred in both the PCT HQ and elsewhere. A number of PCT interviewees, currently in post, stated that they had experienced, or had been aware of instances, which greatly exceeded what could be regarded as legitimate assertive management.

515. There was also concern that the PCT's Whistle-blowing Policy and its Bullying and Harassment Policy were not regularly assessed. The PCT's HR Department advised me that the former was first drawn up in 2003 but not reviewed until February 2007 and the latter had been established in 2004, reviewed in 2005 and is currently being updated.

516. The most disturbing aspect brought to my attention was the perception, by a number of interviewees, that confidentiality would not be respected if a member of staff had recourse to the provisions of these HR Policies.

OPINION:

517. This whole area has some correlation with the morale of an organisation's workforce. This is a notoriously difficult area to measure with any objectivity. The most useful point I can make is to provide a full quotation made by the PCT's HR Department that has co-ordinated the various Staff Opinion Surveys over the years: *"Staff morale has always been low and this year in particular."*

518. I recognise that the number of formal referrals concerning bullying and harassment via the PCT's policies have been small. I do believe, however, the weight of oral testimony indicated this matter is worthy of

being taken most seriously by the PCT's new leadership and my Recommendations address this matter.

Strategic Planning:

519. The PCT produced a far-sighted Service Strategy in 2003, which won plaudits at national level. The strategy took cognisance of the 2001 NHS Plan in relation to the development of Primary Care and its aims included: *"To set the context for new planning within the modern NHS and maximize three year funding allocations…Look beyond the short term and use its commissioning power to secure longer term health gain for the people of Brent…To develop the clinical strategy for the PCT from the bottom up that is informed by people dealing with everyday issues…To integrate service provision between previously distinct sectors."* [50]

520. These aims were produced at a time of unprecedented resource growth in the NHS and new longer term funding allocations. Perhaps it is therefore understandable that the Service Strategy did not include detailed resource assessments. However, the documents provided to me did not contain any financial information at all. One characteristic of the Service Strategy was the comprehensive list of planned capital schemes, deemed necessary to support the achievement of the service aims.

521. The rollout of the Service Strategy has included the development of Care Pathways for certain specialities and conditions. The PCT has received deserved credit for the far sightedness of its approach to putting the Patient at the centre of the care delivery plan.

522. I recognise the vision of the PCT's service planning; equally, I must reflect the views of interviewees as part of this Review. Many stated that the PCT was far too slow in responding to the tighter NHS financial climate and maintained a somewhat slavish adherence to the aims of the original Service Strategy. This adherence was attributed with contributing, in no small measure, to the financial plight that the PCT now finds itself. This situation reflected the statements made by the majority of PCT Board Members, who confirmed that the PCT outlook had been a predominantly developmental one, until overtaken by the financial events of mid-2006/07. Conversely, Dr Llewellyn stated that the service strategy should have reduced unnecessary costs.

523. Mrs Gaffin pointed out that the PCT undertook many schemes funded from non-NHS capital; no comment was provided about the ongoing affordability of the revenue consequences for such schemes. Many PCT interviewees expressed surprise that the organisation had been

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[50] Brent PCT: The PCT Service Strategy – September 2003 – Page 2.

able to continue with sizeable capital schemes when the NHS financial position tightened and development programmes had been frozen elsewhere in London. They stated that they had been assured that the PCT's finances were in good shape. Other specific observations made to me were:

- The PCT's strategy became dominated by the achievement of capital schemes while the financial strategy became dependent on the sale of redundant capital assets.

- The original Service Strategy was not refined or updated.

- The Service Strategy was never allied with a detailed Resource Plan.

- The planning of capital schemes was lengthy and stakeholders were not kept in the loop. The major consequence being that original and vague assumptions about functional content were overtaken by other events.

524. Regrettably, the outcome is that currently the PCT is in possession, at an ongoing cost to the taxpayer, of new buildings that are under used and under occupied e.g. the sizeable new developments at Willesden and Monks Park.

OPINION:

525. The PCT in its early years developed a visionary service strategy that, if resources had not become a constraint, would have probably achieved a pioneering programme of service remodelling. There is equally, no disputing that many service improvements have occurred to the considerable benefit of the Brent population.

526. The strategy had initial buy-in from Primary Care based clinicians. I was however provided with no evidence that it had a complementary level of buy-in from Secondary Care NHS Trusts or their clinicians. I am also of the opinion that the Service Strategy was insufficiently refined to reflect, for example, the impact of PBR on the Care Pathway model nor updated to reflect the impact of PBC.

527. Similarly, such a radical strategy demanded proactive Secondary and Tertiary Care commissioning by the PCT based on the principles of contestability and value for money. Unfortunately, the evidence forces me to the opinion that these essential pillars were missing.

528. As the years passed, I was advised that GPs and other groups had become increasingly disillusioned by the PCT's approach to planning and

the Service Strategy. This was due to the perception that the PCT expected compliance with plans rather than ongoing mutual engagement.

529. In relation to the underused new buildings and from the perspective of the taxpayer; it is to be hoped that such facilities can be fully utilised as part of the new London-plan for health care facilities. Alternatively, through local initiatives, involving the PCT's voluntary and public sector partner organisations and private sector providers.

Operational management of the PCT estate:

530. A high number of PCT interviewees based in Primary Care, Community Care and at the PCT HQ expressed disquiet about the controls exercised in the day-to-day management of the estate. These concerns ranged across the following matters:

- Favoured contractors to undertake building works and maintenance.
- Limited financial input to capital Business Cases approved by the PCT Board.
- Procurement arrangements for furniture, IT kit and other supplies.
- Minor capital schemes proceeding that were of low priority.

531. The fact that these concerns exist at all is disturbing, especially when the PCT is a partner in a shared services arrangement, with other NHS organisations.

532. One existing PCT Board Member stated: *"Estates has been an audit free area."*

OPINION:

533. A detailed assessment of the expressions of concerns about the management of the PCT's estate is well beyond the Terms of Reference of this Review. I do believe that some specialist assurance and due diligence work, via a random sample of past and present schemes and service contracts, is required. I hope that such a piece of work will lay to rest the concerns expressed to me about irregular arrangements and possible improper collusion. My recommendations address this matter.

Relationships and partnership working – Primary Care:

534. For this Review, the oral testimony provided in respect of Primary Care services was essentially from General Practice. It was provided by GPs, Practice Managers, Community Nurses and other community based Clinicians. No evidence was taken from the Dental or Optical professions.

535. It is axiomatic that a PCT should develop a good relationship with the independent contractors delivering all facets of Primary Care. Based on the oral testimony provided to me, the PCT was well regarded in the immediate aftermath of the dissolution of the local PCGs. From what I was told, this honeymoon period was short-lived.

536. Frankly, I was taken aback by the strength of feeling about the inadequacies of the PCT in its management of Primary Care affairs at the sharp-end over the last few years. This criticism was not all from Primary Care. PCT based interviewees were almost equally split; some believing that Practices were largely to blame for the present relationship problems due to their selfish behaviour, whilst others felt that Practices had received a raw deal from the PCT in respect of support, advice and the allocation of various funds.

537. Disturbingly, I was told that a widespread belief existed that, until very recently, the PCT was not in favour of Practice Based Commissioning. Almost universally, the criticism was centred on the perception that the PCT HQ did not want to lose influence or power. In the face of such widespread concern, I asked for some supplementary evidence about other concerns over the years. **Appendix 16** is an example provided on behalf of Practice Managers.

538. From the perspective of GPs, I was told that the PCT was, and still is, seen as being unresponsive. As one GP stated: *"We are asked for advice but it is usually ignored and we receive no feedback."*

539. An area of particular criticism was reserved for the perceived disengagement with the Care Pathway process for which the PCT had received various accolades. I was told that GPs had been engaged with the initial planning and supported the underlying philosophy. After that, it was alleged there had been little engagement with Primary Care.

540. I was advised that prior to a very recent request, from the Interim Chief Executive, regarding governance issues within the Care Pathways that no detailed discussion had taken place. This included such cardinal matters as: clinical safety, costs, basic administrative processes e.g. referral protocols and associated correspondence, which Care Pathways would provide the optimum return and the process of evaluation.

541. As one senior and long serving local GP stated: *"It was all blue sky stuff – detailed planning did not come into it."* Another GP said: *"…Brent was full of innovation – what we have to do is take the innovation make it work, consolidate it and evaluate it. It's those bits that don't happen."*

542. Other interviewees postulated that the PCT had neither the inclination nor ability to gear itself up the practicalities of PBR or PBC. Another GP stated that: *"…the Wembley office is known as the 'Death Star' – it sucks everything in and gives nothing out. They were not equipped for PBR could not see how it could fit with the BECAD Pathways and were also not equipped – I would say opposed to commissioning by Practices."*

543. There was recognition that the PCT had augmented the early work carried by its predecessor PCGs in promoting improved collaboration between Practices; which hitherto had tended to work independently. Increasingly, however concerns began to emerge that the internal bureaucracy of the PCT and internal rivalries began to dominate. Unfortunately, Primary Care interviewees confirmed that they had found the historic working arrangements within the PCT hard to fathom, and once again, the "silo" issue was to the fore in terms of the unnecessary difficulties faced.

544. Scathing criticism was reserved for the proliferation of working groups and the duplication of effort. Primary Care interviewees felt that the PCT did not understand the finite time available to attend meetings. They resented the consequent criticism from the PCT if they were unable to do so. A GP observed: *"…we are not treated as partners – it's been them and us."*

545. Conversely, a number of GPs acknowledged that the PCT had some difficulties. This was because there remained a significant number of GPs who wished to remain individualistic and tended not to be engaged with the wider family of GPs.

546. Of equal concern was the perception that the PCT operated in two distinct halves: the Wembley HQ half and The Rest. This was not helped by the perceived lack of communication between some Directorates based in the Wembley half!

547. Overall, there was a desire to know how the PCT's financial situation had deteriorated so swiftly and why such large deficits had arisen. I was told that, throughout Primary Care, there was wide-ranging despair and anger that the financial crisis had precipitated punitive short-term measures associated with the Turnaround Plan. Particular anger was vented against the PCT for various recent cuts, which had caused a lot of anxiety, been ill thought out, and then reversed. For example, the Interpreter Service and Physiotherapy.

548. More positively, Primary Care interviewees acknowledged that in recent months the PCT had attempted to become more open and transparent in its communications. It was thought, by some interviewees, however, that the new PCT leadership should become more visible and explain its values and plans. More specifically, to explain what safeguards were being implemented to avoid a repetition of past financial failure.

549. The clarion call from Primary Care was for stable and competent senior management of the PCT.

OPINION:

550. Put bluntly, I am of the firm opinion that a schism existed between the PCT HQ, its Primary Care arm and its Community Care arm.

551. It seems rather trite to say that the long-term aims of the PCT will be compromised if the relationship with Primary and Community Care is inadequate. In my view there exists, at present, a feeling of being badly let down by the former leadership of the PCT. This is because optimistic messages were being given including talk of service developments, until late 2006, when the world turned upside down very quickly, because of the financial crisis.

552. I can only provide a distillation of the main issues in this key area of the PCT's responsibility. I am of the unequivocal opinion, that this matter represents one of the largest challenges facing Ms Saunders, her NEDs and the new permanent senior executive team.

553. Based on what I was told a positive outlook exists among the PCT's Primary Care professionals to recover and move forward. It is to be hoped that a rejuvenated PCT can harness and utilise that spirit.

Relationships and partnership working – London Borough of Brent:

554. This key relationship has suffered because of the Turnaround Plan. Both political and executive leaders of the Borough said that it had been a bolt from the blue, in 2006, when the financial crisis emerged. One stated: *"It was a complete surprise – we were regularly told that the PCT was one of the best funded in North London and its finances were in order – these problems go against the grain."*

555. Until the events of 2006/07, the PCT/Borough relationship was viewed as being good with sound joint working in the conventional areas of NHS and Local Authority collaboration e.g. drugs and alcohol programmes. It was also felt that innovative joint working existed in the field of Learning Disability, Children and Physical Disability. The Mental

Health area was felt to be underdeveloped in terms of joint working and joint commissioning was regarded as having yet to develop meaningfully in respect of Older People.

556. There was felt to be some reluctance on the PCT's part to become fully engaged with the Social Inclusion and Regeneration agendas that are pivotal parts of the Borough's agenda. Notwithstanding this, I was provided with examples of current innovative joint working in South Kilburn and with the Area Network Programme.

557. Some Borough interviewees felt that, although Dr Llewellyn and Mr Parker: *"…had made the right noises about wider joint working the delivery was limited…"* There was recognition, however, that the PCT had a large range of national imperatives to meet and that this was a heavy constraint in fully realising the potential from local joint working and the embedding of more joint procedures and systems for service delivery.

558. From the views expressed to me, there was a wholesale desire to ensure that the current disputes and relationship issues at the highest level do not adversely affect LA and Health professionals delivering services and care in the field.

559. The present relationship at political and senior executive level is dominated by the disputed Continuing Care invoices and the impact of the Turnaround Plan. A third issue was a perceived misunderstanding by the PCT about scrutiny and the representative role of the Local Health Select Committee.

560. Some Borough interviewees believed there was a danger that the two areas of dispute could well poison the senior level relationship well into the future and that much work would be required to avoid such an occurrence.

561. Essentially, the Borough believed that the PCT had taken unwarranted and unjustifiable unilateral action in connection with the Continuing Care issue and that its reliance on fine legal arguments will be injurious to restoring trust and confidence. Equally, aspects of the Turnaround process were felt to have been conducted in an unprofessional and unilateral way that ignored the impact on partner organisations.

562. The point was firmly made to me, by LB Brent interviewees, that if the PCT had shown more prudence and had maintained a basic grip on its accounts then much of the present pain would have been avoided.

563. Although denied by Dr Llewellyn infrequent communication and review were the two main reasons cited by LB Brent interviewees as a main contributor to the Continuing Care and Section 28a problems. It was

felt that the PCT's EMT had resisted attempts to set up a regular mechanism for senior level executive liaison. Similarly, it was felt that the Commissioning Directorate had failed to promote and support an effective and regular review of cases. This problem is also evidenced by the LB Brent email of 28 October 2005 within **Appendix 8** about £0.6m of unresolved invoices received from the PCT.

564. In connection with the scrutiny role, the Borough interviewees hoped that the PCT would recognise that the principal role of the Health Select Committee was to represent the community. This meant that, in fulfilling the role it had a fundamental duty to comment on adverse impacts on the population engendered by the PCT's savings proposals and plans.

565. Some Borough interviewees said that the role of the Health Select Committee had to be viewed as outside the political and senior executive machinery. Thus it had the responsibility to "hold a line" as it was felt the PCT had acted improperly in advancing its Turnaround Plan.

566. Despite the present difficulties the PCT was praised for involving the Borough with recent appointments, most notably that of the new PCT Chief Executive and the possible appointment of a Joint Director of Public Health. I was also told that, in spite of the present financial predicament, the PCT still recognised the need for improved investment in certain areas of priority e.g. the recently expanded Joint Equipment Service.

OPINION:

567. The current fragile political coalition in LB Brent and the financial position of the PCT do not make for a comfortable relationship over the next twelve months or so. There exists great potential for political point scoring and this may well have to be tolerated in order to restore some confidence by the Borough in the PCT.

568. At stated earlier, it is plain that an early resolution of the Continuing Care and Section 28a disputes would be advantageous. It appears essential that once the PCT senior executive structure is stable that the new CE should take the first step in establishing regular and focused liaison with senior counterparts at the Borough.

569. At the end of the day, good relationships will have to be restored. This is because, in successfully meeting the priority needs of the Brent population, its two premier Public Service organisations must work together collaboratively and constructively.

CORPORATE GOVERNANCE WITHIN THE PCT

570. I have examined the issue of Corporate Governance at a number of levels in order to understand how the financial and governance problems of 2005/06 and 2006/07 arose and more importantly why they were not "nipped in the bud."

571. I considered the following matters to be particularly relevant:

- **The role of the Clinical and Corporate Governance Committee and the machinery of Governance.**
- **The role and performance of the Audit Committee and its relationship with Auditors.**
- **Corporate Objectives and Appraisal.**
- **Bedrock procedures.**

The role of the Clinical and Corporate Governance Committee and the machinery of Governance.

The role of the Clinical and Corporate Governance Committee:

572. The Committee was chaired by Mrs Gaffin and the lead Executive Director was the Director of Nursing, Quality and Clinical Governance (Ms P Atkinson.)

573. I have examined the Minutes of this Committee since mid-2005 and it is clear that this regular meeting held very thorough debates about Clinical Governance issues.

574. What is also clear is that despite having overall responsibility for Corporate Governance the committee did not address this in any meaningful way. Indeed, in relation to Financial Governance the committee merely received and noted the Minutes of the PCT Audit Committee. I could not find any written evidence that the committee discussed or challenged any matters relating to Financial Governance until the meeting of March 2007.

575. Since then, the committee has highlighted issues relating to the unfortunate financial situation and flagged-up this as an area of Non-Compliance within the "Standards for Better Health" - Final Declaration

submitted to the Healthcare Commission in mid-2007. The 2007 Declaration identified that: *"…the process for overall corporate governance and financial controls were not in place resulting in a major governance and financial failure…A new Audit Committee Chair with financial training has been appointed…"* [51]

576. This contrasts markedly from the Declarations of the previous years. Those submitted, in 2005 and 2006, stated that the PCT was fully Compliant with the standards for corporate governance and risk management. No qualification was provided about any facet.

577. I have also examined the Quarterly Reports produced by the Committee from 2005. No reference is made to financial matters until two Quarterly Reports, produced in December 2006, which related to the April-June and July-September 2006 Quarters. The former indicated that: *"The Committee established arrangements to monitor the risks on the financial savings plan."* [52] Presumably, for the first time.

578. Additionally, no reference is made to financial risks in the Risk Management Annual Progress Reports. For example, the last one considered by the PCT Board, at its September 2006 meeting, placed emphasis on the *"High Open/Live risks at 27 March 2006."* The Report does not refer to the known and escalating financial risks that would be facing the PCT in 2006/07. Nor does it reference the known problems with the achievement of the 2005/06 savings plan, internal budgetary overspendings and the financial over-performance with the acute SLAs in 2005/06.

579. I was advised by PCT personnel, involved in this area, that financial risk was not regarded as a Principal Risk facing the PCT. This area of risk did not feature in the Risk Register, or the Board level Assurance Framework, until mid-2006/07, when five Principal Corporate Objectives within the Sustainable Financial Health Theme [53] were included. It is notable that all five related to savings required in 2006/07. No Principal Corporate Objectives were included relating to Sustainable Financial Health in future years.

580. In marked contrast are the annual and other updates relating to Clinical Governance, which are both comprehensive and forward-looking.

581. I was advised that the operational oversight of Financial Risk was vested in Mr Patel and that he was a regular attendee at the Clinical and Corporate Governance Committee. Moreover, financial matters had not been placed on the agenda by Mr Patel. Conversely, Mr Patel stated that

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[51] Brent PCT: Declaration to Healthcare Commission – May 2007 – Page 9.
[52] Clinical and Corporate Governance Quarterly Report – April - June 2006: December 2006.
[53] PCT Board: 28 September 2006 – Brent TPCT Assurance Framework – Pages 2 – 5.

he never believed the Committee was interested in anything other than Clinical Governance matters and that the PCT Board accepted Financial Governance was the remit of the Audit Committee.

The machinery of Governance:

582. I recognise that NHS governance has been in a state of high-speed national evolution, perhaps revolution, in recent years and that "governance fatigue" affects a number of organisations. I received a considerable amount of oral testimony regarding the machinery of governance within the PCT.

583. Many interviewees felt that they had been overloaded with governance forms and reporting requirements. A number felt that they had received insufficient training in this area and that day-to-day work pressures meant that insufficient time was available to address identified Risks.

584. There was considerable support for Ms Atkinson regarding the progression of Clinical Governance issues and the Risk Manager (Ms C Afolabi) in respect of her efforts to provide a co-ordinated approach. It was however, felt by some interviewees, that Ms Afolabi was expected to exceed her brief of overall coordination.

585. The systematic approach to Risk Awareness, Risk Assessment and Risk Management was felt to be in its infancy. A number of PCT interviewees also questioned the priority afforded by the Integrated Delivery Directorate to these matters.

586. The PCT has already recognised that the Corporate Governance machinery requires overhauling: *"…the Board will review governance, and ensure that there are sound structures, procedures, expectations and accountabilities for integrated governance…"* [54]

587. Furthermore, at the July 2007 PCT Board meeting, new principles together with an action programme were approved which will result in a revised Sub-Committee structure. Crucially, as part of this important initiative, the PCT Board recognised: *"…the high importance of governance and risk management in the PCT's recovery and the importance of ensuring that a holistic approach is taken to risk."* [55]

OPINION:

588. A comprehensive Governance standard has existed since the days of the 21 Standards associated with the original national Controls Assurance

[54] Brent PCT: Declaration to Healthcare Commission – May 2007 – Page 9.
[55] PCT Board: 19 July 2007 – Minute 9.

mechanism. I neither found, nor was provided with, any historic evidence that an active approach was adopted to ensure good practice in respect of the financial risk part of this early Governance Standard.

589. I believe that Mr Patel was regarded as the "repository" of anything bordering on financial risk. This was based on his celebrated ability to achieve financial balance.

590. More importantly, it is clear to me, that the identification of financial risks was not viewed as a priority, until mid-2006, in terms of the Corporate Governance agenda. Furthermore, that the pro-active management of these risks did not commence, in earnest, until the inception of the main Turnaround Plan at the end of 2006.

591. I am of the opinion that the recommended approach to Integrated Governance in the NHS, which emerged in 2005, was slow to take root within the PCT. This is understandable given that the attention of the Audit Committee and senior managers was consumed by issues associated with the 2005/06 Final Accounts until the third quarter of 2006/07. The PCT had in fact made an encouraging start with a specialist Board level seminar held in May 2006 and was taking positive steps to overcome some issues of potential role confusion between the Clinical and Corporate Governance Committee and the Audit Committee. This is evidenced by the PCT Board meeting of January 2006 when the issue of potential overlap between the two committees was raised. [56]

592. I am of the view that a serious mistake was made by the EMT not regularly reviewing the Risk Register; until 2006. Regular review may have prompted financial issues to be incorporated earlier. I do hold some doubts this would have occurred given the historic perception about the good financial health of the PCT.

593. I also consider that the PCT is still running close-to-the-wind in terms of various non-financial statutory requirements that are not being led by a competent specialist e.g. Health and Safety standards.

594. Whilst I am loathe to increase the current Governance workload I believe the PCT's overarching Risk Strategy is in need of updating; if this is not already underway.

595. I believe that the PCT has much work to do in respect of inculcating the value of sound Governance and Risk Management among its senior and junior personnel in order to dispel the present notion that insufficient time exists to undertake the necessary tasks associated with Risk Management. The evidence provided for this Review, by many PCT

[56] **PCT Board: 26 January 2006 – Minute 856.**

interviewees, confirmed that basic, let alone specialist training in this field, had not previously been seen as a priority.

596. Presumably, as part of the PCT's ongoing internal Governance Review, an assessment will be made as to what level of staff training is required to support the proposed new Clinical and Corporate Governance (Board) Sub-Committee. It is axiomatic that it would be wasteful for the Governance Review to recommend new arrangements to support, for example, the approach to Risk Awareness, Risk Assessment and Risk Management, which founder because of inadequate communication and training across all levels of affected personnel.

The performance of the Audit Committee and its relationship with Auditors:

597. Under the Chairmanship of Mr Boucher, the Audit Committee met in full session on seven occasions during 2005/06 and 2006/07. A special Sub-Committee of the PCT Board, involving members of the Audit Committee met on two occasions in August and September 2006 to address issues concerning closure of the 2005/06 Final Accounts.

598. It is evident that the Audit Committee had a full agenda and that Mr Boucher adopted a meticulous approach to understanding the issues under consideration by the Committee. Two other NED members (Ms J Carr and Mr S Maingot) were regular attendees.

599. Mr Boucher advised me that, he believed problems with the accounts started in 2003/04. He felt Mr Patel had been adept: *"…at 'squirreling away' resources and using slippage…"* to achieve financial balance but this was the first year in which the Final Accounts were submitted late. Mr Boucher further stated that: *"…04/05 was the year when we should have declared a deficit."*

600. Additionally, Mr Boucher believed that Mr Patel had a poor working relationship with the External Audit Manager and this compromised a constructively challenging relationship.

601. In respect of finalising the end-of-year accounts Mr Boucher was particularly concerned that he never received a thorough answer about the use of Contingent Liabilities and the degree to which they may, or did, crystallise in the subsequent financial year.

602. I was advised by the Auditors that they found this particular Audit Committee challenging in terms of the length of meetings and the degree of detailed discussion over certain issues. They also found the Committee

frustrating because key matters, relating to inadequate financial controls and procedures, kept reappearing.

603. I have considered the Audit Committee Minutes and Audit Reports from March 2005 with particular attention given to matters relevant to the Terms of Reference for this Review.

External Audit:

604. In a previous section, I have addressed the early warnings issued by PwC as the External Auditor of the PCT. These continued with the issuing, in July 2006, of the *"ISA 260 Report for 2005/06 to those charged with Governance."* This report was not finalised until March 2007 due to the emergence of issues relating to the 2005/06 Final Accounts and other financial control issues that I have discussed earlier. Both the initial and final reports [57] however, provided low comparative Auditor Local Evaluation (ALE) scores, with only one of the 13 assessed areas judged "*Consistently above minimum requirements."*

605. Of particular relevance to this Review is the fact that the initial ISA 260 Report, issued in June 2006, advised the Audit Committee of *"Inadequate Performance"* about the standard and timeliness of its annual accounts. The report also intimated that this lowest ranking could be given to the PCT's system of internal financial control. Indeed, the lowest ranking for this crucial area was subsequently confirmed.

606. At the July 2006 Audit Committee meeting a series of redressing actions were agreed. These were to be led by Mr Patel, most notably: *"To produce an action plan to address internal control weakness…"* [58]

607. The areas of criticism reflected established working practices. At the next full Audit Committee, held in November 2006, Mr Boucher was clearly greatly disappointed that areas of weak practice, which occurred in previous years, had reappeared. This being despite the fact, that he had received assurance from the PCT's senior officers, that procedures had been duly tightened. [59]

608. Unfortunately, this situation was nothing new. In relation to the specific issues of concern to this Review, Mr Boucher and other NED Members of the Audit Committee had received assurance in 2005 about three key areas:

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[57] Brent Teaching PCT: 2005/06 Report to those charged with governance (ISA (UK &I) 260) – June 2006 and Brent PCT 2005/06 Annual Audit Letter: March 2007 – Appendix 1.

[58] PCT Audit Committee: 6 July 2006 – Page 4 - Note 5.

[59] PCT Audit Committee: 6 November 2006 – Pages 5 and 6 - Note 5.

- **July 2005 –** Procedural issues relating to the Final Accounts.

- **October 2005 –** In the light of criticism in the Annual Audit Letter, Dr Llewellyn, Mr Patel and Mr Parker had provided reassurance that the approach to dealing with disputed balances was sound.

- **October 2005 –** The need to reduce reliance on slippage and other non-recurrent tactics to achieve financial balance.

609. It is also important to state that the PCT was praised by the External Auditor, during 2005, about various practices and that in these areas the PCT was felt to be performing very well. For example:

- **March 2005 –** The Performance Management Framework was felt to be an exemplar of its kind.

- **October 2005 –** improved Working Papers and Draft Accounts.

610. The accounting treatments applied to Contingent Liabilities and the Prescribing Expenditure issue are problematical. The question of their full legitimacy remains an issue. Conflicting advice has "muddied the waters" and it will be important for the PCT to receive definitive advice, from Auditors, NHS London or the Department of Health if it wishes to ensure the remaining concerns are finally laid to rest. I have previously mentioned my concerns about the possible impact of these items to past Final Accounts and other formal financial declarations.

611. In March 2007 the PCT's Interim Chief Executive (Mr N Webb) referred concern about the performance of PwC to the Audit Commission as the body responsible for appointing External Auditors to NHS organisations. These concerns centred on issues relating to advice provided by PwC regarding the proper accrual for Prescribing Expenditure, outstanding Continuing Care invoices from LB Brent and a lack of liaison with Finance Department personnel. I am advised that PwC was not criticised in respect of the creditor balances. However, PwC was criticised about not escalating concern about the overall financial position sooner.

Internal Audit:

612. I was advised by the Internal Auditor that longstanding Audit concern existed about the technical abilities and skill mix within the PCT's Finance Department. This was allied with strong and reported concerns about the adequacy of the Financial Management and Financial Accounting systems because so much was tightly controlled by Mr Patel personally.

613. The number of early warnings provided to the PCT was numerous. However, of equal importance is that the PCT received Substantial

Assurance rankings across many areas from its Internal Auditor. The areas that I have identified below tend to dovetail with concerns raised by the External Auditor, since the inception of the PCT, which have been addressed in earlier sections of this Report. I have reviewed relevant reports prepared by the Internal Auditor from 2004/05. I consider that the following are of particular relevance to this Review:

Budgetary Control Reports:

614. The 2004/05 report on Budgetary Control resulted in a Limited Assurance ranking. Central points were: *"Weaknesses in the design or inconsistent application of controls put the achievement of objectives at risk…Records were not available to illustrate that budget holders understood and accepted their financial responsibilities…no documentation is retained where…budgets are altered."* [60]

615. A more limited review, in this same area, undertaken the following year showed that only two of the eight main recommendations, made in the 2004/05 report, had been implemented.

616. When this area was assessed for the third time, in 2006/07, a Limited Assurance ranking was also applied; with many of the same weaknesses that were evident two years previously being flagged-up again. [61]

Continuing Care and Commissioning:

617. From Audit Reports produced in relation to 2003/04, the Audit Committee was aware that controls in these two areas required reinforcement. For example, within the: "*Database of 2003/04 Audit Recommendations"* received by the Audit Committee, in March 2005, it was recommended that assessment arrangements and analysis of commissioning variances were undertaken. [62]

618. In August 2006, the Internal Auditor carried out a detailed assessment, at the request of Mr Boucher, of the unexpected invoices lodged with the PCT from a variety of providers. A timeline provided by the Internal Auditor is within **Appendix 17.**

619. This was followed by a detailed piece of work that culminated in an overall Limited Assurance ranking being provided in respect the extant

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[60] Budgetary Control: Internal Audit 2004/5 – Parkhill Audit Agency – April 2005 – Pages 2 and 3.
[61] Budgetary Control: Internal Audit 2006/07 – Parkhill Audit Agency – April 2007 – Page 3.
[62] Database of 2003/04 Audit Recommendations – Parkhill Audit Agency – March 2005.

systems relating to the PCT's management of Continuing Care commissioning. Cutting to the chase, this Audit Report highlighted: *"At the current time there appear to be differences of opinion between the way in which the PCT's finance department and the Commissioning department see the role of finance. We have recommended that both departments need to engage in clear dialogue and establish clear roles and responsibilities."* [63] Disturbingly, this Audit Report contained - No Assurance rankings for some areas of the PCT's activities.

Financial Ledger and Payable Accounts:

620. Limited Assurance was received in respect of Financial Ledger controls at the April 2006 Audit Committee. Specifically, it was recorded that weak practice occurred in the authorisation and documentation of the financial journals. [64]

621. A very worrying Internal Audit report was received at the January 2007 Audit Committee. This provided a Limited Assurance ranking in respect of many weaknesses in the processing and authorisation of commissioning invoices. Specific concern also existed about the high risk associated with the non-reconciliation of Control Accounts, sizeable invoices not linked to the Accounts Payable process and irregular authorisation of invoices by non-authorised signatories. [65]

622. The January 2007 Audit Committee also received a second Limited Assurance Internal Audit Report. This related to Debtors and Income. [66] The report showed that despite Mr Patel's belief that improvements would occur by transferring these duties into the PCT from a Shared Services arrangement the contrary had occurred.

623. During the interview phase for this Review, I received expressions of concern, from a number of existing and former PCT Finance personnel, that this transfer of activity had resulted in former Parkside Trust Finance personnel being recruited into the PCT. The assessment being that this had exacerbated the "them and us" tensions within the Finance Directorate.

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[63] Continuing Care Structure and Financial Management Processes – Parkhill Audit Agency – November 2006 – Page 4.
[64] Internal Audit Progress Report – 2005/06 – Parkhill Audit Agency – April 2006 – Page 5.
[65] Internal Audit 2006/07: Accounts Payable – Parkhill Audit Agency – January 2007.
[66] Internal audit 2006/07: Income and Debtors – Parkhill Audit Agency – January 2007.

Monitoring of SLAs and overspending:

624. Arising from concerns raised by PCT personnel about secondary care commissioning, as part of the Audit Needs Assessment undertaken in 2005/06 initiated by the Internal Auditor, a number of checks in this area were felt necessary. [67]

625. At the November 2006 Audit Committee the Internal Auditor was asked to undertake, as a matter of urgency, a review of information provided by Ms Patel relating to a significant overspending on the 2006/07 commissioning budget at Month 6 totalling £14.2m. Ms Patel believed that £4.7m arose from the non-accrual into the 2005/06 Final Accounts of various NHS invoices. The issue over the £4+m goes back to enclosures within **Appendix 8** relating to the potential financial pressures at the end of the 2005/06 financial year.

626. This piece of work identified a history of missing audit trails, missing invoices, missing journals, many other basic errors and, well, general chaos within the PCT's Finance Department. [68] An interim report was issued in December 2006 and a Key Findings Summary issued in January 2007. A timeline provided by the Internal Auditor is within **Appendix 17.**

OPINION:

The PCT Audit Committee:

627. I hold the opinion that it is evident the PCT Audit Committee, under the committed leadership of Mr Boucher, was assiduous in its consideration of a wide range of business. I believe that the Audit Committee was equally assiduous in drilling-down into the minutiae of many issues. What is not evident is a rigorous approach in following-up agreed action and holding to account the Executive Members of the Audit Committee.

628. I consider that, to some extent, the NED members of the Audit Committee were let down by the Executive Members. However, I believe that the Audit Committee employed an approach that dragged Mr Boucher into having to deal with far more detailed matters than he should have been. I further believe that the agenda setting and approach to addressing papers should have been far more streamlined.

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[67] Draft Audit Needs Assessment and Strategic Plan for 2006/07, 2007/08 and 2008/09 - Parkhill Audit Agency – May 2006 - Page 16.

[68] Commissioning Balances at 31.3.06 and provision for Prior Year activity paid in 2006/07 – Interim Report: Parkhill Audit Agency – Letter to the PCT Interim Director of Finance – 11 December 2006.

629. I consider that the Audit Committee was too patient with managerial lackadaisicalness in the response to repeated Internal and External Audit concerns. Examples being; the late submission of Final Accounts, inadequate budgetary control and inadequate forward financial planning.

630. This was perhaps understandable during the early years of the PCT, but inappropriate, as the PCT became an experienced organisation. As noted previously, it must also be remembered that the majority of the PCT's senior Finance personnel had also held chief officer or senior positions at their predecessor NHS organisations.

631. I further believe that it was unfair on Mr Boucher to be both the Audit Committee Chair and provide the only NED input to the Forward Financial Planning process. As stated in an earlier section of this Report I believe that a degree of "Separation of Powers" is required in the role of the Audit Committee Chair, in order to provide focused constructive challenge to the Executive Members. This was missing.

632. I do not believe that the Annual Reports of the Audit Committee were satisfactory. They utterly failed to provide a prompt to the full PCT Board about inadequacies. Essentially, they dealt with process and not substance.

633. I am of the firm opinion that the Audit Committee, until 2007/08, was so mired in detail that it was unable to "see the wood for the trees" at critical times.

634. The Audit Committee has already been rejuvenated under a new Chair (Mr C Somani) and I was advised by Auditors and others that it has a focused work agenda. All parties appear confident this will see structured progress being made towards compliance with the best practice approach enunciated within the "NHS Audit Committee Handbook" issued by the HFMA and Department of Health in 2005.

Professional Audit input to the PCT:

635. I hold the opinion that, overall, the standard of Audit Reports presented to the PCT was good. I am also of the opinion that both the Internal and External Auditors were far too tolerant of inadequate and tardy responses by the PCT to clear Audit criticism and Audit recommendations.

636. I do not understand how, after giving the organisation time to bed down, the PCT escaped censure that was more formal from the External Auditor. Repeated expressions of concern were delivered, about the inadequacies of many basic financial controls that were not then rectified

by the PCT. I do accept that individual Auditors' have varying trigger points regarding the initiation of formal reviews into Financial Standing and other escalation measures when they hold serious concerns. In this regard, I can only presume that a key factor was because the PCT met its statutory financial duties until 2006/07.

637. I also believe that the Internal Auditor was too generous with the Assurance Rankings in some Audit reports. Given a history of non-compliance with Audit recommendations in certain key areas, e.g. Budgetary Control and Financial Ledger reconciliations some "Nil Assurance" rankings would have been appropriate. Albeit with hindsight, perhaps this would have acted as a catalyst towards shaking-off a complacent attitude within the PCT. I recognise, however, that the conventional criteria governing the application of various "Assurance Rankings" can act as a constraint to an Auditor. It was conspicuous that rankings of "Nil Assurance" did not appear within Internal Audit Reports, until Quarter 4 of 2006/07.

638. A number of former senior PCT personnel suggested to me that Auditors failed to spot certain problems early enough. I totally disagree. It is my opinion that Auditors did spot problems early enough, because they were able to compare the PCT's practice with other organisations. The evidence, some of which has been presented throughout this Report shows that many early warnings were indeed given. It must also be remembered, in the case of the Internal Audit service, that it is a contractor to the PCT. Accordingly, an Internal Auditor has to reflect and respect the wishes of their client in terms of how much, and where, the finite Audit resource is to be concentrated.

639. I do believe that the situation in the PCT would have benefited from the existence of a proactive network of Audit Committee Chairs in addition to the regular training for Members of Audit Committees. Additionally, if it did not exist, some liaison machinery for both sets of Auditors to alert, informally, the SHA would have been useful.

Corporate Objectives, Individual Objectives and Appraisal.

640. I was advised by numerous PCT personnel, including existing and former Board Members that Corporate Objectives were regularly set. Moreover, that monitoring was systematic; especially in relation to those associated with the attainment of NHS imperatives.

641. The collegiate attainment of Corporate Objectives was all together another matter. Many interviewees stated that a major weakness of the PCT was in the area of joined-up working to achieve the organisation's objectives. Once again, this was attributed to the longstanding "silo"

problem. This constraint was in fact, recognised by Dr Llewellyn in May 2005, when as part of the paper: *"Taking Brent Teaching PCT into the future - Consultation Document"* Dr Llewellyn wrote: *"It has been easier to make improvements where only one directorate is involved, and more difficult to get work prioritised where it cuts across directorates. It appears from this that corporate objectives are sometimes not owned across the organisation."* [69]

642. On the other hand, the PCT must receive credit for consistently meeting many national targets over the years.

643. A mixed position was relayed to me in relation to the setting of Individual annual objectives and associated appraisal for Executive Directors. A minority of interviewees said that they had regular objectives set and their individual performance was appraised by the Chief Executive. Dr Llewellyn agreed that this was the position. The majority denied that this was the case.

644. A similar position existed in relation to Job Descriptions. I was told by some Executive Directors that they had never possessed one; others indicated that they had not been updated since the date of their original appointment. Again, the available documentary evidence was sparse as shown by an email sent on 19 June 2007, on behalf of the Interim Chief Executive regarding new Job Descriptions for the most senior personnel: *"I have been searching for your current job descriptions! Peculiarly, we don't see*(m) *to have these anywhere in the system. I would therefore be enormously grateful if you could look amongst your own paperwork, and if possible furnish me with a copy of your current JD."*

645. A contrasting position existed with the Performance Appraisal of NEDs by Mrs Gaffin. The records existed and showed that the process was regular, searching and comprehensive

OPINION:

646. The approach to setting individual objectives for EDs in recent years appears to have been, at best, ad hoc. This situation also appears to have been the case in the regular up-dating the Job Descriptions of the PCT's most senior managers.

647. These, I believe, are important tasks in an organisation facing increasing challenges and are, therefore, one where crystal-clear delineation is required about objectives and their achievement timetable. Of equal importance is clarity, via up to date Job Descriptions and annual individual Objectives, about who is actually responsible for particular

[69] Taking Brent Teaching PCT into the future – Consultation Document: Paragraph 4.2.

work areas and high-level tasks. These issues are I understand now well on the way to being rectified.

Bedrock Policies.

648. During the course of this Review a number of PCT interviewees who had reason, because of their duties, to be aware of Standing Financial Instructions and Standing Orders professed to being unaware of their existence or their applicability. Clearly, this situation was representative of poor practice.

649. The PCT now possesses a revised consolidated portfolio of Standing Orders, Standing Financial Instructions and a Scheme of Reservation and Delegation of Powers. These were received by the Audit Committee in May 2007.

650. The Minutes of this meeting indicate that this was the first revision of these bedrock policies since 2004. This means that the PCT had been operating with outdated policies in these areas for a number of years. This is because new versions have been regularly issued nationally to reflect the changing responsibilities of PCTs.

OPINION:

651. If not already underway, the situation of relevant PCT personnel professing unawareness of SFIs and SOs requires correcting.

652. The Department of Health is adept at issuing updated versions of the detailed Corporate Governance framework manuals; with at least two updates being issued in 2006 alone. My only advice is that a crosscheck is made between the version received by the PCT Audit Committee and the latest Department of Health version. My own, albeit quick check of these very detailed documents showed some variation between the new PCT version and the current national version. I believe the national version is now based on Department of Health Gateway Reference 7118, issued in the autumn of 2006, not Gateway Reference 6184. However, this is a fast moving area of the NHS central bureaucracy and updates that are even more recent may now be available.

OVERALL OPINION

Specific area of analysis 1 – *"…identify the reasons why the PCT's financial position deteriorated significantly at the end of 2005/06 and during 2006/07, and the causes of implied misrepresentation and under-reporting in returns to NWLSHA, LSHA and the DH."*

653. The main causes for the financial position deteriorating in 2005/06 and 2006/07 were:

- Poor budgetary control.
- No linkage between activity and costs.
- Failure to achieve planned savings.
- Reliance on accountancy adjustments and one-off savings.
- Weak financial management and accounting systems.
- Absence of a performance culture.
- Weak scrutiny by the PCT Board.
- A divided senior executive team.
- Failure to heed early warnings from Auditors.

Specific area of analysis 2: *"…assess the PCT's corporate governance arrangements, financial management, financial control, and reporting that contributed to this situation…*

654. Whilst the Clinical Governance arrangements were sound and comprehensive, other facets of Governance were weak.

655. Financial Governance was vested in the PCT Audit Committee. This Board Sub-Committee could not see the "wood for the trees" in relation to the underlying financial health of the PCT.

656. The financial management systems and financial controls were poor because they were led by a Director of Finance and support staff who were uncomfortable and out of their depth with the demands of a large commissioning organisation.

657. This problem was significantly worsened by an Executive Management Team and PCT Board with weak financial grip and low priority given to executive accountability; until late-2006.

658. The financial reporting to the PCT Board was regular yet tended to paint an altogether too "rosy" a picture; until mid-2006.

659. Risk was highlighted by the Director of Finance; yet financial risk assessments were not taken seriously by the PCT Board because of the Director of Finance's celebrated ability to achieve financial balance.

660. There were a number of technical deficiencies in the management of the accounts and associated systems. Early warnings about the negative cumulative effects were ignored by the PCT Board.

661. The forward financial planning mechanisms of the PCT were ineffective.

662. Effective financial control was compromised by factionalism between certain PCT Directorates.

663. Effective financial control was further compromised because commissioning and associated monitoring was weak.

664. The formal reporting of the PCT's financial position to the super-ordinate NHS authorities was erratic and erroneous; until late 2006.

665. I am of the opinion that the whole PCT Board was responsible for serious corporate failing in the following areas:

- Inadequate oversight of the financial affairs of the PCT.
- Inadequate scrutiny of Executive Reports relating to Finance and Performance.
- Inadequate oversight of the senior Executive Team and its responsibility to ensure that a sensible balance existed between development and grip.
- Inadequate Corporate Governance machinery.

Specific area of analysis 3: *"…identify the extent to which internal and external audit had reviewed the corporate governance and financial reporting processes in the PCT prior to the events of 2006/07 occurring."*

666. The PCT Board received many early warnings from both the Internal Auditor and the External Auditor about flawed systems and processes.

667. A most serious dislocation existed between receiving and taking Audit Reports seriously, as regards the quality of, and commitment to, follow-up action.

668. I also consider that the Internal Auditor was too lenient in various assurance assessments.

669. The Internal Audit service is in a contractual relationship with NHS clients and accordingly has a difficult balancing act to perform.

670. I am of the opinion that the External Auditor provided clear reports to the PCT about serious flaws and lapses in the technical management of its financial resources. Similarly, the External Auditor provided many early warnings about the need for the PCT to move away from undue reliance on end-of-year accountancy adjustments and other manoeuvres. These early warnings complemented unequivocal advice that the PCT needed to construct a realistic medium term financial strategy.

671. I do not understand why the External Auditor remained so tolerant of the PCT Board.

672. I consider that that the professional management of the PCT's finances was so poor, and regularly reported as such by the External Auditor, that some escalation of concerns should have occurred.

673. I am of the opinion that the legitimacy of the PCT's reported financial balance in 2004/05 and 2005/06 is questionable, along with the accuracy of associated formal declarations e.g. the SIC. I consider that a specialist deep-seated Audit analysis is the only way of establishing the definitive position.

674. The cost-effectiveness of undertaking such an exercise is a decision for the recipients of this Report. Such action has to be balanced against the good progress now being made by the new leadership of the PCT in implementing much tighter processes to provide effective stewardship of public funds.

Specific area of analysis 4 – "To make recommendations to secure sound financial management and corporate governance arrangements in the future."

675. My Recommendations for consideration cover these issues.

676. I am satisfied that the PCT Board now takes, most seriously, the need for effective Corporate Governance.

677. I am further satisfied that good progress is being made to implement modern financial management procedures and their associated operational processes.

678. I believe the PCT Chair has a responsibility to ensure that the new PCT Chief Executive and the new PCT Director of Finance fully understand their local duties and wider accountabilities for the good stewardship of public funds. The Chief Executive as an Accountable Officer to the NHS Accounting Officer and the Director of Finance as the Chief Financial Officer and Advisor to the PCT Board.

Specific area of analysis 5 – "To identify and review the involvement of individual members of the PCT Board, the Management Team and senior staff in regards to the facts associated with the deteriorating financial situation for 2005/06 and 2006/07."

679. I have endeavoured to structure the sections of this Report to ensure these matters are clearly presented and assessed.

Specific area of analysis 6 – "To highlight the lessons that can be learnt from the apparent corporate governance and financial failure in the PCT and to make recommendations…"

680. Many financial governance and associated systems failed because of limited professional skills, a failure to balance development with control and lax oversight by the PCT Board.

681. The oversight exercised by the former NWLSHA was also limited, due largely to the PCT reporting a healthy financial position. I believe that long before 2006/07, the spot-checking by the SHA of the PCT's reported position against its underlying financial standing would have revealed serious deficiencies.

682. The PCT Board, as a semi-autonomous body, possessed the first line of responsibility to ensure accuracy in its financial reporting.

683. In fulfilling this pivotal responsibility, I am of the opinion the PCT Board failed over a number of years.

Specific area of analysis 6 – "The Review will need to take account of the provisions of the DH's Code of Conduct for NHS Managers and similar codes of good practice."

684. I am of the opinion that Mr Parker made a series of errors of judgement during 2006, which contributed to the financial failures of

2005/06 and 2006/07. These concerned: a) the failure to heed early warnings about the 2005/06 financial outturn: b), a wrong decision, in both process and result, which led to the appointment of an inexperienced manager to progress the 2006/07 savings programme, prior to the engagement of KPMG and subsequently an experienced Turnaround manager: c) a serious misjudgement in September 2006 regarding the likely 2006/07 financial deficit and: d) a serious misjudgement in the initial formal reporting of the PCT's financial position to the SHA in November 2006.

685. I am of the opinion that Mr Parker was in breach of Principle 4 of the "Code of Conduct for NHS Managers." [70] The fact that the PCT was in breach of its own Standing Orders by failing to incorporate the provisions of the Code into the Contracts of Employment of senior managers does not, in my opinion, reduce the impact of the Code, in the context of this Review, as it is a nationally recognised reference point governing standards of professional conduct. I am also concerned that the secondment, arranged by Mr Parker, of Mr Hellier to undertake a pivotal task for which he was inexperienced, was based on an interview involving Mrs Gaffin, Mr Boucher and Mr Parker rather than a competitive externally assessed interview.

686. I believe that Mr Parker worked hard in trying circumstances. I consider that he was insufficiently experienced to identify effectively the necessary corrective executive action in such a complex PCT.

687. I do not believe that the PCT's Accountable Officers i.e. Dr Llewellyn and Mr Parker fully understood their responsibilities. In the case of Dr Llewellyn, mitigation exists because the PCT met its statutory financial duties during her tenure. Although I do have reservations about the 2004/05 position, Dr Llewellyn had no reason to doubt the financial advice received.

688. As Acting CE, Mr Parker received an increased salary on top of his original Acting-up allowance. This was advocated by Mrs Gaffin, to the PCT Remuneration Committee, due to Mr Parker's responsibilities as the PCT's Accountable Officer. [71] The PCT Board, should accordingly, have ensured that Mr Parker was made fully aware of his stewardship responsibilities as Accountable Officer. Equally, as he received extra pay Mr Parker should have familiarised himself with the full extent of these responsibilities. He stated to me that: *"Yes - I was aware in principle of the duties as accountable officer."*

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[70] **"Code of Conduct for NHS Managers – Principle 4 – "I will…accept responsibility for my own work and the proper performance of the people I manage."**

[71] **PCT Remuneration Committee: 22 June 2006 – Note 4 –** *"JG asked the Committee to consider the responsibility of being accountable officer. In view of the fact that AP will carry this responsibility for a longer period than had originally been envisaged."*

689. I am of the opinion that Mr Patel was out of his depth in running the financial affairs and controlling the accounts of a complex NHS commissioning organisation.

690. I believe that he relied on a small cadre of colleagues with whom he had worked with for many years. I also consider that Mr Patel had the best interests of the PCT at heart; this however cannot ameliorate the fact that his professional leadership was unsound.

691. I hold the opinion that Mr Patel breached Principles 4 and 6 of the "Code of Conduct for NHS Managers." [72] The fact that the PCT was in breach of its own Standing Orders by failing to incorporate the provisions of the Code into the Contracts of Employment of senior managers does not, in my opinion, reduce the impact of the Code, in the context of this Review, as it is a nationally recognised reference point governing standards of professional conduct.

692. I further consider that Mr Patel was responsible for regularly allowing misleading statements to be made about the financial position of the PCT. I therefore find Mr Patel to have been in breach of a further provision of the Code. [73]

693. I also hold serious concerns that lax financial controls in the area of financial payments and income and debtors could have resulted in poor practice and that these areas should be thoroughly checked. I also believe some checks should be undertaken in respect of the management of the PCT estate.

694. In my opinion, the PCT Board as a collective whole, until late 2006/07, did not fulfil certain expectations within the "Code of Accountability for NHS Boards." [74]

695. The leadership of Mrs Gaffin was exemplary in the ambassadorial and community representative role. I also recognise the long and devoted service Mrs Gaffin gave to the NHS. Regrettably, I believe Mrs Gaffin, as the leader of the PCT Board, was ineffective in the role of ensuring that the Board acted with balance and that the Non-Executive arm had a firm approach in holding their most senior executives to account.

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[72] Code of Conduct for NHS Managers – Page 3 - Principles 4 and 6 – "I will…accept responsibility for my own work and the proper performance of the people I manage…take responsibility for my own learning and development.

[73] Code of Conduct for NHS Managers – Paragraph 3 – Page 4 – *"I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer."*

[74] Code of Accountability for NHS Boards – Page 4 "…provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed…set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance."

696. I am therefore forced to the opinion that Mrs Gaffin, as the PCT Chair, was responsible for inadequate leadership of the PCT Board and in breach of two provisions of the "Code of Accountability for NHS Boards" which relate to the duties of the Chair. [75]

Specific area of analysis 7 – "The overall aim of the Review is to assist the PCT in moving forward…"

697. This Review has revealed a series of inadequacies both corporate and individual. I recognise that many will be distasteful and attempts will be made by some parties to distance themselves from and/or find fault with the findings.

698. More importantly, the PCT has now turned a corner and has the opportunity to construct entirely new approaches and standards. From what I have both seen and heard a good start has been made.

699. Of equal importance, is the fact that the PCT has greatly benefited from the loyalty, professional experience and skill of personnel working across its spectrum of responsibility. Many of whom feel badly let down by the previous PCT leadership and feel guilty that they were also, in some way, partly responsible for the financial crisis and other problems. I believe the new PCT Board has a responsibility to recognise these anxieties and demonstrate commitment to the valuing of its personnel.

700. A Review such as this, in meeting the Terms of Reference, is inevitably focused on adverse issues. Conversely, there is much to celebrate in the services provided to the population. Many PCT interviewees were; quite rightly, keen to inform me of excellent clinical and other initiatives in the following areas:

- Learning Disability.
- Intermediate Care and Rapid Response Teams.
- Public Health Profiling.
- PALS Outreach.
- IWL Practice Plus Status.
- Collaborative arrangements for disease prevention programmes and health promotion programmes.

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[75] *Code of Accountability for NHS Boards – "The key responsibilities of the chair are…leadership of the board, ensuring its effectiveness on all aspects of its role…arranging the regular evaluation of the performance of the board, its committees and individual directors…"*

- The philosophy underpinning the Care Pathway approach.
- Health Visiting service.
- Rehabilitation services for Older People.
- Patient Focus Groups.
- Innovative General Practice.
- The regular achievement of difficult Primary Care targets given the diversity and fluidity of the population e.g. Access and Immunisation/Vaccination.
- A range of services, which respect and reflect the cultural, religious and ethnic diversity of the Brent population.

701. This is far from being a complete list but it does provide a glimpse of the eclectic range of excellence delivered. I found among many interviewees, that whilst feeling tarnished by the problems of 2006, there existed great determination to overcome past events and move forward. I did not attribute this to simply being a PCT employee, but rather, loyalty and a pride in delivering services to the diverse population of Brent.

702. I hope this Report is of value in revealing and understanding the reasons for past errors. More importantly, that it is of practical use in avoiding future errors and is of some assistance to the PCT Board in discharging its responsibilities to Patients, the population of Brent, its own personnel and the taxpayer.

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