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### **Austerity and hospitals in deficit**

Is PPP termination the answer?

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## **Austerity and hospitals in deficit: Is PPP termination the answer?**

### **Introduction**

Eight years of historically low funding growth for the English National Health Service (NHS) (with per capita increases slowing from a long-term average of 4.4% a year to 0.1% a year from 2009-10 to 2017-18 (Charlesworth and Johnson, 2018)), has been coupled with increasing demand pressures from a growing and ageing population (Charlesworth and Johnson, 2018). Consequently, the NHS has found it increasingly difficult to perform on several high-profile targets (Harker, 2018). This failure has occurred in the context of several consecutive years of substantial overspending by NHS provider organisations – NHS Trusts and Foundation Trusts (Gainsbury, 2016). With the government intent on continuing its deficit and debt reduction path within a framework of ‘austerity’ focused almost exclusively on the expenditure side (Bramall, 2013), the longer-term outlook for NHS spending is unclear. In this context, NHS organisations have begun to explore radical solutions for reducing their costs. Payments made under Private Finance Initiative (PFI) contracts (called Public Private Partnerships, or PPPs, outside of the United Kingdom) are ring-fenced and indexed to inflation (Pollock *et al.*, 2011). Reported savings obtained by the early termination of a PPP contract at the Hexham General Hospital led to calls, by politicians and some NHS managers, to repeat this experience elsewhere (Tizard, 2017). Our aim in this paper is to examine the financial feasibility of responding to the pressures created by austerity in this particular way. Following Bracci *et al.*, (2015), we argue that accounting is too challenging and complex to be pigeonholed as a process of simply ‘balancing the books’. The strategy of reducing expenditure by terminating PPP contracts early will inevitably create winners and losers in society, and its impact on social welfare as a whole is in question.

The paper is structured as follows. The next (second) section briefly discusses approaches to austerity in the United Kingdom and its impact on public spending on the NHS. Section three provides some background on the use of PPP in the health sector and the potential for early contract termination. Section four sets out the research methods underpinning our empirical results. These draw on publicly available data regarding NHS funding, and financial statements relating to eight potential termination cases for which we have identified the expected financial costs of termination. Section five presents our findings, which highlight the legal restrictions and financial realities that influence the decision about whether a project should be terminated or not. However, as the concluding section discusses, they also provide evidence of an alternative story to be told about public spending on the NHS and the social usefulness of accounting information.

### **Background to austerity and its impacts on NHS provider organisations**

In the aftermath of the financial crisis, the government of the United Kingdom had the largest budget deficit as a proportion of national income in the peacetime history of the

country. While a proportion of this borrowing was a result of the short-term reduction in growth attributable to the economic crisis, a large proportion of it was judged by government to represent a permanent imbalance in the government's income and expenditure. Since the crisis, policymakers have implemented a fiscal consolidation with the stated intention of reducing this part of this structural deficit as a proportion of national income. The total value of discretionary tax increases and public expenditure cuts implemented in the nine years prior to the 2017 Budget is approximately £199 billion in today's money. Of this, just £32 billion was achieved through net tax rises, while 84% was achieved through reductions in spending (Institute of Fiscal Studies, 2018).

The imbalance between tax rises and spending cuts promoted by the UK government illustrates how austerity and the decisions made in its name are shaped by complex ideological phenomena (Bramall, 2013). In particular, the emergency conditions that create the context for austerity may facilitate a government's desire to reduce services and shrink the state in a way that is politically unviable in more normal times (McCann, 2013). Not all public services are equal, however. Due to the political sensitivity of the NHS in particular (Blyth, 2013), the coalition government that took charge in 2010 pledged to ring-fence its funding from cuts. The 2010 *Spending Review* outlined cash spending plans for the period 2011/12 to 2014/15 that were just sufficient to freeze NHS spending in real terms. In practice some additional funding was provided, however in per capita terms, the increases in spending nonetheless slowed from a long-term average of 4.4% a year to 0.1% a year from 2009-10 to 2017-18 (Hellowell et al, 2018).

As the demand for and relative prices of healthcare have increased over this period (Hellowell et al, 2018), the pressure for cost containment within the NHS has increased. In practice, this pressure has been transmitted from central government to the main provider organisations - NHS Trusts and Foundation Trusts - through reductions to the NHS tariff, which determines a national price for the treatments and packages of care these organisations provide. For example, the tariff paid for finished courses of treatment for patients was reduced in real-terms (i.e. adjusting for NHS provider inflation) every year between 2010/11 and 2015/16, by an average of 3.8% per annum (Gainsbury, 2016). Providers have needed to make a 4% cut in their operating costs every year from 2011/12. The Office for Budgetary Responsibility estimates that long-term healthcare productivity increases at an average rate of 1.2% per annum (OBR, 2016), yet NHS providers' annual cost-cutting efforts were nearer 2% by 2015/16. In that year, a £600 million underlying deficit emerged in NHS provider financial statements. The following year the underlying deficit more than doubled to £1.5 billion, and then in 2015/16 it doubled again, to £3 billion (NHS Improvement 2016a). Although £1.8bn was made available in 2016/17 to NHS providers, through the Sustainability and Transformation Fund, financial performance information from providers showed them on track to record a deficit of £670 million by the end of that year (NHS Improvement 2016b).

## **Background on PPP and PPP termination**

Under PPP contracts, private operators (normally special purpose vehicles owned by a consortium of construction companies and financial investors) are contracted by governments to finance and deliver defined units of infrastructure and related services. The payment to the private operator is made as, when, and to the extent that the outputs specified in the contract are delivered. In practice, the payment to the private operator is constituted as a prospective global budget but its payment is influenced by performance – specifically, performance in terms of making available the contracted assets and services at the standard outlined in the contract (Hellowell et al, 2015). So long as this is achieved, the public authority is obliged to pay the defined fee.

The most recent figures available show that the health sector has used PPP for more capital investment than any other department (at £13 billion in total) (Treasury, 2017). NHS organisations made total unitary charge payments of £2 billion in 2016-17. At 1.7% of the total cash budget for the Department of Health and Social Care, this is a manageable sum at the aggregate level. However, this figure obscures a significant variation between NHS organisations. Most have no PPP deals but some have several. For the latter, unitary charges vary between 5.6% and 20.1% of their turnover (National Audit Office, 2018). It is known that these payments are a source of budgetary pressure for the affected organisations (Pollock *et al.*, 2011). In total, 121 PPP deals have been procured by NHS providers in England, with an aggregate capital value of £11.8bn and a projected cash cost of £81.5bn

The unitary charge payment, which is a legally binding commitment, includes the costs for cleaning, catering, laundering and porters and interest charges. Therefore, efficiency savings have to focus on clinical services, which are not provided in UK PPPs. But cutting clinical services is organisationally and politically sensitive and may not be achieved quickly. So, it is not a surprise that, while only a minority of trusts have a PPP deal, in 2014/15, two thirds of trusts with a deficit greater than £25m had one (National Audit Office, 2014). While refinancing of capital or renegotiation of unitary payments is theoretically possible, there is limited scope to secure gains from such arrangements. For most long-established contracts, the decision to refinance rests with the SPV not the public sector (National Audit Office, 2018). Furthermore, the National Audit Office (2018) notes that only a 1% reduction in total future unitary charges is achieved on average by renegotiation. Therefore, hospitals under pressure to cut deficits wondered if early termination was a viable option.

### ***PPP termination***

Although there is limited scope to reduce the payments to private operators, NHS organisations normally have the right to terminate them, although in these instances a fee must be paid. Treasury guidance is that compensation must be paid to contractors so that they make the same profit as if the contract had run to full term. This non-confiscation approach avoids legal disputes and reputational damage to government although it incurs cost for taxpayers. Compensation typically comprises (Treasury, 2015):

- The Base Senior Debt Termination Amount
- Redundancy payments for employees of the contractor;
- Sub-contract break costs; and
- Compensation for either the base case value or open market value of contractor equity and junior debt (Treasury, 2015 section 3.9)

The UK has experience of 31 terminated PPP contracts, most of which have been forced by the procuring authority due to sustained performance problems (Whitfield, 2017). Five terminations are in the health sector, but only two are hospital projects<sup>1</sup> – West Park in Darlington and Hexham. Both were bought out on a voluntary basis in order to reduce operational expenditure. The West Park contract (capital value £16m) had run for just 6.2 years when it was terminated at a cost of £18m in order to obtain expected net total savings of £14m (Whitfield, 2017). Hexham (capital value of £54m) was terminated at a cost of £114.2m, with the press reporting expected savings as £3.5m per annum for the remaining 19 years of a 30 year contract (Plimmer and Neville, 2014).

Following a successful Freedom of Information Act request, Hellowell (2015) obtained access to advice received by the Hexham Trust on which its termination decision was based. This shows that having paid some £67m during the ten year life of the contract the Trust was still committed to pay unitary charges totalling £222.5m over the remaining term in relation to services such as cleaning, laundry and porters, interest charges to service the debt and the capital cost of the infrastructure. The service element of the charge rises in line with RPI, and it is likely to be increased by benchmarking or market testing exercises (National Audit Office, 2007). While Hexham would still need to pay for cleaning etc. services if the PPP contract was terminated early, the expectation was that services could be provided more cheaply so that overall early termination would be beneficial.

The Freedom of Information data shows various scenarios but Hellowell (2015) uses the data for termination on 1<sup>st</sup> April 2014 for illustrative purposes. This shows a total potential saving of £14.3m based on an estimated £107.2m compensation payment. It is notable that this estimate is much lower than the level of savings later reported in the press.

The compensation payment included £51.8m to repay senior and mezzanine debt and an estimated £14.5m for the market value of the SPV's equity. The compensation was reduced by cash balances in the SPV which would belong to its shareholders and there were additional relatively small estimates to cover sub-contract breakage and transactions costs. However, Hellowell's report makes clear the large scale of some additional elements of the expected compensation. There were estimates of £27m for interest rate and retail price

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<sup>1</sup> The others are relatively small scale relating to IT and energy projects and a care homes project.

index swap breakage and £18.2m to cover the SPV's expected corporation tax liability that would inevitably arise on the receipt of compensation.

The Treasury's guidance note (Treasury, 2015) on early PPP termination is written in cautious and unenthusiastic terms, and it has pressed for alternative means of cost saving such as more rigorous application of performance penalty mechanisms and refinancing. Nevertheless there is support for terminating other PPP deals. For example, Owen (2016) reports Chris Philp, a Conservative member of the Treasury Select Committee, as saying:

*The PFI (PPP) debt burden is unacceptably high. I would like these PFI deals unwound as quickly as possible.*

Mason (2015) notes that Simon Stevens, Chief Executive of NHS England, has suggested that other Trusts might be able to reduce their costs by following the Hexham decision to terminate early. During his successful mayoral campaign Sadiq Khan offered to buy up the debt owed on London's hospitals which 'are suffocating under the weight of (PFI/PPP) debt and radical action needs to be taken to alleviate the growing financial pressures' (reported by Perraudin, 2015).

## **Research Method**

We seek to create a counter account (Lehman *et al.*, 2016) about the adequacy of macro-level funding, and the related proposed response of terminating PPP contracts early. Our counter account challenges government rhetoric that funding is adequate but under pressure because of inefficiencies, unreasonable patient expectations and rising demand for services especially from an *ageing* population.

Counter accounts have been defined as alternative representations of individual organisations, sectors or industries created by individuals who are beyond the control of the entity that is the subject of the account with the intention of rectifying an undesirable state of affairs (Thomson *et al.*, 2015). Counter accounts make visible information that has the potential to mobilise public action, although it is recognised that empirically they have mixed outcomes because their transformational potential is contingent upon the nature of the conflict arena and the tactics and interactions associated with their use (Vinnari and Laine, 2017). While Lehman *et al.*'s (2016) counter account was based upon informal qualitative sources we use formal and numerical sources of information. We recognise as a limitation that there is no definitive counter-factual (Heald and Hodges, 2015).

We draw a distinction between the provision and the commissioning of health care. Increasing demand is essentially a problem for commissioners' budgets, who, in the UK, commission services from providers such as hospitals and community health services. While there are concerns about access to community services, citizens' major concerns are focused on capacity in hospitals. That is, the problem is perceived to be one of provision not commissioning. Furthermore, it is the providers, and especially the providers of acute

services, that are exhibiting financial distress. Therefore, we deploy statistics that show how hospitals experiencing stable funding levels are facing reducing tariffs in exchange for the services they deliver while attempting to meet the needs of *growing* populations. Thus we present an alternative accounting to that provided by government, and like Lehman *et al.*(2016) seek to focus on new knowledge and reinstate the ethical dimension to the rendering of accounts. Our contribution is that we move away from a corporation-centric perspective that has largely dominated prior studies on counter accounts (Vinnari and Laine, 2017) to present a public perspective.

To critically assess the feasibility of early termination, we used the Treasury's spreadsheet of Department of Health projects. We chose the top 12 projects by capital value, listed in Table 1, to assess their suitability for this study. We immediately discarded the Liverpool project (number 9 in Table 1) because it is not yet operational and so reports no financial data. Secondly, we identified the name of the procurer. In three cases a single project has been procured by more than one NHS Trust, which means that we will not be able to disentangle the costs and so projects 2, 6 and 8 on Table 1 have also been excluded. Thus, our sample consists of eight of the largest operational hospital PPP contracts.

#### **Insert Table 1 about here**

We use the Hexham case as a model for these eight cases because we have the benefit of the report by its advisors Deloitte obtained under a Freedom of Information request. The Hexham model identifies three crucial questions:

- What are the financial costs of early termination?
- How can these costs be funded?
- Are the expected savings sufficient to make the termination financially desirable?

Regarding termination costs, data sources include the procuring Hospital Trusts' financial statements and those of the special purpose vehicles (SPV) with which they signed the contract. As SPVs are normally established for each individual contract, their financial data is known to relate to that contract. As became evident from the reporting of the Hexham case, there are costs that are not easy to identify with any degree of accuracy. Our narrative makes any uncertainties clear, but this remains a limitation of the paper.

West Park hospital used a surplus in its financial statements to fund the £18m cost of termination (Whitfield, 2017). The Hexham termination was financed by a loan from Northumberland County Council, the relevant local government authority. As the Council was able to borrow at below market rates of interest from the Public Works Loan Board, interest payments faced by the Trust were reduced. As the financial crisis imposed on local government by austerity measures means this level of support is unlikely to be repeated by

other local authorities (Hellowell, 2015; Whitfield, 2017), we examine the financial statements of our eight cases for evidence of surpluses or ability to borrow externally<sup>2</sup>.

Termination is financially desirable, that is costs are reduced, if the expected future cost of the remaining PPP unitary payments is greater than the cost of compensation plus the cost of providing the PPP services in-house. In the West Park and Hexham cases the decision to terminate was based on estimates of the costs of compensation and in-house provision of services. Our study replicates the Hexham compensation cost calculations, but as our cases are prospective not actual terminations there is no equivalent information available about expected future in-house costs. Our conclusions thus relate to the financial feasibility, not the desirability, of termination, which is a limitation.

For reasons of space, in the paper we examine the detailed information in relation to just one hospital - the Mid Yorkshire case which provided the fullest disclosure of accounting information - and provide summary information calculated on the same basis for the other seven cases<sup>3</sup>.

### ***The international context***

While there are always difficulties with international comparisons, extracts from the World Health Organisation database are presented in Table 2. Despite having increased spending by a larger percentage than is common in the developed world since 1995, the UK spends less per capita than the norm for the wealthiest European countries. For example, the UK spend per capita in 2014 was 73% and 79% of the German and French spends respectively. Furthermore an analysis by Reeves *et al.* (2014), using data from the World Health and Eurostat, shows that UK government health spending per capita adjusted for inflation and purchasing power reduced in common with countries such as Ireland, Spain and Greece, whereas spending in countries such as Germany, France and the Netherlands increased.

Table 2 also shows that while all countries are increasing their commitment to health as a proportion of GDP, the UK government has been spending at a consistently lower level than its Northern European neighbours, remaining below the average EU spend. This is significant because, as Table 2 shows, the UK has been consistently more dependent on public spend

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<sup>2</sup> Hospitals are either designated as NHS Foundation Trusts, which have operational autonomy and some borrowing powers, or NHS Trusts, which have limited autonomy. In this analysis we ignore the legal ability to borrow to terminate a contract as our focus is on the cost of so doing, and our argument is that these costs are so high as to be unaffordable for an individual Trust.

<sup>3</sup> The same explanations of the calculations as provided for Mid-Yorkshire, not presented in detail here for reasons of space, are available from the authors. Supplementary information available on line provides an expanded version of Table 8 for all cases.



as a proportion of the total health spend than is common for the largest European countries and compared to the EU and OECD averages.

**Insert Table 2 about here**

It is clear from international comparative analysis, that the UK is currently a lower spender on health services than its Northern European neighbours and the OECD average.

**What are the costs of early PPP termination?**

Our second set of questions focus on the early termination of PPPs: what are the nature and size of terminations costs? Is there adequate information in the public domain for an evaluation of a termination decision? This section follows the model established for the Hexham termination to determine the expected financial costs associated with a decision to terminate. In the Hexham case estimates were assessed based on internal Trust data and data made available to the Trust and its advisors by the SPV. We rely upon information in the public domain drawn from the financial statements of the Trusts and the related SPVs. Our figures are drawn from the 2015/2016 financial statements of the Trusts and the most recent financial statements for the SPVs relevant to that period. Based on Hexham the termination costs to compensate are: the repayment of debt; the market value of equity; transactions and sub-contract breakage costs; the corporation tax liability; and the cost of breakage of interest rate and inflation swaps. These costs are mitigated by any cash balances held by the SPV. There may also be additional costs associated with the early redemption of bond finance, which was not relevant to the Hexham case. We provide detailed figures for each of these items in turn for Mid Yorkshire, produce an estimated cost of termination for this case, and then provide summary information and estimated costs for the other Trusts.

Before commencing this analysis we briefly provide information about the financial performance of the cases.

***Financial performance of the Trusts***

Table 3 is drawn from the Comprehensive Income and Expenditure Statements for 2015/2016. Only Central Manchester and Derby are generating operating surplus, and all except Derby have a deficit for the year. The Derby 2015/2016 financial statements describe the Trust as performing reasonably well financially and it has generated a surplus in the last two years although its revenue reserves show a small negative.

**Insert Table 3 about here**

A more detailed review of Mid Yorkshire is provided in Table 4, which shows the persistence of its financial difficulties since 2012/2013 to 2015/2016. For each of the past four years the trust has shown deficits for the year. These deficits persist, albeit at a lower level, even after the Trust's reported financial performance position is adjusted for items which the

Department of Health does not consider to be part of the organisation's financial performance<sup>4</sup>.

**Insert Table 4 about here**

Table 5 shows the surplus or deficit for the financial year in the last four years for each of the eight case Trusts. Nationally, whereas only 10% of Trusts were in deficit in 2012/2013, five of our sample, all of which have large PPPs, were in deficit in that year (62.5%). With the exception of North Midlands in 2014/15, these five Trusts exhibit persistent deficits in the last four years. For seven of the eight Trusts there is no clear pattern to the size of the deficits across the four years, but Barts shows a steadily worsening financial position. In September 2013 Barts published a turnaround plan, which included aspirations to run a deficit below £50m for 2013/14 and to breakeven by 2015/16. The actual outcomes for these two years were deficits of £111.8m and £222.3m respectively.

**Insert Table 5 about here**

In a change to how they were viewed in the past, public sector entities are now seen as quasi-autonomous entities that are responsible for their own financial performance and must balance the books (Heald and Hodges, 2015). At least five of these eight Trusts face persistent financial difficulties which could lead to a search for solutions, including the possibility of an early PPP termination. We now turn to examine the associated costs of early termination in detail. Table 6 provides a summary relating to the Mid Yorkshire case and this is followed by a discussion of the various cost elements.

**Insert Table 6 about here**

***What is the outstanding debt?***

Table 7 shows the bonds and loans initially raised to finance the project and the outstanding indebtedness of the Mid Yorkshire SPV at year end 2016. The notes to the financial statements do not show a sub-division of the outstanding debt between bond and loans, but the total is £392.2m. The debt outstanding has increased from the date of issue due to the index linking of the bond, which will likely increase both the principal due and the amount of interest payable.

**Insert Table 7 about here**

***What is the market value of the equity?***

In regard to PPP financing, commentators often refer to share capital and subordinated debt as together representing the equity stake, which is then said to be of the order of 10% of the total financing, the balance being long term bonds or loans. The subordinated debt is

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<sup>4</sup> These adjustments include, for example, impairments to the estate, impacts of eliminating donated asset and government grant reserves, and the first time application of IFRIC 12.

often subscribed by the shareholders, and for this reason the Deloitte's report on Hexham states that SPV equity stakes are normally valued on the basis of forecasts of distributions relating to dividend payments and returns on sub-ordinated debt. Such forecasts are based upon the project's current operating model and discounted to give the present value of future cash flows. Deloitte's report uses its own research showing a secondary market range of between 8 and 11 percent, and their report provides information about the valuation placed on the SPV by Ernst and Young who were acting on behalf of the SPV.

The data shows valuations by Deloitte of £14.1m (discounted at 9.5%) and £17.6m (at 7.5%) and compares these valuations with the £20m valuation (at 6.2%) by Ernst and Young, acting for the SPV. The valuations have different dates, but over the 19 – 21 years remaining on the contract at the date of the calculations the valuations suggest expected cash flows from dividends and subordinated debt of approximately £1.6 - £1.8m per annum assuming these are equally spaced over the years. The Hexham SPV's financial statements for the year end December 2013 immediately prior to the termination show annual interest on the unsecured loan amounting to £462,379 and a dividend payment of £361,000. Thus the forecast for future years anticipates greater returns than those currently achieved.

In the absence of access to the operating model, which is deemed to be commercially confidential, it is difficult to estimate market values for other hospitals' SPV stakes. The following information relates to providing a range of values that might be relevant in relation to Mid Yorkshire.

- To date the SPV has not made dividend payments.
- The SPV has share capital of £50,000 and £30,862,000 in subordinated debt, which together represent approximately 9% of the total finance initially raised of £352m.
- The subordinated debt carries an interest rate of 10.17% plus RPI indexation. As RPI has been increasing the minimum return to the shareholders is 10.17%.

The annual return on the subordinated debt is £3.1m. Applying the same discount rates as used by Deloitte and Ernst and Young noted above, an annual income of £3.1m over the remaining 25 years of this contract suggests a valuation of between £29m and £39m. In line with the Hexham findings, the return in future years per the operational model may be greater. However, our estimate in Table 6 is based on the lower valuation of £29m.

#### ***What is the reduction for cash balances?***

The SPV's financial statements report cash balances of £25.2m in December 2015.

#### ***What are the transactions costs and sub-contract breakage costs?***

Whitfield (2017) notes that transactions costs are not normally disclosed on terminations, however, the value for the Hexham deal was an estimated £1m based on estimates of the

final compensation payment to the SPV of £107m and the raising of a matching loan. The Mid Yorkshire deal is a substantially larger deal but assuming there will be economies of scale in relation to transactions a cautious estimate of £2m has been included. The sub-contract breakage costs need to be identified by reference to the contracts in place, but these were immaterial costs in the Hexham deal and our working assumption is therefore that they would also be immaterial in relation to Mid Yorkshire.

### ***What is the corporation tax gross up?***

The termination payment used to repay the SPV's debt is a taxable receipt. The Hexham case contained a 'tax gross up' clause implying that early termination payments must be increased to compensate for any consequent tax liability arising in the SPV. This taxation charge may be mitigated by any relief due in relation to the breakage costs on the swap agreements. As Table 6 shows, the compensation payment excluding the costs of swaps breakage is likely to be a minimum of £398m, equating to a tax liability of £75.6m. However, information provided to Hexham by their financial advisors indicated that there would also be a grossing up of the corporation tax payment. This adds approximately an additional £14.4m to the compensation for corporation tax.

While the corporation tax compensation is a loss to Trusts and to the health sector, it would not be a loss to the public sector assuming that the SPV did in fact pay tax to HM Treasury at this rate on the transaction. However, under UK tax rules, in practice the norm has been that less tax is paid than expected due to group offset rules (Edwards *et al.*, 2004).

### ***What are the consequences of early redemption of bonds and loans?***

In addition to the repayment of outstanding debt at the date of termination further costs may arise if there is bond finance or if there are interest rate swaps in place for loans.

Bond finance has a contractual feature, known as the Spens clause, which is a potentially strong form of protection for investors designed to mitigate the adverse effects of call risk (Association of Corporate Treasurers, undated). In case of an early redemption the compensation formula includes a par floor, implying that investors will always benefit, whether interest rates have risen or fallen since the bond was issued: early redemption can be prohibitively expensive for the borrower (Association of Corporate Treasurers, undated).

Interest rate swaps are a commonly used mechanism in PPP deals whereby SPVs fix rates of interest as a protection against the possibility of rising interest rates. Because interest rates have fallen since many deals were signed, SPVs are tied into swap contracts which from their perspective have a negative value, against which they expect compensation in the event of early termination. In relation to the Hexham case, Deloitte used a specialist quotation and provided only a combined value for interest rate and inflation swap breakage of £27m, representing 52% of the outstanding debt of £51.8m.

The Mid Yorkshire Director's report states that the SPV 'uses interest rate derivatives to manage the mix of fixed and variable rate debt so as to reduce its exposure to changes in interest rates'. The annual financial statements for the first year of accounting in 2007 state that for both the bond and the loans:

*early redemption may be made at the trust's option, at a price being the higher of the indexed outstanding principal and a price calculated with regard to the yield of a reference gilt over the period to the original bond maturity date.*

That is, an early termination will result in costs related to both the Spens clause and interest rate swaps. But calculations based on information available in the public domain and for hypothetical cases of termination are too uncertain to be reliable. We have therefore not included any values for these elements of the compensation payment<sup>5</sup>.

### **Summary of costs of termination for Mid Yorkshire**

Summarising these various cost elements, Table 6 shows an expected minimum cost of £488m to terminate this contract before the breakage costs on the swaps and the Spens clause effects. That is, £488m would be the minimum loan the Mid Yorkshire Trust would need to borrow to realise the deal.

Note 29 of the Trust's 2015/2016 financial statements show the current carrying value of its indebtedness relating to the PPP project as £302.8m and that the relevant fair value is £354.5m. That is, any prospective termination will replace on Balance Sheet debt of just over £300m debt with close to a minimum of £500m. Table 8 provides a summary of the Mid Yorkshire Trust's Balance Sheet at year end 2016, which shows a net asset position of just £65.1m. It would therefore appear that the Trust's Balance Sheet would need to be restructured to sustain such a large increase in the long term liabilities.

### **Insert Table 8 about here**

Table 9 shows our estimate of the compensation needed to effect an early termination of the eight Trusts calculated on the same basis as for Mid Yorkshire. While the Barts and Bristol projects are larger, typically the other six contracts will require a compensation payment of about £500m each with additional payments for the Spens effect, if there is bond finance, and for swaps.

### **Insert Table 9 about here**

With the exceptions of Derby and Central Manchester all currently have negative retained earnings that are considerably greater than their net assets. Furthermore in all cases the

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<sup>5</sup> The NAO (2018) has estimated an out of the money value of £2.3bn in relation to interest rate swaps on 33 PPP deals.

minimum borrowing to enable an early termination is considerably higher than the recognised on Balance Sheet PPP liability. As for Mid Yorkshire, any attempt to borrow to make early terminations would require large external capital inputs to restructure the Balance Sheets going forward<sup>6</sup>.

## Discussion and conclusions

As demand for healthcare has increased, alongside the relative price of healthcare, NHS England has transmitted the emerging funding constraints to providers through incremental cuts to the tariff they earn from providing services. From 2012/13, when 10% of Trusts were in deficit, to the time of writing, there has been a substantial increase in the number of Trusts in financial distress as they have been unable to cut costs at the pace required to match the reductions in tariffs. Furthermore, between 2014-15 and 2015-16, NHS organisations reported an increase in the critical infrastructure maintenance backlog of more than 50% to £2.3 billion (National Audit Office, 2018). This has been driven by concepts of austerity and perceptions about the necessity of reducing public expenditure. Despite the political rhetoric that has sought to disguise the per capita reductions in NHS spending and the tariff reductions for health care providers, the austerity agenda has impacted on NHS spending and is changing the NHS funding game. That is, if austerity is defined as declining government expenditure in consecutive years when adjusted for inflation and purchasing power and expressed in per capita terms (Reeves *et al.*, 2014), rather than simply as nil or negative annual growth in financial resources (Prowle and Harradine, 2014) the NHS has been subject to austerity measures. The funding realities require it to provide more services for less money; a formulation unlikely to be consistent with *increasing* population health need.

PPP schemes that have undoubtedly enhanced the NHS estate are part of the revenue problem. Fourteen years ago Edwards *et al.* (2004) signalled their concerns about the disproportionate number of the first thirteen PPP schemes that were in deficit compared to other Trusts, although Lafond *et al.* (2016) find no statistical association between financial position and the existence of a PPP scheme. Nevertheless, at least part of the problem for Trusts that have had to be bailed out by substantial assistance from the Department of Health is that unitary charges are linked to inflation and benchmarking exercises tend to increase costs (National Audit Office, 2014). That is, early termination is about affordability rather than performance, although motivation to terminate would likely rise if performance were poor or a project no longer met needs. An additional problem may be an expectations gap in relation to rates of return on capital (Froud *et al.*, 2018).

In 2017/18, 44 per cent of trusts overspent their budgets, with acute hospitals (those most likely to be involved in a PPP contract) accounting for just under 90% of all providers in deficit. The NHS provider sector as a whole ended 2017/18 with a deficit of £960 million

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<sup>6</sup> Supplementary information available on line provides summarised Balance Sheets for all 8 cases.

(King's Fund, 2018). One resolution is that savings to non-clinical costs may be made by terminating some of the PPP projects. However, the Hexham case was probably unique in that it was supported by local government finance which is unlikely to be available elsewhere (Hellowell, 2015). Furthermore, unlike the West Park hospital identified by Whitfield (2017), the Trusts with large PPP schemes do not typically have surpluses to facilitate early termination. The evidence presented here shows that the Trusts with large PPP schemes do not have sufficiently strong Balance Sheets on an individual basis to support the massive increase in borrowings that terminations require. Thus government intervention would be necessary, raising questions about the opportunity costs involved in supporting healthcare in this way.

Although this critical assessment of the costs of early termination is focused on UK contracts, it also has international value. Many countries followed the UK's lead into various forms of PPP, and indeed in an age of austerity some form of PPP arrangement is often promoted as the only viable mechanism for obtaining much needed infrastructure. But should long term contractual commitments prove unsustainable in an age of austerity, because typically they are legally binding agreements, compensation must be paid to avoid legal suits and reputational damage, meaning the costs of early termination may be prohibitively high. One lesson learned in the UK is that the new PF2 type of PPP arrangement includes a partial termination contractual mechanism, intended to 'slightly lower' the level of compensation payable in the event of a full termination (National Audit Office, 2018).

Our analysis has shown that there is only limited information in the public domain upon which to base an assessment of the potential costs of early terminations, yet the UK has a reasonable reputation for transparency of financial reporting and a Freedom of Information Act to support transparency in relation to government, although not private corporations', activities. Should early termination come onto other countries' austerity agendas, our problems estimating the costs of termination are likely to be repeated and may even be greater in developing nations. Our conclusion is that early termination of long term contracts is not financially viable if the main purpose is a short term measure to reduce politically inconvenient deficits in the financial statements of healthcare providers.<sup>7</sup>

We recognise as a limitation that providing a counter account may not be effective in producing change but take heart from Brennan and Merkl-Davies' (2014) finding that there must be persistent critique of practices, such as the austerity agenda, over a period of time and that the mode and content of the counter account needs to change to reflect reactions from the institution under critique. In the politically charged environment of the UK's health

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<sup>7</sup> The Labour party is considering nationalisation of SPVs across all sectors using PPPs. Mercer and Whitfield (2018) estimate an initial annual cost reduction of £1.4bn that will decline over time, but their work includes significant assumptions around acquisition costs and operational cost reductions which could be difficult to realise in practice.

service, the rhetoric for a policy of austerity could not be pursued in the same way as for other services in terms of necessary pain shared to balance the books. Rather reductions in purchasing power and per capita spend had to be disguised. In 2018, as we write, the political agenda has swung towards the potential for more spending supported by a dedicated health tax, because citizens' perceptions of the quality of services could not be ignored, although undoubtedly, conditions about efficiency gains will be attached to additional funding. Thus, the hidden austerity measures have impacted the service so that a complete restoration is unlikely (Grimshaw and Rubery, 2012). We hope that this paper is one step in a process of critique of the way in which the austerity agenda has impacted, largely under the radar, the financing of a public service that was supposed to have been protected from austerity.



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**Table 1 – The initial group of largest projects by capital value**

Name	First Date of operation	Capital Value £m	Included v/ excluded x with reason
1 Barts Health	01-07-2006	1149.0	√
2 Birmingham and Solihull	14-05-2008	695.0	X 2 Trusts
3 Central Manchester	01-07-2005	512.0	√
4 North Bristol	27-03-2014	430.0	√
5 North Midlands (Staffordshire)	20-08-2012	415.1	√
6 Coventry and Warwickshire	01-07-2006	378.9	X 2 Trusts
7 St Helens and Knowsley	18-11-2008	338.0	√
8 Peterborough and Stamford	02-10-2010	336.0	X 3 Trusts
9 Royal Liverpool	01-04-2017	329.4	X Not yet operational
10 Sherwood Forest	01-04-2011	326.0	√
11 Derby Hospitals	05-05-2006	312.2	√
12 Mid Yorkshire	14-04-2008	311.5	√

Source: Department of Health spreadsheet

**Table 2 Health expenditure statistics**

	Expenditure per capita in current US \$			Total health expenditure as a percentage of GDP		Public expenditure as a percentage of total health expenditure	
	2014	1995	Change as % on 1995	2014	1995	2014	1995
<b>UK</b>	<b>3,935</b>	<b>1,364</b>	<b>188%</b>	<b>9.1</b>	<b>6.7</b>	<b>83.1</b>	<b>83.9</b>
OECD	4,735	2,100	125%	12.4	9.2	62.2	63.3
EU	3,613	1,651	119%	10.0	8.3	77.8	78.2
North America	8,990	3,594	150%	16.5	12.8	49.6	46.5
Switzerland	9,674	4,308	125%	11.7	9.3	66.0	53.6
Sweden	6,808	2,292	197%	11.9	8.0	84.0	86.6
Netherlands	5,694	2,262	152%	10.9	7.4	87.0	71.0
Germany	5,411	3,129	73%	11.3	9.4	77.0	81.4
France	4,959	2,745	81%	11.5	10.1	78.2	79.7
Spain	2,658	1,129	135%	9.0	7.4	70.9	72.2

Source World Bank <http://data.worldbank.org/indicator/SH.XPD.PCAP> and <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> compiled from World Health Organisation data.

**Table 3 - Comprehensive Income and Expenditure Accounts 2015/2016**

<b>£'000s</b>	<b>Barts</b>	<b>C.M/cr</b>	<b>Bristol</b>	<b>North Midlands (Staffs)</b>	<b>St Helens &amp; Knowsley</b>	<b>Sherwood Forest</b>	<b>Derby</b>	<b>Mid Yorkshire</b>
Income	1,342,594	967,394	543,638	702,917	313,287	296,711	130,949	482,792
Operating expenses	(1,537,545)	(961,128)	(550,223)	(720,992)	(323,475)	(304,827)	(126,082)	(515,008)
Operating surplus/(deficit)	(194,951)	6,266	(6,585)	(18075)	(10,188)	(8,116)	4,867	(32,216)
Deficit as % of income	14.5%	surplus	1.2%	2.6%	3.3%	2.7%	surplus	6.7%
Finance costs* (net)	(28,655)	(35,476)	(34,820)	(19,673)	(16,310)	(18,415)	(3,738)	(8,950)
Retained Surplus/(deficit) for the year	(223,606)	(29,210)	(41,405)	(37,748)	(26,498)	(26,531)**	1,129	(41,166)
Deficit as % of income	16.7%	3.0%	7.6%	5.4%	8.5%	8.9%	surplus	8.5%
Other CI	(47,123)	9,944	5,069	37,570	(5,787)	2,111	6,585	5,446
<b>Total C I&amp; E</b>	<b>(270,729)</b>	<b>(19,266)</b>	<b>(36,336)</b>	<b>(178)</b>	<b>(32,285)</b>	<b>(24,420)</b>	<b>7,714</b>	<b>(35,720)</b>

\*Including dividends payable on public dividend capital. \*\* Deficit of 55,046k if exclude impact of impairment reversals

Source: Financial statements for these Trusts for the year ending 31<sup>st</sup> March 2016

**Table 4 - Mid Yorkshire NHS Trust - Four year financial results**

<b>£m</b>	<b>2015/16</b>	<b>2014/15</b>	<b>2013/14</b>	<b>2012/13</b>
Operating income	482.8	483.4	457.1	460.8
Operating surplus/(deficit)	(32.2)	0.2	(5.8)	(22.2)
As % income	6.7%	0	1.3%	4.8%
Deficit for the year	(41.2)	(13.2)	(19.5)	(36.9)
Deficit as % income	8.5%	2.7%	4.3%	8.0%
Financial Performance Reported to Department of Health				
Adjusted retained surplus/(deficit)	(20.5)	(9.1)	(19.2)	(21.8)
Adjusted Deficit as % income	4.2%	1.9%	4.2%	4.7%

**Table 5 – Surplus (deficit) for the financial year as a percentage of operating income**

<b>£m</b>	<b>2015/16</b>	<b>2014/15</b>	<b>2013/14</b>	<b>2012/13</b>
Barts Health NHS Trust	(16.7)	(10.3)	(8.7)	(3.7)
Central Manchester	(3.0)	8.8	0.1	8.9*
North Bristol	(7.6)	(5.0)	(29.4)	(3.4)
North Midlands (Staffs)	(5.4)	12.3*	(4.2)	(11.3)
St Helens and Knowsley**	(8.5)	(13.4)	0.3	3.8
Sherwood Forest	(8.9)	(4.9)	(8.8)	(6.0)
Derby Hospitals	0.9	(0.1)	(3.4)	0.1
Mid Yorkshire	(8.5)	(2.8)	(4.3)	(8.0)

\*In 2012/13 Central Manchester, and in 2014/15 North Midlands benefited from gains arising on the absorption of other healthcare Trusts. Without these gains Central Manchester's 2012/13 deficit is 3.5% and North Midlands 2014/15 deficit is 0.6%.

\*\*St Helens and Knowsley 2014/2015 deficit was originally reported at a deficit of 0.2%, but expenses were restated to correct a prior period error, increasing the deficit to 13.4% as shown in the table.

**Table 6 – Summary of costs of compensation for Mid- Yorkshire**

Costs	Estimate £m	
Repayment of debt	392.2	Per Balance Sheet
Market value of equity	29.0	Using the lowest value based on sub-debt return
Cash balance reduction	(25.2)	Per Balance Sheet
Transactions costs	2.0	Hexham estimate £1m this is a much bigger project but assuming some economies of scale
Total subject to corporation tax	398.0	
Corporation tax gross up at 19%	90.0	At 19% on the compensation of £398m = £75.6m + gross up on tax.
Total including corporation tax gross up	488.0	
Interest and inflation swap breakage and bond redemption costs		Too uncertain to quantify.
<b>Total compensation</b>	<b>In excess of £488m</b>	

**Table 7 Debt outstanding for Mid Yorkshire**

£m	Finance Issued	Outstanding 2015/2016	Outstanding 2015/2016
Bond	171.5	Greater than 12 months	375.9
Loan	150.0	Less than 12 months	16.3
Sub-debt	30.9		
<b>Total</b>	<b>352.4</b>	<b>Total cost of compensation</b>	<b>392.2</b>

Source Mid-Yorkshire SPV financial statements

**Table 8 Summarised Balance Sheet for the Mid Yorkshire Trust.**

£m	31 <sup>st</sup> March 2016
Non-current assets	419.4
Current Assets	29.7
Current liabilities	(56.5)
Non-current liabilities	(327.5)
Total assets	65.1
Financed by:	
Public dividend capital	196.1
Retained Earnings	(193.3)
Revaluation reserve	59.6
Other reserves	2.7
<b>Total</b>	<b>65.1</b>



**Table 9 – Summary of costs of compensation for the eight Trusts**

<b>Costs £m</b>	<b>Barts</b>	<b>Central M/cr</b>	<b>Bristol</b>	<b>North Midlands (Staffs)</b>	<b>St Helens and Knowsley</b>	<b>Sherwood Forest</b>	<b>Derby</b>	<b>Mid Yorkshire</b>
Repayment of debt	1,426.2	459.3	569.0	404.8	357.2	384.9	426.9	392.2
Market value of equity	74.0	61.0	98.0	16.0	35.0	34.0	48.0	29.0
Cash balance reduction	(3.2)	(73.6)	(1.0)	(10.0)	(1.6)	(1.5)	(12.2)	(25.2)
Transactions costs	4.0	2.5	2.5	2.0	1.5	0.5	0.5	2.0
Total subject to corporation tax	1,501	449.2	668.5	412.8	392.1	417.9	463.2	398.0
Corporation tax gross up at 19%	339.4	101.6	151.2	93.3	88.7	94.5	104.7	90.0
Total including corporation tax gross up	1,840.4	550.8	819.7	506.1	480.8	512.4	567.9	488.0
Interest and inflation swap breakage and bond redemption costs	All too uncertain to quantify	All too uncertain to quantify	All too uncertain to quantify	All too uncertain to quantify	All too uncertain to quantify	All too uncertain to quantify	All too uncertain to quantify	All too uncertain to quantify
<b>Total compensation</b>	<b>In excess of £1,840m</b>	<b>In excess of £551m</b>	<b>In excess of £820m</b>	<b>In excess of £506m</b>	<b>In excess of £481m</b>	<b>In excess of £512m</b>	<b>In excess of £568m</b>	<b>In excess of £488m</b>

**Supplementary Information: Expansion of Table 8 to show Summarised Statements of Financial Position for all 8 Trusts as at 31<sup>st</sup> March 2016**

Barts, Bristol and Derby show a similar balance sheet position to Mid Yorkshire, and would thus require significant restructuring. St Helens&Knowsley and Sherwood Forest already show deficits. Central Manchester and North Midlands show higher net assets positions, but these are still insufficient to sustain the size of increase in long term liabilities that would be required to terminate the contracts.

<b>£m</b>	<b>Barts</b>	<b>C.M/cr</b>	<b>Bristol</b>	<b>North Midlands (Staffs)</b>	<b>St Helens &amp; Knowsley</b>	<b>Sherwood Forest</b>	<b>Derby</b>	<b>Mid Yorkshire</b>
Non-current assets	1283.8	629.1	528.1	572.3	246.8	277.8	89.3	419.4
Current Assets	157.6	136.2	87.3	81.7	19.9	18.9	20.4	29.7
Current liabilities	(214.3)	(113.9)	(114.8)	(106.9)	(38.1)	(44.4)	(15.1)	(56.5)
Non-current liabilities	(1221.9)	(380.1)	(486.1)	(325.2)	(260.4)	(394.9)	(30.5)	(327.5)
<b>Total assets</b>	<b>5.2</b>	<b>271.3</b>	<b>14.5</b>	<b>221.9</b>	<b>(31.9)</b>	<b>(142.6)</b>	<b>64.1</b>	<b>65.1</b>
Financed by:								
Public dividend capital	306.5	196.0	241.4	362.5	64.5	144.5	16.1	196.1
Retained Earnings	(475.0)	29.6	(314.2)	(284.3)	(101.0)	(302.0)	(1.2)	(193.3)
Revaluation reserve	173.7	45.7	87.3	143.7	4.6	14.9	40.5	59.6
Other reserves							8.7	2.7
<b>Total</b>	<b>5.2</b>	<b>271.3</b>	<b>14.5</b>	<b>221.9</b>	<b>(31.9)</b>	<b>(142.6)</b>	<b>64.1</b>	<b>65.1</b>