



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health and Social Care**

# Sustainability and transformation in the NHS

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Department of Health and Social Care

# Sustainability and transformation in the NHS

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB  
Comptroller and Auditor General  
National Audit Office

17 January 2018

This report examines the progress the Department of Health and Social Care, NHS England and NHS Improvement have made towards achieving financial balance.

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## Key facts

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**£791m**

combined deficit of NHS trusts and NHS foundation trusts (trusts) in 2016-17

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**£1.8bn**

sustainability and transformation funding for trusts in 2016-17

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**£2.7bn**

extra revenue funding given to trusts as interest-bearing loans in 2016-17

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- £111 million** net surplus of NHS bodies (NHS England, clinical commissioning groups, and trusts) overall in 2016-17, not including adjustments needed to report against the Department's budget for day-to-day resources and administration costs<sup>1</sup>
- 62** clinical commissioning groups reported a cumulative deficit in 2016-17, up from 32 in 2015-16
- 44** number of sustainability and transformation partnerships set up to improve system-wide strategic planning
- £10 billion** independent estimate of the extra capital needed to implement sustainability and transformation partnerships' plans
- £1.2 billion** capital budget transferred to revenue budget in 2016-17
- £623 million** net deficit forecast by the trust sector in 2017-18 based on the first six months of the year

<sup>1</sup> See footnote 6 on page 16.

# Summary

**1** This is our sixth report on the financial sustainability of the NHS. To be sustainable, the NHS needs to manage its activities, the quality of its work and financial pressures successfully within the income it receives. This income has been protected in recent years, but increasing demands on the NHS makes achieving financial balance more difficult.

**2** The Department of Health and Social Care (the Department) has overall responsibility for healthcare services. It is accountable to Parliament for ensuring that its spending, as well as spending by NHS England, NHS Improvement, other arm's-length bodies and local NHS bodies is contained within the overall budget authorised by Parliament. It is responsible for ensuring that those organisations perform effectively and have governance and controls in place to ensure that they provide value for money. The Department has made NHS England and NHS Improvement responsible for ensuring the NHS balances its budget.

**3** In our past two reports, in December 2015 and November 2016, we concluded that financial problems in the NHS are endemic and that this situation is not sustainable. To address this, local partnerships of commissioners, NHS trusts and NHS foundation trusts (trusts) and local authorities have been set up to develop long-term strategic plans and transform the way services are provided more quickly.

**4** Since the NHS was formed in 1948, health spending in real terms has increased by 3.7% a year on average. Since 2010, this rate of increase has slowed considerably, and within this spending the NHS England budget will increase by an average of 1.9% between 2014-15 and 2020-21. However, within this period, in 2015-16 and 2016-17 it saw relatively large increases in funding, compared with 2017-18 onwards. Additional funding announced in the government's 2017 Autumn Budget has shifted the slowdown in funding increases to later in this period (**Figure 1** overleaf). Funding per person, once adjusted for age, will fall by 0.3% in 2019-20.

**5** In this report on financial sustainability in the NHS, we:

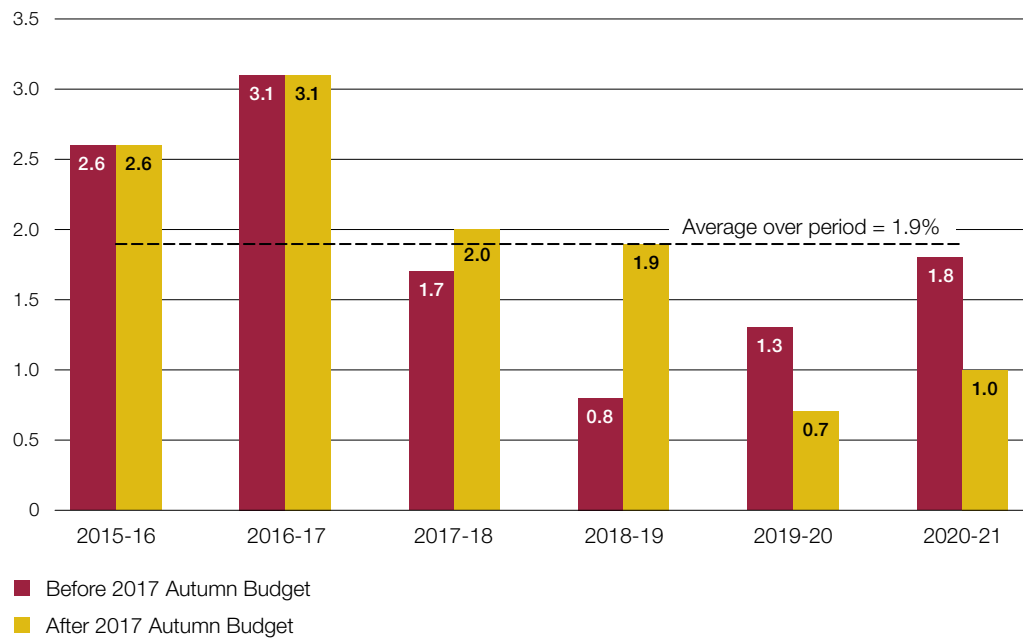
- give a summary of the financial position of NHS England, clinical commissioning groups and trusts (Part One);
- look at what the Department, NHS England and NHS Improvement (the national bodies) have done to support local NHS bodies to improve their financial positions (Part Two); and
- examine the support the national bodies have given local NHS bodies to help them work better in partnership, in order to enable the NHS to become financially sustainable (Part Three).

**Figure 1**

Growth in NHS funding, 2015-16 to 2020-21

Additional funding announced in the 2017 Autumn Budget has shifted the slowdown in funding increases further towards the end of this period

Annual real-terms change (%)



**Notes**

- 1 The increase in funding in 2016-17 included £900 million (0.9%) for additional pension costs.
- 2 In November 2017, HM Treasury announced an additional £335 million for the NHS in 2017-18, £1.6 billion in 2018-19 and £0.9 billion in 2019-20. The average real-terms increase over the period is 1.9% both including and excluding this additional funding.
- 3 Percentages rounded to one decimal place.

Source: Department of Health and Social Care

**6** We set out our audit approach in Appendix One and evidence base in Appendix Two. Technical notes explaining how we have used financial data are in Appendix Three. We do not look in detail at primary care, social care, the integration of health and social care, public health or similar services, although the transformation and sustainability of these services are key elements of these new partnerships' work and to the sustainability of the NHS. For example, we reported in 2016 that pressures in adult social care were causing delays in discharging older patients from hospital.<sup>2</sup>

<sup>2</sup> Comptroller and Auditor General, *Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016.



## Key findings

Financial and operational performance of NHS bodies

**7 In 2016-17, NHS commissioners and trusts reported a combined surplus of £111 million, not including adjustments needed to report against the Department's budget for day-to-day resources and administration costs.** This was made up of:

- NHS England achieving an underspend of £748 million, against the £29,072 million available for its national functions and centrally commissioned services;
- clinical commissioning groups together achieving an underspend of £154 million, against the £76,630 million available for locally commissioned services, but 62 clinical commissioning groups reported a cumulative deficit, up from 32 in 2015-16; and
- trusts reporting a combined deficit of £791 million against their total income of £80,552 million (paragraphs 1.4 and 1.7).

**8 The NHS achieved its overall surplus in 2016-17 by planning a series of measures to rebalance its finances, some of which have restricted the money available for longer-term transformation.** For instance, the Department transferred £1.2 billion of its £5.8 billion budget for capital projects to revenue budgets to fund the day-to-day activities of NHS bodies. NHS England required commissioners to hold back 1% of their income in a risk reserve to help balance overspends elsewhere in the NHS. Total savings amounted to just under £800 million (£707 million by clinical commissioning groups and £92 million by NHS England's direct commissioning of primary care). It also spent £1.8 billion through the Sustainability and Transformation Fund to improve the financial position of trusts (paragraphs 1.8, 1.10 and 1.18).

**9 In 2016-17, the national bodies gave £4.1 billion in financial support to trusts outside of service contracts with commissioners, which does not support effective planning.** NHS Improvement hoped that the Sustainability and Transformation Fund would replace the need for most direct departmental cash funding for trusts. While £1 billion of the committed £1.8 billion was given as cash within the year, cash support on top of this increased from £2.4 billion in 2015-16 to £3.1 billion in 2016-17. Most (£2.7 billion) was revenue support to allow trusts to maintain services. These payments bypass local commissioners by funding trusts directly rather than through the purchase of health services (paragraphs 1.10 and 1.17).

**10 The financial deficit position of the trust sector significantly reduced in 2016-17, but failure to achieve its target position has limited the resources available to transform services and built financial pressure for future years.** The Department initially intended the Sustainability and Transformation Fund to return trusts to aggregate financial balance and give the NHS the stability to improve performance and transform services. However, in the NHS financial reset in July 2016 NHS England and NHS Improvement clarified the Fund's objective for 2016-17 was to support the trust sector to achieve its target deficit position of £580 million. The additional £1.8 billion funding incentivised most trusts to improve their financial discipline. It helped the trust sector greatly improve its overall financial position, from a combined deficit of £2,447 million in 2015-16 to £791 million in 2016-17. The national bodies directed most funding towards acute trusts to relieve pressures in providing emergency care services, although the largest deficits remain in this sector. Some 60% of fund payments (£1,069 million) helped trusts reduce or eliminate their in-year deficits. However, the remaining 40% (£727 million) created or increased trust surpluses, with these trusts not necessarily able to spend the extra cash in 2017-18 because of financial planning targets. Financial problems in the trust sector have since continued: based on the first six months of the year, trusts have forecast a combined deficit of £623 million by the end of 2017-18 (paragraphs 1.11 to 1.16, and Figures 3 and 6).

**11 Clinical commissioning groups and trusts are increasingly reliant on one-off measures to deliver savings, posing a significant risk to financial sustainability in the future.** Financial sustainability relies on local bodies making recurrent savings; otherwise, they will need to make additional savings the following year to replace any non-recurrent savings made in the current year. Commissioners and trusts delivered more savings in 2016-17 than in 2014-15 and 2015-16: between 2014-15 and 2016-17, clinical commissioning group savings increased from £1.4 billion to £2.0 billion and trust savings increased from £2.8 billion to £3.1 billion. However, between 2014-15 and 2016-17 the percentage of savings that were non-recurrent cost savings increased from 14% to 17% for commissioners, and from 14% to 22% for trusts (paragraphs 2.3 to 2.6, and Figures 10 and 11).

**12 While the headline financial position of the NHS markedly improved in 2016-17, increased reliance on financial support and non-recurrent savings suggest the financial problems of NHS bodies have not eased.** The aggregate financial position improved, from a £1,848 million deficit in 2015-16 to a £111 million surplus in 2016-17. The underlying position of the NHS is difficult to quantify, but two measures indicate the position may not be getting better. Firstly, the sharp increase in the level of cash support to trusts outside of service contracts with commissioners suggests that healthcare providers are increasingly struggling to deliver care under the contracts they hold and the prices they are paid. Secondly, the rise in non-recurrent savings made by clinical commissioning groups and trusts means NHS bodies are increasingly reliant on making savings that they cannot rely on being made the following year (paragraphs 1.4 and 1.19).

**13 In 2016-17, demand for health services continued to increase and performance against key access targets declined further.** The Department estimates that population and demographic changes increased demand for health services by 1.3% in 2016-17. Activity carried out by acute trusts increased at a greater rate. For example, hospital admissions increased by 1.9%. Trusts are struggling to manage this activity within their budgets, particularly given higher than planned non-elective activity in 2016-17. Performance against key access targets declined further in 2016-17, for instance only 89% of accident and emergency patients were seen within four hours, against a target of 95% and a rate in 2015-16 of 92%. We found that on average, trusts in deficit performed worse against key access targets than trusts in surplus (paragraphs 1.20, 1.21 and Figure 8).

### National savings initiatives

**14 It has taken time for the national bodies to bring together their savings initiatives into a coordinated programme with effective monitoring arrangements.** In response to the efficiency gap identified in the *NHS Five Year Forward View*, published in October 2014, the national bodies introduced a number of savings programmes. In March 2017, NHS England and NHS Improvement realigned their savings programmes to a new 10-point efficiency plan, and are working together to help local NHS bodies and wider systems achieve the expected savings. Some national programmes have already helped local bodies to make savings. For example, central controls have helped trusts reduce spending on agency staff to 5.9% (£3.0 billion) of their total staff costs in 2016-17, following a peak of 7.5% (£3.7 billion) in 2015-16. However, significant challenges remain. Some programmes still lack reliable data to enable effective monitoring, local bodies have limited capacity to engage effectively with these programmes, and some programmes are reliant on delivering most of their savings from 2018-19 onwards, increasing the risk that they are not realised by 2020-21 (paragraphs 2.2 and 2.13 to 2.17, and Figure 12).

**15 The cap on NHS staff pay is planned to be lifted in 2018, which will increase the NHS's costs above forecast levels.** In 2015, the government announced that wage increases for all public sector workers would be restricted to 1% each year until 2019-20. The Department estimated that the public sector pay cap would result in £3.3 billion of savings between 2016-17 and 2020-21. However, in November 2017, the government committed to funding pay awards as part of a pay deal for NHS staff on the Agenda for Change contract, including nurses, midwives and paramedics. The government noted that any pay deal will be on the condition that the pay award enables improved productivity in the NHS, and is justified on recruitment and retention grounds. It is not clear what impact this will have on NHS finances (paragraph 2.12).

## Sustainability and transformation partnerships

**16 New partnership arrangements across health and local government are laying the foundations for more strategic system-wide planning and delivery, and these arrangements are at different stages of development.** In March 2016, clinical commissioning groups, trusts and local authorities grouped into 44 sustainability and transformation partnerships. In October 2016, they submitted five-year plans setting out how local services will change and improve to meet rising demand within the resources available. Partnerships are not new statutory bodies; they supplement rather than replace the accountabilities of individual organisations. However, they do require a board, a system leader and a programme management function. NHS England has provided some funding for leadership and programme management, but partnerships are reliant on constituent organisations contributing resources to develop plans and deliver transformation projects. Partnerships are at very different stages of development. Partners in some areas had a long history of working together and planning collectively. In others, the process has required partners to collaborate in ways they had not done before. Many still have a lot to do to establish effective governance arrangements and realise their plans (paragraphs 3.2, 3.4 and 3.8 to 3.11 and Figure 14).

**17 Local transformation of care is being hampered by a lack of resources and ongoing pressure to make increasingly tighter finances balance each year.** Effective transformation takes time and resources. But the partnerships we visited told us they were struggling to find the resources to further develop and implement their plans. Partnerships' tight financial positions make it difficult to shift focus from short-term day-to-day pressures. For example, NHS England and NHS Improvement told partnerships with unbalanced plans for 2017-18 and 2018-19 to quickly identify and pursue new savings opportunities to ensure that their finances balance. A lot of transformational change relies on additional funding. An independent review by Sir Robert Naylor estimated that partnerships needed an additional £10 billion of capital funding by 2020-21 to carry out their transformation plans and for backlog maintenance. So far, HM Treasury has given the Department an extra £425 million, and committed a further £3.5 billion over the next four years (paragraphs 3.3, 3.11, 3.14, 3.15 and 3.19).

**18 Investment for transformation is more focused on those partnerships most advanced, which risks those that are relatively under-developed or complex being left further behind.** In July 2017, NHS England published ratings of the progress that partnerships have made so far. The Department has allocated early capital funding to those partnerships rated as the most advanced. NHS England has stated that transformation funding, for example for mental health and cancer services, will increasingly be targeted at those partnerships that make the most progress. NHS England has selected 10 of the most advanced partnerships to become accountable care systems, including two to become devolved health and social care systems. These will be given more autonomy over how they spend their resources and manage their own performance. NHS England and NHS Improvement are supporting partnerships and organisations in difficulty through other, non-financial ways. However, these partnerships and organisations face additional challenges. For example, to discourage trusts in financial special measures from seeking additional financial support, the Department imposes on them higher interest rates on loans (6% compared with 1.5% for most other trusts) (paragraphs 2.9, 2.10, 3.3, 3.5, 3.8, 3.15 and 3.16).

**19 NHS England and NHS Improvement need to further develop the way they regulate these new arrangements.** NHS England and NHS Improvement are integrating more of their functions, such as creating joint appointments in key roles and a joint programme to track and oversee delivery of savings across the partnerships. However, partnerships cited issues that potentially took capacity away from transformation work such as the number of returns these organisations require and duplicated efforts to complete similar returns for different regulatory teams. NHS England and NHS Improvement have also given partnerships mixed messages on the balance between achieving system-wide sustainability and protecting individual organisations' financial positions. From 2017-18, some partnerships will be trialling system-wide target financial positions, but some organisations we spoke to highlighted the challenge of making these work in a challenging financial environment (paragraphs 3.7 and 3.17 to 3.21).

**20 The NHS will need to make difficult choices to stay within its resources.** Most sustainability and transformation partnerships' plans are overly optimistic, relying on transforming services to move more care out of hospital and into the community. However, there is limited evidence to suggest that these changes will achieve the level of savings required. In addition, partnerships are at different stages in their development and some may take longer to achieve their plans than others. For 28 of 44 partnerships, planned savings in 2017-18 are in excess of savings achieved in 2016-17 for both the commissioner and trust sectors. Partnerships need to find effective ways of managing demand for services or delivering services at a lower cost, or both. Without these, the NHS will have to make difficult choices about which services it can and cannot afford (paragraphs 3.8, 3.12 and 3.19, and Figure 18).

## **Conclusion on value for money**

**21** The NHS received extra funding in 2016-17 to give it breathing space to set itself up to manage on significantly less funding growth from 2017-18 onwards. On top of this, trusts are receiving large levels of in-year cash injections in the form of loans that worsen rather than improve their reported financial performance. Some progress has been made in setting up local partnerships. However, it looks, based on our work, as if these extra sources of money have been spent on coping with current pressures rather than the transformation required to put the health system on a sustainable footing, and trusts are still a long way from being able to live within their means without it.

## **Recommendations**

- a** **The Department, NHS England and NHS Improvement should, within the confines of current legislation, move further and faster towards system-wide incentives and regulation.** Partnerships are seen as the way forward, but many of the incentives and oversight arrangements are still based on an institution-by-institution basis. The national bodies need to consider future incentives that would support local partnerships in developing system-wide working.
- b** **The Department, NHS England and NHS Improvement should assess how funding currently available from the Sustainability and Transformation Fund can best support trusts beyond 2018-19.** Current arrangements are only in place for 2017-18 and 2018-19. In 2016-17 40% of payments were paid to create or increase trust surpluses, but these trusts may not be able to spend the extra cash in 2017-18 because of financial planning targets.
- c** **The Department, NHS England and NHS Improvement should assess whether the various financial flows and management approaches they use are working as intended, and take remedial action if necessary.** These approaches include a higher rate of interest on loans for trusts already in difficulty, and a risk reserve held by clinical commissioning groups which has been used to balance trust deficits. The national bodies should provide clarity to clinical commissioning groups and trusts about how these approaches are working and how they fit within a coherent financial strategy.
- d** **The Department and NHS England need to gain greater clarity over the fundamental financial pressures in the trust sector when allocating funding to clinical commissioning groups and directly to trusts.** As part of this work, the Department, NHS England and NHS Improvement should define the underlying financial position of the trust sector and report this position annually.

- e **NHS England and NHS Improvement should continue to align their resources and regulatory functions to better support local partnerships.** Partnerships need consistent, streamlined oversight from NHS England and NHS Improvement, such as coordinated data requests and aligned efficiency programmes. NHS England and NHS Improvement should continue to improve their regulatory approach, within the confines of current legislation, in order to support system-wide working.
- f **The Department, working with NHS England and NHS Improvement, should set out when the committed capital investment for transformation and backlogs of essential maintenance will be made available.** To plan more effectively, local partnerships need clearer information about what resources they will have to invest in services.
- g **NHS England and NHS Improvement should give those local partnerships making the slowest progress sufficient financial support and opportunities to transform services.** NHS England and NHS Improvement are currently targeting funding for transformation at those partnerships deemed to have made the most progress, and are giving early accountable care systems greater freedom over how they spend their transformation funding. The national bodies must ensure this approach does not create additional difficulties for those partnerships already struggling.

# Part One

## Financial performance in the NHS

**1.1** This part of the report examines the financial position and sustainability of the NHS overall and of NHS bodies (clinical commissioning groups, and NHS trusts and NHS foundation trusts (trusts)). We also look at the financial support available to commissioners and trusts, and trends in activity and performance.

**1.2** Since the NHS was formed in 1948, health spending in real terms has increased by 3.7% a year on average. Between 2014-15 and 2020-21, the NHS England budget will increase by an average of 1.9% a year (see Figure 1 on page 6).<sup>3</sup> Between 2014-15 and 2016-17, it saw larger increases in funding, compared with 2017-18 onwards. A proportion of these increases covered rising unit costs. For example, before allowing for improvements in efficiency, NHS England and NHS Improvement increased national prices in 2016-17 by 3.8% to allow for cost inflation, changes to pensions and national insurance contributions and increases in clinical negligence payments. Additional funding announced in the government's 2017 Autumn Budget has shifted the slowdown in funding increases to later in the period 2014-15 to 2020-21. Funding per person, once adjusted for age, will fall by 0.3% in 2019-20.

### NHS funding and spending in 2016-17

**1.3** In 2016-17, the Department of Health and Social Care (the Department) gave £105.7 billion to NHS England to plan and pay for NHS services.<sup>4</sup> The greatest share of the budget was spent by 209 clinical commissioning groups, which largely bought healthcare from 235 trusts.<sup>5</sup> These trusts provide acute, community, ambulance, specialist and mental health and disability services. **Figure 2** gives a summary of the financial performance of NHS commissioners and trusts in 2016-17.

<sup>3</sup> The expected growth in NHS England's budget is not directly comparable with growth in historic health spending because before 2013-14 this growth was measured using total health spending by the Department, including spending on public health and education.

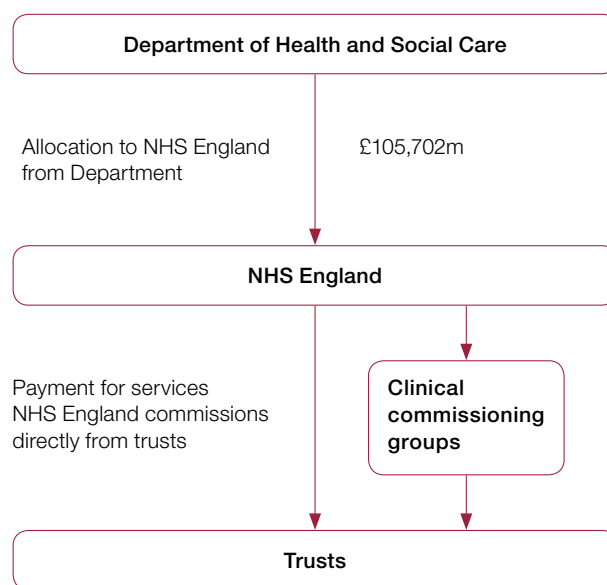
<sup>4</sup> This is NHS England's revenue budget for day-to-day spending. It excludes depreciation and impairment charges.

<sup>5</sup> Number of organisations at 31 March 2017.



**Figure 2**

Summary of the financial performance of NHS commissioners and trusts, 2016-17



	Allocation/income 2016-17 (£m)	Underspend/overspend 2016-17 (£m)	Underspend/overspend 2015-16 (£m)
Centrally commissioned services including primary care, specialised services and public health	29,072	748 underspend (surplus)	614 underspend (surplus)
Clinical commissioning groups	76,630	154 underspend (surplus)	15 overspend (deficit)
Trusts	80,552	791 overspend (deficit)	2,447 overspend (deficit)
<b>Net underspend/overspend by NHS commissioners and trusts<sup>6</sup></b>		<b>111 underspend (surplus)</b>	<b>1,848 overspend (deficit)</b>

**Notes**

- NHS England's total revenue budget (including depreciation and impairment charges) was £106,528 million. The core measure for NHS England's financial performance is its non-ring-fenced revenue budget of £105,702 million, which excludes depreciation and impairment charges.
- Trusts generate income as opposed to receiving 'allocations'. This is because they work on a more commercial basis than NHS England and clinical commissioning groups, which work within an annual resource limit.
- Trusts receive income from clinical commissioning groups, NHS England and other trusts, including from services provided to other trusts. The gross income from all these sources was £80,552 million.
- NHS England and clinical commissioning groups also buy healthcare services from other providers.
- Spend on centrally commissioned services includes underspends or overspends on the legacy NHS continuing healthcare claims programme.
- These figures exclude any central accounting adjustments that the Department makes when reporting its total revenue budget position to Parliament.

Source: National Audit Office analysis of Department of Health and Social Care, NHS England and NHS Improvement data

**1.4** Commissioners and trusts in aggregate ended 2016-17 with a £111 million surplus, a significantly better financial position than the £1,848 million deficit recorded in 2015-16.<sup>6</sup> In 2016-17, the surplus was made up of:

- NHS England reporting an underspend of £748 million, against the £29,072 million available for national functions, centrally commissioned services and legacy claims;
- clinical commissioning groups reporting an underspend of £154 million against the £76,630 million available for locally commissioned services; and
- trusts reporting a combined deficit of £791 million against their income of £80,552 million.

### **Trends in the financial performance of healthcare commissioners**

**1.5** The financial performance of clinical commissioning groups is measured against the planned position at the end of the financial year agreed between each group and NHS England. Any differences between the actual and planned position are reported as either underspends or overspends. In 2016-17, the £154 million underspend was made up of:

- a collective underspend of £120 million on locally commissioned services (compared with an overspend of £28 million in 2015-16); and
- an underspend of £34 million on the Quality Premium programme (compared with an underspend of £13 million in 2015-16).<sup>7</sup>

**1.6** While clinical commissioning groups in aggregate reported an increased underspend in 2016-17, data suggest there is an increasing gap between the financial performance of different groups. In 2016-17:

- 152 clinical commissioning groups had either a balanced position or reported underspends totalling £476 million, compared with 153 in 2015-16 being in balance or reporting underspends totalling £122 million;
- 57 clinical commissioning groups reported overspends totalling £359 million, compared with 56 in 2015-16 reporting overspends totalling £152 million; and
- six clinical commissioning groups were under severe financial pressure with overspends that made up more than 5% of their funding (there were none in 2015-16).<sup>8</sup>

<sup>6</sup> The trust deficit position does not include £144 million in adjustments needed to report against the Department's budget for day-to-day resources and administration costs, including adjustments relating to income and depreciation of donated assets, private finance initiative (PFI) spending and provisions. Against this budget, NHS bodies overspent by £33 million.

<sup>7</sup> This programme rewards clinical commissioning groups for improving the quality of the services they commission and for associated improvements in health outcomes.

<sup>8</sup> Underspend and overspend figures for 2015-16 and 2016-17 do not add up to the total underspend figures of £28 million and £120 million respectively due to central adjustments made by NHS England. We have defined a balanced position as the difference between the actual and planned positions being zero, to the nearest £1,000. This will include any clinical commissioning group in each year with an overspend less than £500.

**1.7** NHS England calculates clinical commissioning groups' financial position compared with their funding allocation each year. A cumulative surplus or deficit for each group is created by adding any surplus or deficit to previous years' calculations.<sup>9</sup> In 2016-17:

- the number of clinical commissioning groups reporting a cumulative deficit increased to 62, up from 32 in 2015-16 and 19 in 2014-15; and
- the total net cumulative surplus fell to £175 million from £328 million in 2015-16, indicating that commissioners increasingly needed to use their reserves as well as their allocated funding to commission healthcare services.

**1.8** In 2016-17, NHS England required each commissioner to hold 1% of their income in a reserve, in case it was needed to offset deficits in the NHS. The trust sector's deficit position at the end of the year meant that NHS England would not allow these reserves to be used, which effectively improved their financial position by just under £800 million (£707 million from clinical commissioning groups and £92 million from NHS England's direct commissioning of primary care).

**1.9** In 2016-17, NHS England underspent by £748 million against its central and direct commissioning budget. It achieved this by spending £439 million less than planned on programmes, administration and other central budgets, achieving an underspend of £13 million on legacy NHS continuing healthcare claims, and making savings of £296 million from direct commissioning, including preventative services such as primary care.<sup>10</sup>

## **Trends in the financial performance of trusts**

**1.10** Following several years of declining financial performance, NHS England and NHS Improvement published a plan in July 2016, known as the NHS 'financial reset', with two main objectives: to cut the trust deficit and to strengthen accountability.<sup>11</sup> For 2016-17, they allocated £1.8 billion to a Sustainability and Transformation Fund to encourage trusts to improve their financial performance. NHS Improvement gave each trust a financial control total: a target financial position that the trust must meet in order to access the Fund (see paragraphs 1.14 to 1.16). Initially, the NHS 'financial reset' noted that the trusts' existing plans would result in a combined deficit of £580 million in 2016-17, but with additional action, such as tackling the growth in pay costs at some trusts, this could be reduced to around £250 million.

**1.11** Although neither of these objectives were achieved, the sharp decline in the financial position was halted (**Figure 3** overleaf), with trusts reporting a combined deficit of £791 million at the end of 2016-17. At 30 September 2017, trusts reported a deficit for the first two quarters of 2017-18 of £1,151 million. They have forecast that their financial performance will improve, with a net deficit of £623 million by 31 March 2018, based on performance in the first six months of 2017-18.

9 NHS England assesses the financial performance of clinical commissioning groups differently, by a measure of their in-year financial position plus any agreed use of previous years' surpluses.

10 NHS continuing healthcare provides free care outside of hospital that is arranged and funded by the NHS. Clinical commissioning groups now provide funding, but NHS England is responsible for claims made before the healthcare system was reorganised following the Health and Social Care Act 2012.

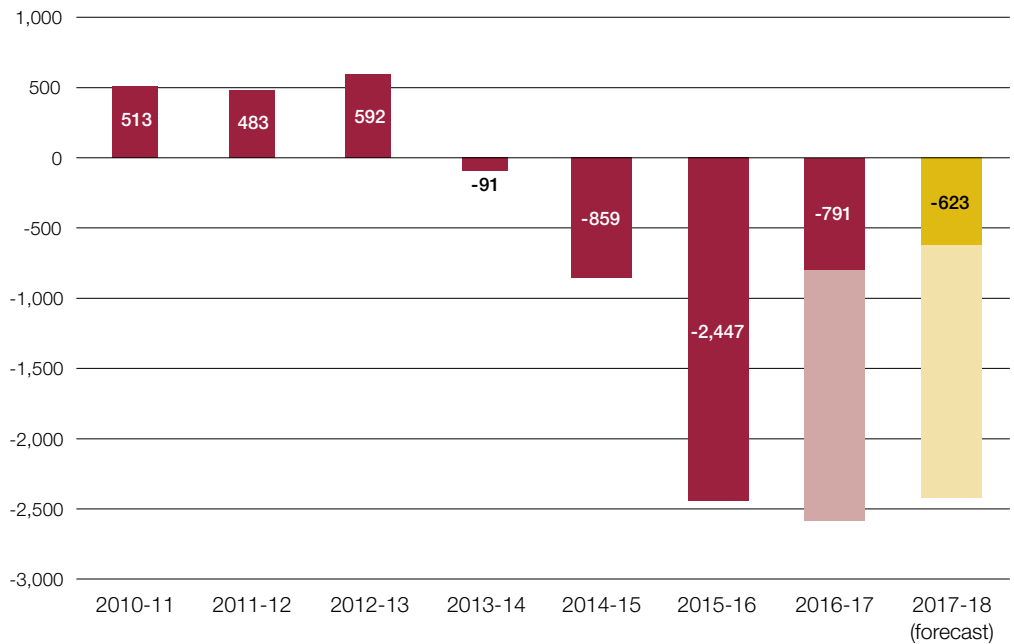
11 NHS England and NHS Improvement, *Strengthening financial performance and accountability in 2016/17*, July 2016.

**Figure 3**

Surplus/deficit of trusts, 2010-11 to 2016-17, and forecast for 2017-18

The financial position of trusts significantly improved in 2016-17, helped by Sustainability and Transformation Fund payments

Surplus/deficit (£m)



Actual

■ Surplus/deficit

■ Sustainability and Transformation Fund payments

Forecast

■ Surplus/deficit

■ Sustainability and Transformation Fund payments

**Notes**

- 1 Sustainability and Transformation Fund payments totalled £1,796 million in 2016-17, and are forecast to be £1,800 million in 2017-18.
- 2 Forecast taken from NHS Improvement, *Quarter 2 sector performance report*, November 2017.

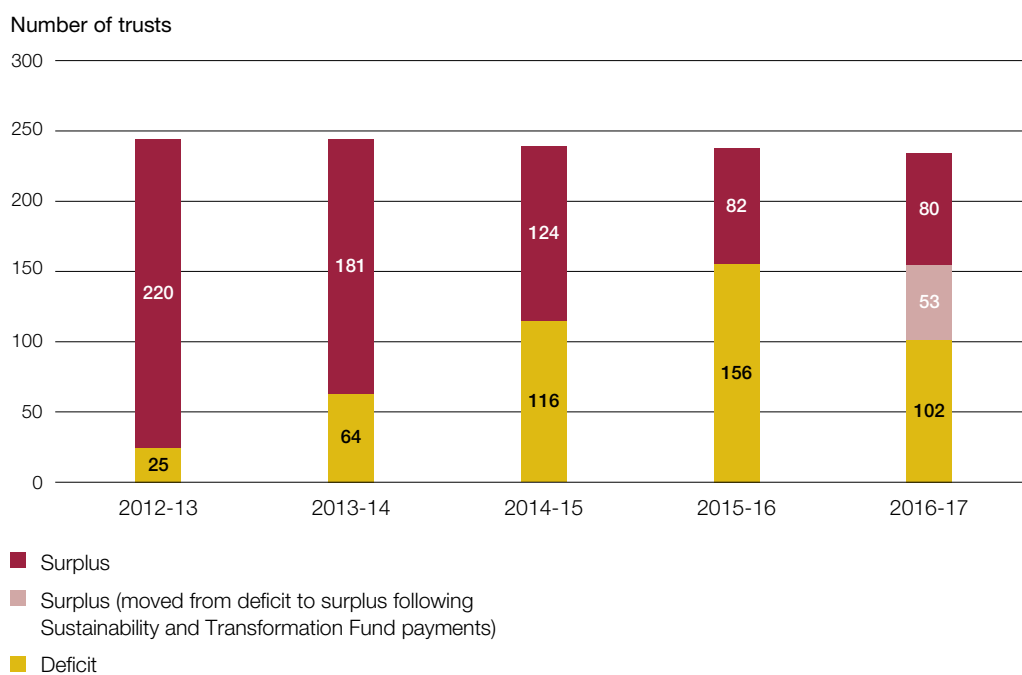
Source: National Audit Office analysis of trusts' financial data

**1.12** The proportion of trusts reporting a deficit fell in 2016-17, after several years of steady increase (**Figure 4**). In 2016-17, 57% of trusts (133) reported a surplus, including 53 trusts that had moved from a deficit to a surplus position as a result of Sustainability and Transformation Fund payments. In 2016-17, 16% of trusts had deficits that made up more than 5% of their income, compared with 24% in 2015-16. Financial pressures are felt more keenly in the acute sector: 61% of acute trusts reported a deficit in 2016-17, compared with 30% of ambulance trusts and 18% of specialist, mental health and community trusts. The acute sector reported a combined deficit of £1,106 million in 2016-17, helped by £1,500 million in Sustainability and Transformation Fund payments, compared with a £2,508 million deficit in 2015-16. All other sectors reported surpluses.

**Figure 4**

Number of trusts in surplus and deficit, 2012-13 to 2016-17

In 2016-17, the number of trusts reporting a deficit decreased

**Notes**

- 1 Number of trusts at 31 March each year.
- 2 Surpluses and deficits of trusts that ceased to provide services in each year were added to the successor trusts' surpluses and deficits.
- 3 Figures exclude NHS Direct.

Source: National Audit Office analysis of trusts' financial data

**Indicators of trusts' financial sustainability**

**1.13** The balance of net current assets held by trusts shows how much capital trusts are generating or using through day-to-day activities. Negative net current assets may indicate that trusts are having difficulty financing their day-to-day operations.

**Figure 5** overleaf shows that, in 2016-17, trusts reported a positive total net current assets balance of £699 million. This was an improvement from the negative balance of £25 million in 2015-16 but almost £1 billion less than in 2013-14. Cash balances continued to fall in 2016-17. Trusts may have fewer reserves that they can easily draw on in times of need, increasing the risk that trusts in difficulty will need financial support from the Department.

**Figure 5**

Cash and other current assets and liabilities at the end of the financial year, 2012-13 to 2016-17

**Trusts' net current assets balance improved in 2016-17 but remains well below the 2013-14 balance**

	2012-13 (£m)	2013-14 (£m)	2014-15 (£m)	2015-16 (£m)	2016-17 (£m)
Cash and cash equivalents	5,791	5,482	4,976	4,134	4,027
Other current assets	4,102	5,429	5,892	6,038	7,271
Current liabilities	-8,261	-9,247	-9,540	-10,197	-10,598
Net current assets	1,632	1,664	1,328	-25	699

**Notes**

- 1 Current assets and current liabilities include balances between trusts (figures are gross, not netted off for transactions between trusts).
- 2 Data exclude trusts' charitable funds.
- 3 Data taken from trusts' statements of financial position at 31 March each year; balances of trusts that dissolved in-year are included in the balances of the successor trusts for that year.
- 4 Figures may not sum due to rounding.

Source: National Audit Office analysis of trusts' financial data

**Financial support and incentives****Sustainability and Transformation Fund**

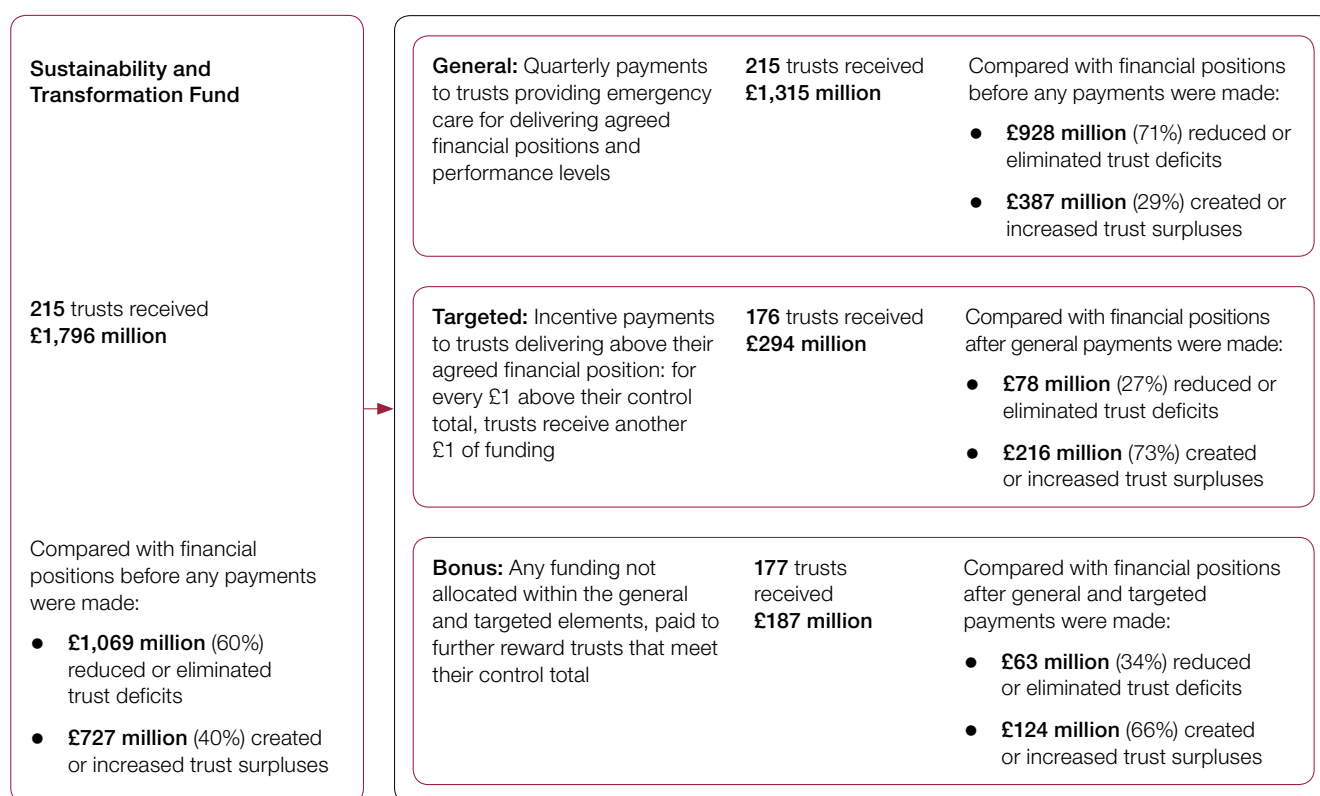
**1.14** In April 2016, the national bodies introduced the Sustainability and Transformation Fund, to support the financial recovery of trusts and give the NHS the stability to improve performance and transform services. The Department initially intended this Fund would return trusts to aggregate financial balance. However, in the July 2016 financial reset, NHS England and NHS Improvement clarified the Fund should instead support the trust sector to achieve its target deficit position in 2016-17 of £580 million. They have committed funding of £1.8 billion each year until 2018-19; in 2016-17, they directed most of this funding towards acute trusts providing emergency care services to relieve pressures in that sector. Acute trusts received general funding each quarter by meeting their individual target financial positions and, for the first three quarters, target performance levels. Of the available £1.686 billion general fund, £371 million was withheld from 114 trusts for not accepting their control total, not meeting their control total or not meeting their performance targets each quarter. NHS Improvement used these unallocated funds, as well as the Fund's remaining £0.114 billion balance, to give additional targeted and bonus payments to all trusts that met or exceeded their target financial positions at the end of the year (**Figure 6**). Only 20 of 235 trusts received no funding.

**1.15** The Fund incentivised most trusts to improve their financial discipline: 79% of the trusts (177) that accepted their control total hit these targets in 2016-17, including 15 of the 25 trusts with the largest deficits as a proportion of income.<sup>12</sup> However, some local bodies we spoke to expressed concern that the consequences of not meeting their control total meant they had shifted focus to delivering short-term,

## Figure 6

### Sustainability and Transformation Fund payments, 2016-17

In 2016-17, 60% of payments helped trusts reduce or eliminate their in-year deficits, with the remaining 40% creating or increasing trust surpluses



#### Notes

- 1 A total of £4 million was paid back to the Department.
- 2 For trusts moving from deficit to surplus as a result of Fund payments, payments that eliminated their deficits have been presented separately to any payments above these amounts that created a surplus.

Source: National Audit Office analysis of NHS England and NHS Improvement data

non-recurrent efficiencies.

<sup>12</sup> Trusts with a deficit more than 10% of income, before any Sustainability and Transformation Fund payments.

**1.16** In total, £1.1 billion of payments helped 140 trusts reduce or eliminate their in-year deficits. Typically, the funding helped those trusts most in need: for the 50 trusts with the largest deficits (as a proportion of their income), the payments improved their financial positions by an average of 3.0 percentage points, compared with 1.8 percentage points for the 50 trusts with the largest surpluses. However, not all elements of the Fund worked in the same way. More than 70% of the general allocations (£928 million) helped trusts reduce or eliminate their in-year deficits. But once these general allocations were taken into account, more than 70% (£340 million) of the additional targeted and bonus payments created or increased trust surpluses (Figure 6).<sup>13</sup> In 2017-18, trusts in surplus will again need to manage their spending to hit their control total, meaning they may leave this extra cash unspent. The Department, NHS England and NHS Improvement (the national bodies) are reviewing how the Fund worked in its first year. The nature and size of the Fund after 2018-19 have not been confirmed.

### Other financial support

**1.17** NHS Improvement hoped that the Sustainability and Transformation Fund would replace the need for most direct cash funding from the Department to trusts. However, extra financial support from the Department and NHS England for trusts in financial difficulty increased from £2.4 billion in 2015-16 to £3.1 billion in 2016-17. To deter trusts from overspending and incurring deficits, the Department has increasingly been offering this support in the form of interest-bearing loans rather than public dividend capital.<sup>14</sup> In 2016-17, 95% of the Department's support (£2.8 billion) was given in this way. Most of it was given as revenue support (£2.661 billion) to allow trusts to maintain services, rather than as longer-term capital support (£163 million). NHS Improvement has expressed doubts about the ability of the most distressed trusts to service and repay these loans. On all loans and overdrafts in 2016-17, 172 trusts paid £173 million in interest, compared with 167 trusts that paid £117 million in 2015-16.

### Transferring funding from capital to revenue budgets

**1.18** Since 2014-15, the Department has used money originally intended for capital projects, such as building work, to cover a shortfall in the revenue budget. In 2016-17, the Department decided at the start of the year to transfer £1.2 billion of its £5.8 billion capital budget to revenue budgets to fund day-to-day services. This followed transfers of £950 million in 2015-16 and £640 million in 2014-15. In 2017-18, the Department plans a further substantial transfer. While this revenue support is needed to fund healthcare services, there is a risk that property and equipment will not be maintained effectively. In 2016-17, trusts estimated that they had accumulated £5.5 billion in maintenance costs that need to be addressed, up from £4.0 billion in 2012-13. Within this, required maintenance classified as a high and significant risk increased from £1.4 billion in 2012-13 to £2.7 billion in 2016-17.

<sup>13</sup> This includes payments to trusts above what was needed to eliminate their deficit as well as payments to trusts that were already reporting a surplus.

<sup>14</sup> Public dividend capital is a non-repayable injection of cash provided to trusts by the Department to ensure they have the money needed to pay creditors and staff and to fund essential building works.



## Achieving long-term sustainability

**1.19** To be sustainable in the long term, the NHS will need to continue to deliver efficiencies and improvements to ensure it can meet increased demand with limited resources. The underlying position of the NHS is difficult to quantify as some assumptions and judgements are needed in order to calculate it. However, two measures indicate the position may not be getting better (**Figure 7**). The sharp increase in the level of cash support to trusts outside of service contracts with commissioners suggests that healthcare providers are increasingly struggling to deliver care under the contracts they hold and the prices they are paid. In addition, the increase in

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### Figure 7

Indicators of the underlying financial position, 2015-16 and 2016-17

**In 2016-17, the national bodies gave £1.7 billion more financial support to trusts outside of service contracts, and the NHS made an additional £0.3 billion in non-recurrent savings**

Cash support outside of service contracts	2015-16 (£m)	2016-17 (£m)
Sustainability and Transformation Fund	0	976 <sup>1</sup>
Financial support to trusts	2,398	3,141
<b>Total</b>	<b>2,398</b>	<b>4,117</b>
<b>Non-recurrent savings</b>		
Clinical commissioning group non-recurrent savings	150	331
Trust non-recurrent savings <sup>2</sup>	646	789
<b>Total</b>	<b>796</b>	<b>1,120</b>

#### Notes

- 1 Of the £1,796 million Sustainability and Transformation Fund payments committed in 2016-17, £976 million was made in-year; £820 million was paid to trusts after 31 March 2017.
- 2 Trust non-recurrent savings include non-recurrent efficiency savings and non-recurrent income-generating schemes.

Source: National Audit Office analysis of Department of Health and Social Care, NHS England and NHS Improvement data

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non-recurrent savings made by clinical commissioning groups and trusts means NHS bodies are increasingly reliant on making savings that they cannot rely on being made the following year.

## Activity and patient access

**1.20** The Department estimates that population and demographic changes increased demand for health services by 1.3% in 2016-17. Activity carried out by acute trusts increased at a greater rate: accident and emergency (A&E) attendances increased by 2.2%; hospital admissions by 1.9%; and outpatient appointments by 3.3%.<sup>15</sup> Trusts are struggling to manage this activity within their budgets and meet NHS access targets. In particular, higher than planned non-elective activity impacted trusts' financial and operational performance in 2016-17. We have previously reported how rising emergency admissions can have an adverse impact on trusts' income.<sup>16</sup>

**1.21** One of the aims of the Sustainability and Transformation Fund was to give trusts an incentive to improve performance against access standards, but this declined further in 2016-17 (**Figure 8**). Between April 2012 and March 2017, the number of patients

### Figure 8

Trusts' performance against key access targets, 2012-13 to 2016-17

#### Performance continued to decline in 2016-17

Target	Target (%)	2012-13 (%)	2013-14 (%)	2014-15 (%)	2015-16 (%)	2016-17 (%)
A&E: Patients should be admitted, transferred, or discharged within four hours of arrival	95	95.9	95.7	93.6	91.9	89.1
Cancer: Patients referred via the urgent suspected cancer route should start definitive treatment within 62 days of receipt of referral at hospital	85	87.2	86.0	83.4	82.4	82.0
Routine, non-urgent conditions: Patients should start their treatment within 18 weeks of being referred	92	94.2	93.7	93.1	91.5	90.3

#### Note

1 Figures for A&E and cancer are annual data. Figures for routine, non-urgent conditions are reported performance at the end of March each year.

Source: NHS England

waiting for treatment increased from 2.5 million to 3.9 million. Our analysis indicates that, on average, trusts in deficit performed worse against key access targets than trusts in surplus. In July 2016, to ensure trusts missing out on Sustainability and Transformation Fund payments are not penalised further, NHS England and NHS Improvement suspended fines for trusts missing access targets, provided they accepted their financial control totals.

<sup>15</sup> Data have been adjusted to account for differences in the number of days available each year for A&E attendances and non-elective admissions, and the number of working days available each year for elective admissions and outpatient appointments.

<sup>16</sup> Comptroller and Auditor General, *The financial sustainability of NHS bodies*, Session 2014-15, HC 722, National Audit Office, November 2014.

## Part Two

### Support to improve local bodies' financial positions

**2.1** This part examines what the Department of Health and Social Care (the Department), NHS England and NHS Improvement have done to help local bodies develop and deliver their plans to make sustainable efficiency savings.

#### **Strategic oversight and programme management**

**2.2** The *NHS Five Year Forward View*, published in October 2014, estimated that there would be a £30 billion gap between patients' needs and resources by 2020-21 if no action was taken. The government committed to increasing funding for the NHS by £8.4 billion by 2020-21. In 2016, we reported that the Department, NHS England and NHS Improvement (the national bodies) had a shared plan for closing the remaining £22 billion gap by improving efficiency.<sup>17</sup> In March 2017, they set out 10 key efficiency opportunities for the NHS (**Figure 9** overleaf), requiring greater system-wide working to take advantage of large-scale efficiencies. NHS England and NHS Improvement are working together to: align their savings programmes to the '10-point efficiency plan'; better support local bodies achieve these savings; and track these savings more effectively.

#### **Trusts and clinical commissioning groups' savings plans**

**2.3** NHS trusts and NHS foundation trusts (trusts) and clinical commissioning groups need to make savings to deliver the 10-point efficiency plan. Financial sustainability relies on these local bodies making year-on-year savings (recurrent), rather than one-off savings (non-recurrent). Otherwise, these bodies will have to find new savings the following year, to replace any non-recurrent savings, in addition to savings already planned. Examples of non-recurrent savings include selling surplus buildings and land to generate income or leaving staff posts temporarily vacant.

<sup>17</sup> Comptroller and Auditor General, *Financial sustainability of the NHS*, Session 2016-17, HC 785, National Audit Office, November 2016.

## Figure 9 NHS 10-point efficiency plan

### NHS England and NHS Improvement have set out 10 key opportunities for making savings

Programme	Detail
Free up 2,000 to 3,000 beds	The government provided an additional £1 billion funding for adult social care in 2017-18, to increase the availability of care home places and care at home and ease the pressures on the NHS.
Manage staffing costs and improve productivity	Through continued use of controls over agency staff spending and better use of clinical staff.
Use the NHS procurement clout	NHS Improvement estimates that savings of £350 million in 2017-18 could be achieved by trusts.
Get best value out of medicines and pharmacy	NHS Improvement expects savings of £250 million in 2017-18 from improved hospital prescribing, and NHS England expects savings from reducing prescriptions of drugs with low clinical value, against current spending of £141 million a year.
Reduce avoidable demand	Including programmes to reduce minor cases in A&E, manage growth in GP referrals, and reduce unwarranted variations in care.
Reduce unwarranted variation in clinical quality and efficiency	Including the Getting It Right First Time programme to improve quality of care and outcomes for patients, and the redesign of hospitals and services, for example to separate emergency care from planned admissions.
Estates, infrastructure, capital and clinical support services	NHS Improvement estimates that savings of £230 million could be achieved from improving estates management and clinical support services, and that sales of unused hospital land would generate additional income.
Cut the cost of corporate services and administration	NHS Improvement estimates that consolidating services with neighbouring trusts could save £100 million in 2017-18. NHS England expects savings of £150 million by 2019-20 from clinical commissioning groups and by cutting its own costs.
Collect income the NHS is owed	The government has set a target for the NHS to recover up to £500 million a year from overseas patients.
Financial accountability and discipline	Including local efficiency plans to deliver control totals, incentivised by the Sustainability and Transformation Fund.

Source: NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017

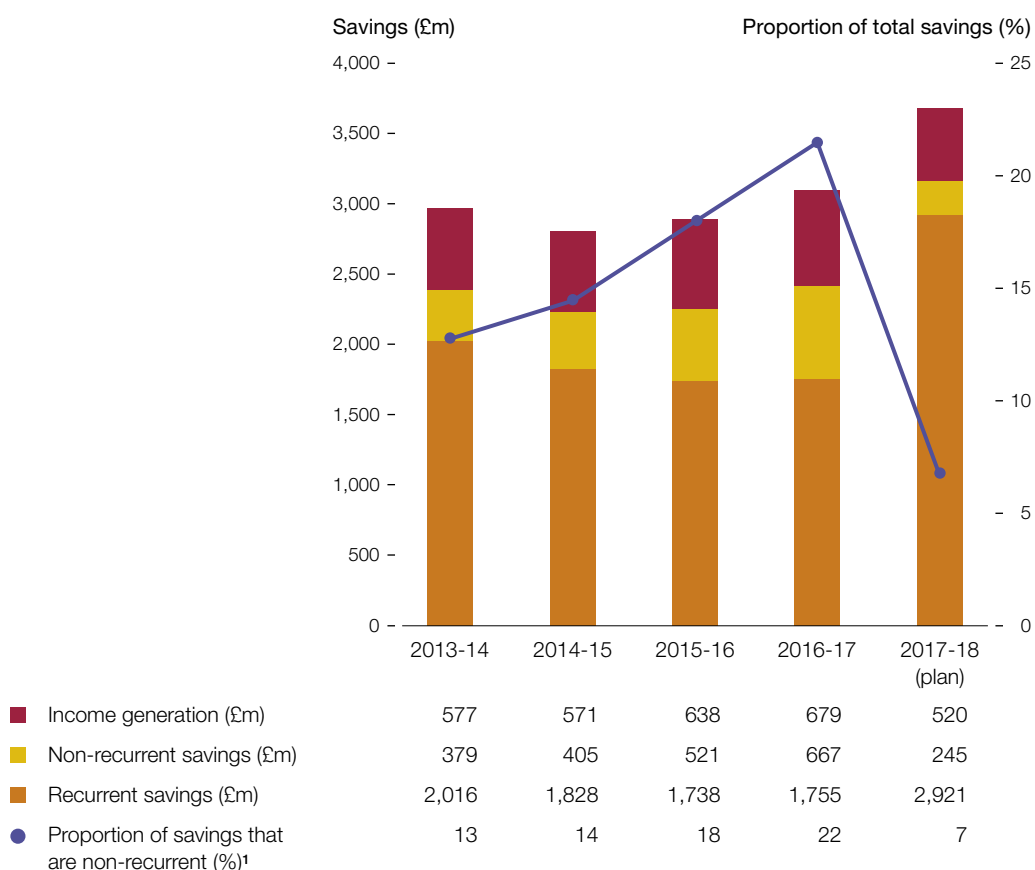
**2.4** Trusts use cost improvement programmes to make efficiency savings. In 2016-17, trusts saved £3,101 million, 92% of the savings they planned through these programmes. However, while overall savings and the proportion of planned savings increased, the proportion made from non-recurrent cost savings also continued to increase, from 14% in 2014-15 to 22% in 2016-17 (**Figure 10**).<sup>18</sup> This trend means that achieving planned savings in 2017-18 will be even more challenging because trusts will need to make additional savings in 2017-18 to replace the non-recurrent savings made in 2016-17. Trusts plan to make £3,687 million of efficiency savings in 2017-18, a 19% increase on the savings achieved in 2016-17. In July 2017, trusts classified 39% of these planned savings as high risk. NHS Improvement is working with trusts to reduce these risks.

<sup>18</sup> This assumes that all savings from income-generating schemes are recurrent. In 2015-16 and 2016-17, 20% and 18% of savings from income-generating schemes were non-recurrent, but these data were not available before 2015-16.

**Figure 10**

Savings achieved by trusts, 2013-14 to 2016-17, and planned for 2017-18

Trusts have increasingly relied on non-recurrent savings but have planned significantly less in 2017-18

**Notes**

1 This analysis assumes that all savings from income-generating schemes are recurrent. In 2015-16 and 2016-17, £125 million and £122 million of savings from income-generating schemes were non-recurrent, but these data were not available before 2015-16.

2 NHS Direct is excluded from 2013-14 data.

Source: National Audit Office analysis of NHS Improvement data

**2.5** In March 2016, NHS Improvement established the financial improvement programme to help trusts develop and implement their 2016-17 savings plans. It selected 22 trusts to receive short-term structured support from management consultants at a cost of £28.1 million, excluding VAT. The 16 trusts that completed the programme estimated that it helped them achieve additional savings in 2016-17 of £107.2 million.<sup>19</sup> Other trusts used the programme resources to identify ways to improve their in-house support. NHS Improvement has shared the learning from the programme with all trusts, and has selected 18 trusts for the programme in 2017-18.

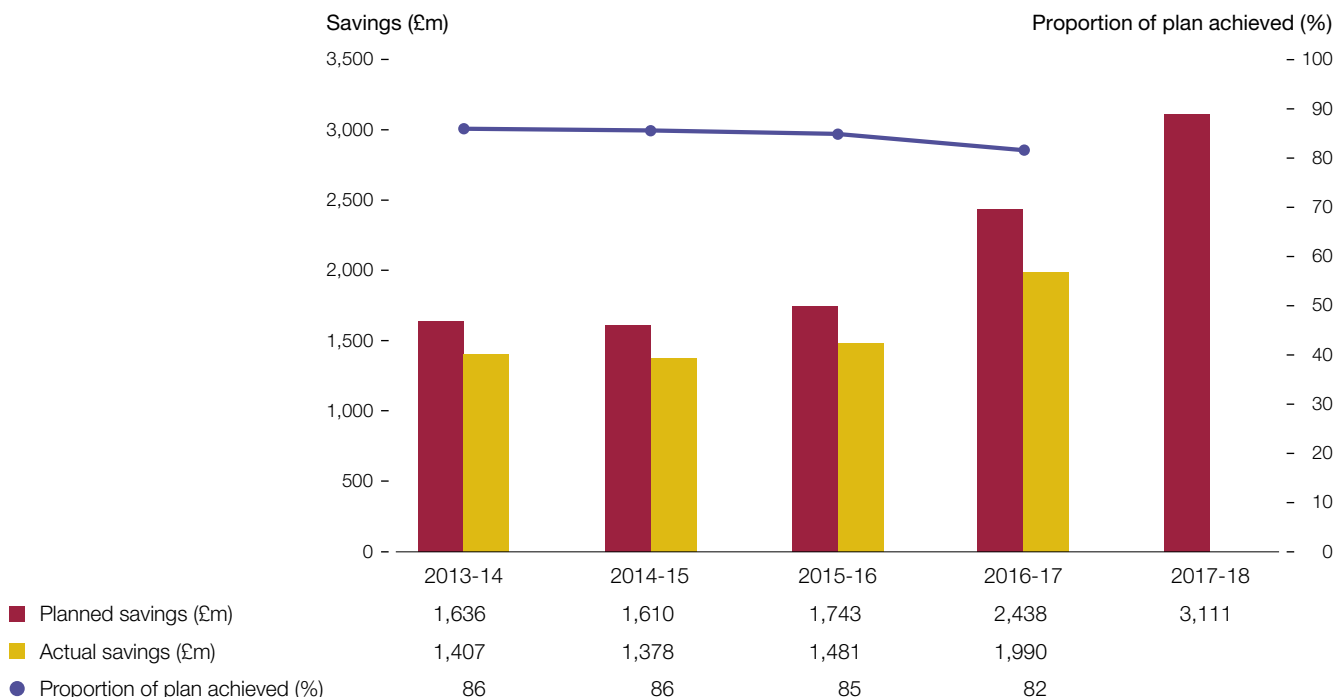
<sup>19</sup> Some of this support started part-way through the year; its full-year effect was savings of £135.4 million.

**2.6** Clinical commissioning groups set out their efficiency savings in quality, innovation, productivity and prevention (QIPP) plans. In 2016-17, they achieved £1,990 million of savings, 82% of their planned savings (**Figure 11**). Between 2013-14 and 2016-17, the amount of savings made increased by 41%, but the proportion of groups achieving planned efficiencies fell each year, from 49% to 27%. Between 2014-15 and 2016-17, the proportion of non-recurrent savings increased from 14% to 17%.<sup>20</sup>

**2.7** Clinical commissioning groups' planned efficiency savings for 2017-18 (£3,111 million) are considerably higher than the savings they have previously achieved. In 2017, NHS England launched a programme to help commissioners identify and implement savings opportunities by, for example, peer-reviewing GP referrals for hospital appointments. Between February and May, NHS England helped 106 clinical commissioning groups to identify additional savings of £78.2 million, an 8% increase in planned savings for those involved, and to develop savings plans worth a further £43.2 million. While earlier support would have benefitted commissioners, NHS England is now developing best practice guides and a database of evidence-based case studies to help them plan and achieve future savings.

**Figure 11**  
Efficiency savings planned and achieved by clinical commissioning groups, 2013-14 to 2017-18

Groups are making more efficiency savings each year but are failing to meet targets



Source: National Audit Office analysis of NHS England data

20 Data showing the split between recurrent and non-recurrent savings for 2013-14 are not available.

## Supporting local bodies in financial difficulty

**2.8** NHS Improvement uses the Single Oversight Framework to identify where trusts may benefit from support across different areas, including management of their finances. In June 2017, it identified 126 trusts in need of mandated support or special measures, including the 38 trusts with deficits making up more than 5% of their income. If the causes of financial difficulty are within the trust's control, it may use its powers to impose changes on the trust, such as the replacement of board members. If the trust's performance is linked to wider challenges, it works with the local health economy to develop solutions such as strategic partnerships or mergers and system-wide recovery plans. In March 2016, NHS England introduced a new Improvement and Assessment Framework for clinical commissioning groups. The assessment identifies groups that may benefit from additional support. It is based on performance, transformation, finance and quality of leadership indicators.

**2.9** Since July 2016, NHS Improvement and NHS England have placed the most financially challenged trusts and clinical commissioning groups into financial special measures. Trusts are considered for financial special measures if they do not accept their control total and are planning a deficit for the year, or significantly fail to meet their control total plan throughout the year. To support them, NHS Improvement appoints a director-led team to help produce and deliver recovery plans and rapidly improve financial performance. Fourteen trusts have now been placed in financial special measures, of which three have since improved sufficiently to come out. The first eight trusts improved their 2016-17 year-end position by £96 million compared with forecasts prior to the support.

**2.10** However, some local organisations we spoke to told us that the recovery plans are not aligned with system-wide plans. The plans focus on short-term financial results, which places a strain on systems' ability to deliver long-term strategic plans. In addition, trusts in financial special measures face higher interest rates on loans (6% compared with 1.5% for most other trusts), imposed by the Department. This may discourage them from getting additional financial support, but adds to their financial challenge by pushing them further into deficit. Trusts that do not accept their control total remain subject to contract penalties for missing performance standards. As money raised from interest payments and contract penalties stay within the NHS, these do not affect its overall financial health.

**2.11** In July 2016, NHS England placed 10 clinical commissioning groups into financial special measures, although at the time it had not set clear criteria for placing groups in or out of the programme. NHS England also lacked sanctions to apply beyond those it was already using for struggling commissioners. These include increased support from NHS England's regional teams, more scrutiny and using legal directions to enforce change, such as a leadership change. At the end of March 2017, four out of the 10 groups met their control totals and were taken out of financial special measures. For 2017-18, NHS England has aligned entry criteria with the Improvement and Assessment Framework, providing more transparency and clarity, and is refining the support it provides to groups. All 23 clinical commissioning groups assessed as inadequate at the end of 2016-17 are in financial special measures for 2017-18.

## **Support to make long-term sustainable savings**

### Central controls over pay costs

**2.12** In 2015, the government announced that wage increases for all public sector workers would be restricted to 1% each year until 2019-20. The Department estimated that the public sector pay cap would result in £3.3 billion of savings between 2016-17 and 2020-21. However, in November 2017, the government committed to funding pay awards as part of a pay deal for NHS staff on the Agenda for Change contract, including nurses, midwives and paramedics.<sup>21</sup> The government noted that any pay deal will be on the condition that the pay award enables improved productivity in the NHS, and is justified on recruitment and retention grounds.

**2.13** In October 2015, the Department introduced specific spending controls on agency staff to help trusts control staff costs. These included approved frameworks for trusts to use, an annual spending limit for each trust, and caps on the rates that trusts can pay. NHS Improvement created a framework to help trusts with workforce planning and provides support for trusts that are struggling to improve. Local bodies we spoke to credited these measures with helping them to control agency staff costs. In 2016-17, trusts spent £3.0 billion of their total staff costs on agency staff, following a peak of £3.7 billion in 2015-16 (**Figure 12**).

**2.14** Spending on medical agency staff has not reduced as quickly as spending on nurse agency staff. Therefore, in February 2017, NHS Improvement announced additional controls to reduce spending on medical locums, including:

- a national target to reduce medical agency spending, with an initial aim of reducing spending by £150 million in 2017-18; and
- a target for each trust to reduce medical locum spending.

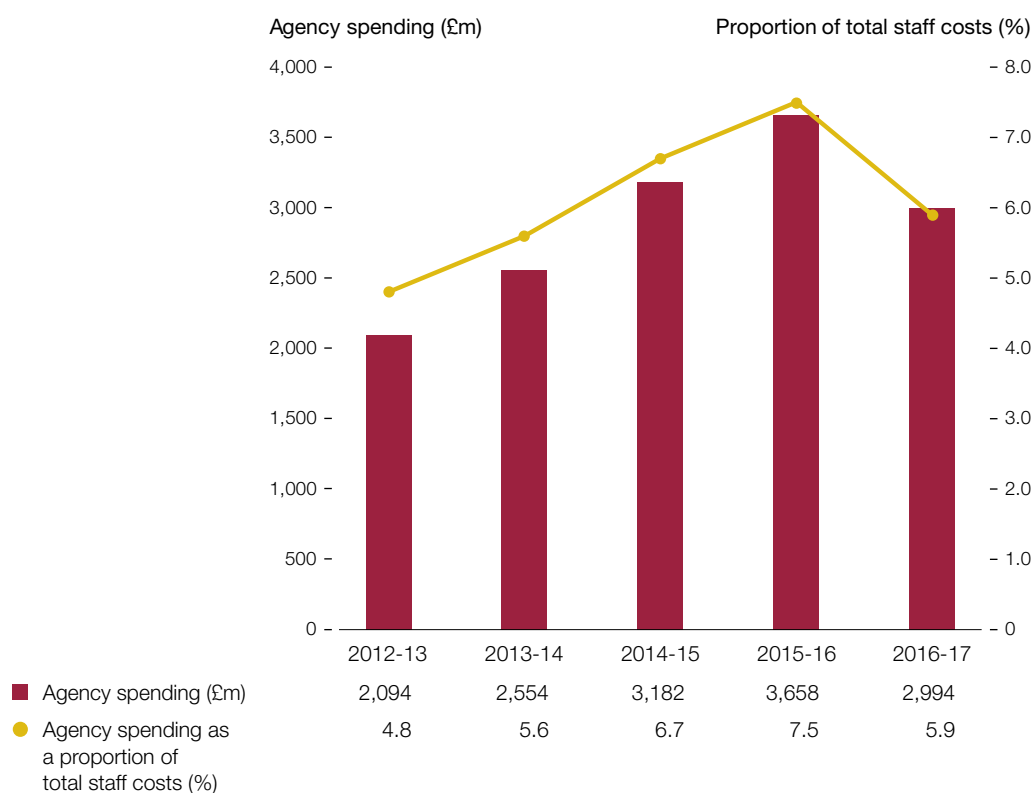
21 HM Treasury, *Autumn Budget 2017*, HC 587, November 2017.



**Figure 12**

Trusts' spending on agency staff, 2012-13 to 2016-17

Spending on agency staff reduced in 2016-17

**Notes**

- 1 Figures for NHS Direct are not included.
- 2 These figures differ from those reported in our report *Financial sustainability of the NHS*. For consistency with NHS Improvement's internal monitoring figures, we have restated the agency spending figures to exclude external bank staff from 2014-15 to 2016-17. It is not possible to remove external bank costs from agency spending prior to 2014-15.
- 3 These figures may differ from those presented by NHS Improvement – its analysis is based on internal management information, not trusts' accounts data.

Source: National Audit Office analysis of trusts' accounts data

## **National efficiency programmes**

**2.15** NHS England and NHS Improvement have established several efficiency programmes to help clinical commissioning groups and trusts deliver savings (**Figure 13** on pages 33, 34 and 35). As part of the 10-point efficiency plan, they are assessing progress by tracking performance against planned targets, rather than focusing on the £22 billion gap.

**2.16** NHS England and NHS Improvement are developing support for local bodies to deliver these programmes. For example:

- NHS England has increased the regional support available for commissioners to interpret RightCare data and develop plans to improve clinical pathways and outcomes for patients.
- NHS Improvement's Operational Productivity directorate is setting up regional teams to help trusts deliver the expected savings from its work to reduce unwarranted variation in acute non-specialist trusts. It now requires trusts to categorise their savings plans against the work of the directorate. NHS Improvement plans to expand this work to cover all other trusts.

**2.17** Local bodies we spoke to welcomed this support. However, local and national bodies face a number of challenges in delivering savings and tracking progress, including:

- ensuring clinical commissioning groups and trusts have the capacity to plan and manage their savings programmes effectively;
- developing appropriate datasets to track savings and monitor progress effectively; and
- some programmes are reliant on delivering most of their savings from 2018-19 onwards, increasing the risk that they are not realised by 2020-21.

## Figure 13 Key NHS savings programmes

NHS England and NHS Improvement have established several efficiency programmes to help clinical commissioning groups and trusts deliver savings

Programme	Description	Planned savings	Achievements to date	Challenges
Operational productivity	<p>NHS Improvement's Operational Productivity directorate was set up in September 2016 to support trusts in identifying more recurrent and sustainable savings. It includes:</p> <ul style="list-style-type: none"> <li>the Getting It Right First Time programme, which involves national clinically led reviews of medical and surgical specialities; and</li> <li>the Model Hospital, a data portal that shares examples of best practice, allowing trusts to identify savings opportunities and track progress.</li> </ul>	<p>£6 billion savings by 2020-21.</p> <p>In January 2017, the Department increased the savings target for 2017-18 from £1 billion to £1.8 billion. Trusts' savings plans for 2017-18 identified £1.4 billion of the £1.8 billion expected savings.</p> <p>For Getting It Right First Time, a greater proportion of savings are forecast to be delivered in 2019-20 and 2020-21 than originally planned.</p>	<p>Too early to determine whether programmes are on track to achieve planned savings.</p> <p>The directorate has highlighted to local areas the opportunities for greatest potential savings.</p> <p>The directorate estimates it has saved enough in its first year to cover costs for the next four years.</p> <p>Every local area has been provided with a Getting It Right First Time data pack.</p>	<p>Further work is needed to develop sufficiently detailed data to monitor progress.</p> <p>NHS Improvement has expressed concern about whether trusts have the capacity to engage with the programme.</p>
RightCare	<p>NHS England's programme supports clinical commissioning groups to reduce wasteful and ineffective spending and to improve clinical outcomes. The teams for RightCare and Getting It Right First Time are working together to provide more coordinated support to local NHS bodies.</p>	<p>£1.7 billion savings by 2020-21.</p> <p>84% forecast for delivery between 2018-19 and 2020-21. NHS England has rolled out the programme to more clinical commissioning groups more quickly to speed up delivery of savings.</p> <p>However, to make up for expected under-delivery over the next three years, NHS England is now planning a greater proportion of savings in 2020-21 (from 18% to 31%) to reach the £1.7 billion.</p>	<p>The RightCare approach is now used in every clinical commissioning group.</p> <p>NHS England estimates that the first wave of 65 groups using RightCare generated approximately 200 new transformation programmes.</p> <p>Estimated savings by individual groups in 2016-17 ranged from £20 million to £65 million.</p>	<p>Clinical commissioning groups are struggling to assess the financial impact of changes to patient pathways.</p> <p>NHS England has experienced significant problems in developing datasets to monitor and evaluate performance but now has a proposed solution.</p> <p>RightCare will need to support commissioners with the data to take advantage of opportunities across larger footprints than clinical commissioning groups.</p>

**Figure 13 continued**  
Key NHS savings programmes

Programme	Description	Planned savings	Achievements to date	Challenges
<b>Vanguards</b>	NHS England is funding 50 pilot sites, between April 2015 and March 2018, to develop new models of care to integrate services around the needs of the patient, with the aim of replicating them elsewhere. It has allocated £349 million over three years (2015-16 to 2017-18) to help develop these new models of care.	£900 million savings by 2020-21, later revised to £215 million because plans to expand the vanguards to cover an additional 10% of the population each year did not happen.  This is a long-term savings plan due to the time needed for initial investment and transformation of services.	There are early indications that vanguards are helping to reduce demand: they are reporting lower growth rates for emergency admissions to hospital and emergency inpatient bed-days compared with the rest of the NHS.  NHS England has shared best practice and learning between the vanguard sites.  In 2016-17, vanguards reported savings of £15 million not including national funding (excluding eight urgent and emergency care vanguards).	Local bodies we spoke to noted that learning had not been effectively spread to the wider NHS.  National funding for vanguards ends in 2017-18. It is unclear whether the vanguards will be able to deliver the planned future savings without continued funding and support.
<b>Urgent and emergency care</b>	NHS England's programme is based on the development of networks of hospitals and community services to ensure people are treated in the most appropriate setting. It includes eight of the 50 vanguards, which are testing models of care designed to reduce pressure on A&E, such as providing clinical advice through NHS 111 services.  In March 2017, the government announced it would provide £100 million of capital funding to support this: £90 million was given to 103 trusts to meet A&E access targets, and £10 million to help the system manage winter pressures.	£893 million expected savings by 2020-21, revised to £790 million after some of the planned work was transferred to the self-care programme.  73% forecast for delivery in 2019-20 and 2020-21.	Clinical involvement in NHS 111 calls increased to almost 40%.  More than 100 urgent treatment centres designated, incorporating direct booking from NHS 111.  Ambulance Response Programme successfully rolled out, designed to reduce conveyance to A&E.	It is difficult to achieve transformation at the speed required to deliver the necessary savings, while managing the operational pressures created by increased demand on services in the winter.

**Figure 13 continued**  
Key NHS savings programmes

Programme	Description	Planned savings	Achievements to date	Challenges
Other programmes	<p>Other NHS England programmes include:</p> <ul style="list-style-type: none"> <li>• <b>Primary care:</b> savings can be delivered by applying the 1% pay cap to GPs and dentists, changing the funding for community pharmacies and reducing prescription and dental fraud.</li> <li>• <b>NHS continuing healthcare</b> (healthcare funded by the NHS for ongoing healthcare needs provided outside hospital): savings against predicted growth in spending, to be achieved by reducing variation between local areas, increasing standardisation and adopting best practice.<sup>1</sup></li> <li>• <b>Self-care:</b> to support people to manage their own healthcare.</li> <li>• <b>Prevention:</b> to improve the health of the population, such as through smoking cessation.</li> </ul>	<p>Savings expected by 2020-21:</p> <ul style="list-style-type: none"> <li>• Primary care: £2,190 million.</li> <li>• NHS continuing healthcare: £855 million (increased from original estimate of £511 million).</li> <li>• Self-care: £584 million.</li> <li>• Prevention: £179 million.</li> </ul>	<p>£245 million saved by restricting pay uplifts in primary care.</p> <p>£385 million saved by restructuring community pharmacy contracts.</p> <p>£17 million recovered from patients who wrongly received free prescriptions or dental care.</p> <p>NHS England is sharing with local areas the opportunities for making savings in NHS continuing healthcare.</p>	<p>NHS England is focusing on challenging existing variation in how NHS continuing healthcare is commissioned and delivered; however, it is not clear whether this could increase spending.</p> <p>Self-care rebadged as an enabler to other programmes, meaning data on savings achieved from self-care alone are not available.</p> <p>Funding is not available to run the prevention programme.</p>

**Note**

1 Comptroller and Auditor General, *Investigation into NHS continuing healthcare funding*, Session 2017–2019, HC 239, National Audit Office, July 2017.

Source: National Audit Office analysis of internal documentation provided by NHS England and NHS Improvement

## Part Three

### Supporting local partnerships and transformation

**3.1** In this part of the report, we look at how local partnerships of health and care organisations are planning long-term transformation of services, and what NHS England and NHS Improvement are doing to support these partnerships.

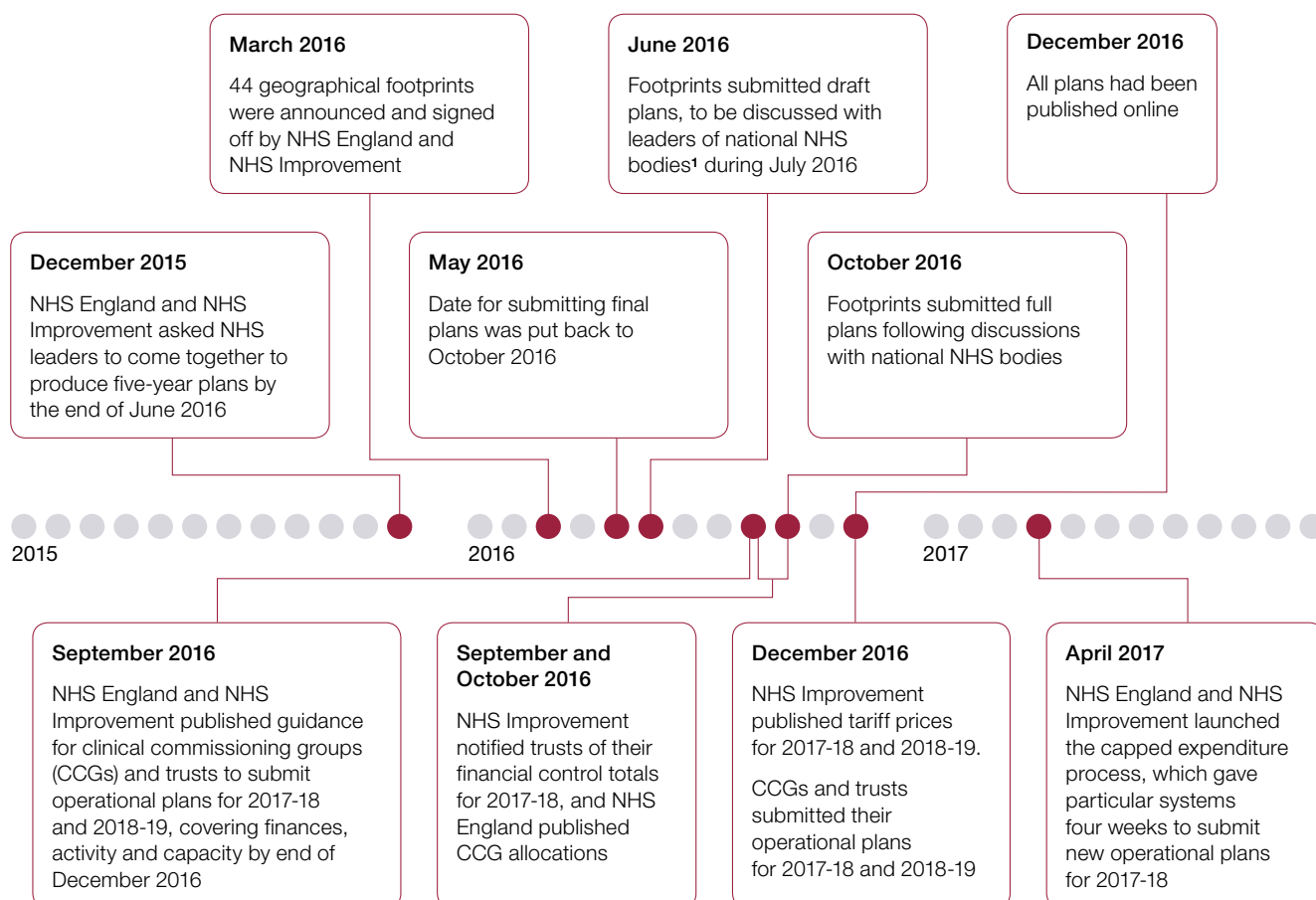
#### Local planning

**3.2** Over the past two years, NHS England and NHS Improvement have been encouraging local NHS bodies to take a more long-term, strategic approach to planning services and achieving sustainability (**Figure 14**). In December 2015, they published shared planning guidance that asked local health and care systems to collectively produce a strategic plan covering the period 2016-17 to 2020-21. The guidance required these plans to address gaps in health and wellbeing, care and quality, and finance and efficiency, and set out how local services will change and improve to meet rising demand within the resources available. As a result, clinical commissioning groups, NHS trusts and NHS foundation trusts (trusts) and local authorities grouped into 44 footprint areas. These areas represent between 312,000 and 2.8 million patients and comprised between six and 42 member organisations in 2016 (**Figure 15** on page 38). Some areas already had a long history of working together and planning collectively; others had never collaborated in that way with those partners before.

**3.3** To support the move to more long-term, system-wide planning, NHS England and NHS Improvement streamlined the annual NHS planning and contracting process. For the first time, they asked organisations to submit two-year operating plans, covering 2017-18 and 2018-19, that were aligned to their area's strategic plan. Commissioners then agreed two-year contracts with trusts. NHS England and NHS Improvement use operational plans to assess risk in the system and to track progress against them throughout the year. Their review of these plans found that a number of local systems were planning to spend significantly more than their 2017-18 control total. To address this, they launched the capped expenditure process in April 2017. This challenged 13 local systems to identify additional savings and agree new spending plans that fitted within the available system control total.

**Figure 14**

Timeline for developing strategic and operational plans

**Note**

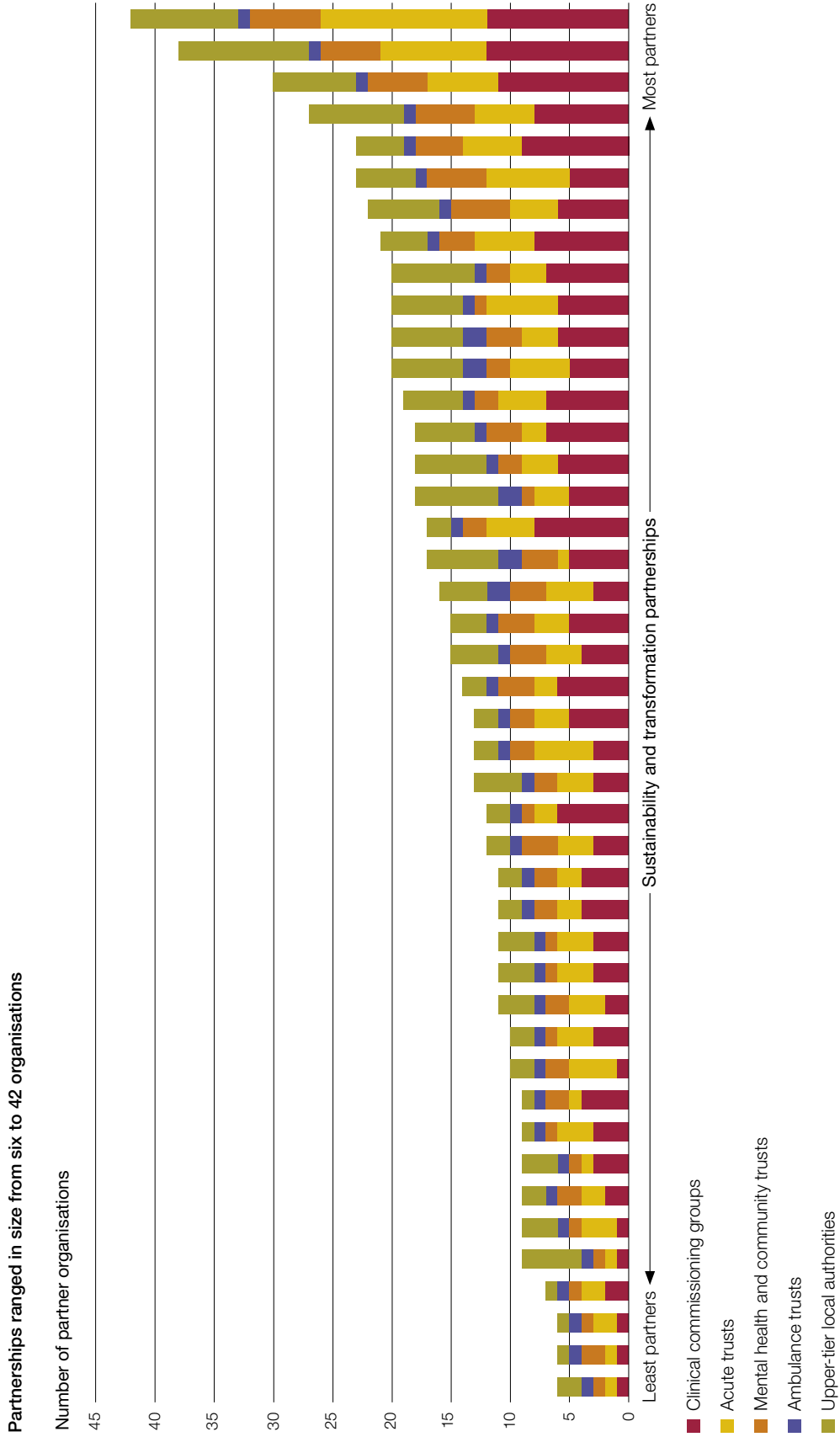
<sup>1</sup> This included leaders from NHS England, NHS Improvement, the Care Quality Commission, Health Education England, Public Health England and the National Institute for Health and Care Excellence.

Source: National Audit Office

**3.4** In March 2017, NHS England set out its vision that these footprint areas should become more formalised into partnerships, supported by, where not already in place, a board, a system leader and a programme management function.<sup>22</sup> NHS England has been clear that these sustainability and transformation partnerships are not new statutory bodies, and supplement rather than replace the accountabilities of individual organisations. However, these partnerships are increasingly recognised as a management unit.

<sup>22</sup> NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017.

**Figure 15**  
Key organisations involved in each partnership, 2016



**Note**  
1 A small number of organisations are members of more than one partnership.

Source: National Audit Office analysis of sustainability and transformation plans



**3.5** To help integrate care services further, NHS England and NHS Improvement are encouraging partnerships, or smaller groupings of organisations within each footprint, to evolve into accountable care systems. This involves commissioners and trusts taking on clear collective responsibility for resources and population health while being given more control and freedom over funding and regulating their own performance. In June 2017, NHS England and NHS Improvement identified eight local systems to trial this new approach, supported by a joint programme of work to tackle a set of practical problems. They have selected two further systems to become devolved health and social care systems.

## **Progress to date**

### Developing plans

**3.6** In August and September 2017, we visited six areas to gain insight into how plans and partnerships had developed. The timescale set by NHS England and NHS Improvement for developing and submitting five-year plans was challenging for local systems. Many had to develop a strategic plan while forging partnerships and while component organisations were developing their own individual plans. The five-year plans varied in quality and robustness. They often did not achieve financial balance in the years before 2020-21. NHS England and NHS Improvement acknowledge that these plans were a starting point for development and have therefore taken a pragmatic approach to ensuring operating plans align with area plans. Since October 2016, partnerships have been developing and refining their plans further.

**3.7** Local systems also found it challenging to submit capped expenditure process plans within four weeks. NHS England and NHS Improvement planned to approve these plans by 2 June 2017, but some areas we visited had yet to receive support for some of the more challenging aspects of their plans. The process brought commissioners and trusts together to form joint plans to manage spending. However, local bodies we spoke to felt it has suffered from a lack of transparency and conflicting messages from NHS England and NHS Improvement. NHS Improvement later asserted that submitted plans were at that stage proposals only, and that trusts must not be distracted from delivering their individual savings plans.

## Developing partnerships

**3.8** The partnerships provided the framework for system leaders to come together to think collectively through their local challenges and potential solutions. In the areas we visited, the process has helped facilitate better relationships between constituent organisations. The process has also encouraged openness and transparency in providing financial data. For some areas, this has helped them to identify additional savings. However, areas still face challenges in forming effective partnerships. Those we visited highlighted a particular challenge in maintaining engagement with local authority partners. Similar concerns have been raised in a number of surveys of councillors and council officers. Progress in developing relationships and implementing plans has been variable across the partnerships, as shown in NHS England's and NHS Improvement's assessments of system performance in July 2017. Initially intended to be published in November 2016, the baseline assessment combines 17 indicators into a total score, rating partnerships from outstanding (1) to needs most improvement (4) (**Figure 16**).

**3.9** Since forming, these partnerships have been refining how they will make and approve decisions locally, and are at different stages in establishing effective governance arrangements. Many partnerships have set up groups of organisations below the partnership level to carry out more local programmes of work. The partnerships we visited that were most developed had a clearer idea of what decisions would be made for the overall system and what decisions would be made for smaller areas. They had also created mechanisms, typically joint committees or committees-in-common, by which these decisions could be delegated to single decision-making forums, as many felt hampered by the number of organisations that needed to approve decisions. In some areas, clinical commissioning groups were in the process of formally merging, to better align their decision-making with the work of their partnership. However, many partnerships have a lot to do to establish effective governance arrangements and realise their plans. NHS England and NHS Improvement have not prescribed a particular way that decisions should be made locally, but have shared emerging good practice from across the partnerships in June 2017.

## Leadership and capacity

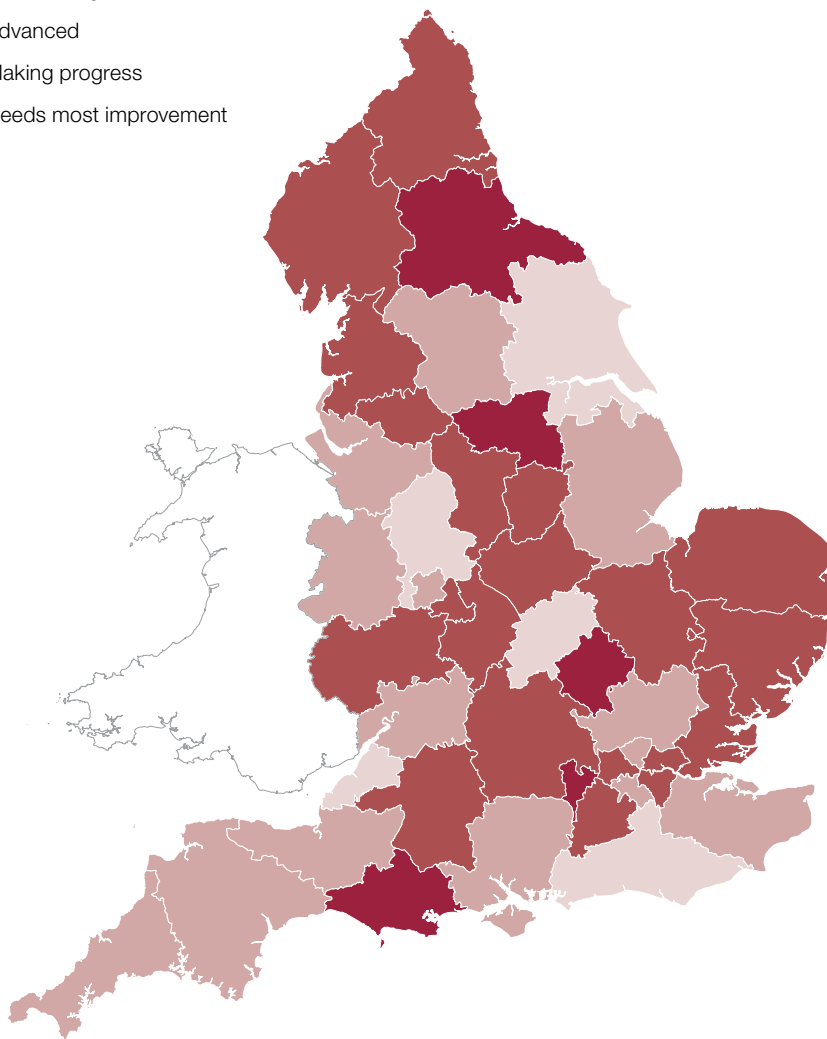
**3.10** As the new partnerships are not statutory bodies with formal accountabilities, they need stable leadership to bring the local system together and facilitate collaboration. In March 2016, NHS England confirmed the system leaders for 41 of the 44 partnerships. These leaders were typically chief executives or chief officers from a local trust, clinical commissioning group or local authority. By September 2017, the three vacancies had been filled, but 17 partnerships now had different leaders in post. Stakeholders told us that progress had been disrupted where system leaders had changed. In some partnerships, NHS England and NHS Improvement were involved in the local recruitment process and advised on their preferred choice of system leader. NHS England and NHS Improvement are supporting system leaders through leadership development, regional events and an expert panel to explore and solve problems.

**Figure 16**

Baseline assessment of partnerships' progress, July 2017

NHS England and NHS Improvement rated each partnership from outstanding to needs most improvement

- Category 1 – Outstanding
- Category 2 – Advanced
- Category 3 – Making progress
- Category 4 – Needs most improvement



Source: NHS England

**3.11** Initially, system leaders and staff had been voluntarily contributing time from their day jobs to help develop plans and manage the partnership's work programme. Gradually partnerships have built up more dedicated programme management offices. For 2017-18, NHS England contributed £11 million towards running costs, an average of £256,000 per partnership.<sup>23</sup> In some areas, NHS England has seconded members of its regional teams to partnerships to enhance their capacity. NHS England has also been supporting partnerships with their communication and public engagement plans. Given the scale of the work needed, partnerships told us they were struggling to find the resources to further develop and implement their plans, with particular gaps in capacity in estates and systems analysis.

## Challenges

**3.12** Most of the plans rely on transforming services to move more care out of hospital and into the community. Built into plans are significant reductions in hospital activity. For example, clinical commissioning groups' plans for 2017-18 and 2018-19 expect non-elective admissions to fall by an average of 0.2% a year, compared with actual growth between 2014-15 and 2016-17 of 2.2% a year. Additional funding announced in the government's 2017 Autumn Budget means that local plans may not need such a significant reduction in activity to achieve financial balance. Plans are based on a greater role for primary, community and mental health services. However, currently there is limited evidence to suggest that these changes will achieve the level of savings required.<sup>24</sup>

**3.13** While partnerships were making progress, our visits highlighted a number of challenges that they face in trying to deliver their plans (**Figure 17**), many of which have been highlighted by other stakeholders.<sup>25</sup> Key challenges include funding, aligned incentives and improved regulatory processes.

## Funding

**3.14** Transformation takes time and requires funding, to cover both new and existing services while pathways are in transition and to cover any capital costs involved. Between 2013-14 and 2016-17, the NHS spent an average of £3.3 billion a year on capital. In March 2017, an independent report for the Secretary of State for Health estimated that sustainability and transformation partnerships will require approximately £10 billion in additional capital investment by 2020-21 to achieve their plans: £5 billion to address a backlog of maintenance work and £5 billion for transformation.<sup>26</sup> Partnerships' plans indicate an additional capital requirement between 2017-18 and 2020-21 that is broadly in line with this independent estimate.

23 Due to devolution arrangements, Greater Manchester did not receive a share of this funding.

24 For example: Nuffield Trust, *Shifting the balance of care: Great expectations*, March 2017.

25 For example: Healthcare Financial Management Association, *HFMA briefing: Sustainability and transformation partnerships – developing robust governance arrangements*, October 2017.

26 Sir Robert Naylor, *NHS Property and Estates: Why the estate matters for patients*, March 2017.

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**Figure 17**

## Challenges facing local partnerships

**Key challenges include funding, system incentives and regulatory processes****Resources**

**Funding:** a shortage of additional central funding for transformation could limit what partnerships can achieve. The tight financial position of most partners makes it difficult to release any funds locally.

**Programme capacity:** partnerships outlined a lack of capacity among leaders and stakeholders to implement plans. They said they were unable to free up sufficient time from their day jobs.

**Workforce challenges:** local areas face shortages of key staff groups, including GPs and care workers, that are pivotal to new ways of providing services.

**Partnership working**

**NHS and local government:** while some progress has been made, there remains a huge challenge in reconciling the culture and processes of local government and NHS partners.

**Short-term pressures:** the need for individual organisations to achieve financial balance and/or secure Sustainability and Transformation Fund payments encourages competitive, self-interested behaviour.

**Engagement:** the pace and scale of changes makes it difficult for partnerships to effectively consult and engage with clinicians, patients and the public.

**System incentives:** partnerships told us that the different ways in which partners are funded and paid are not complementary and do not encourage system-wide efforts to reduce demand.

**Decision-making:** partnerships' ability to make decisions quickly and efficiently is hampered by complex governance structures comprising multiple autonomous organisations.

**Regulation**

**Reporting:** the new requirement to present plans, performance and progress at a system level has added an extra level of reporting, and has increased the demands on system leaders' time.

**Statutory responsibilities:** partnerships are not statutory bodies supported by a legislative framework, and so regulation defaults to individual organisations and their legal duties, rather than any wider system-working.

Source: National Audit Office

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**3.15** Only a fraction of this capital need has been met to date:

- In March 2017, the government announced that an extra £325 million of capital would be available between 2017-18 and 2019-20 for the most advanced sustainability and transformation partnerships. In May, NHS England and NHS Improvement, on behalf of the Department of Health and Social Care (the Department), received 144 bids totalling £2.5 billion and have selected 25 schemes to receive this money, covering 15 partnerships. Those with bids not accepted, including partnerships making the slowest progress, have had to wait until the government made further capital monies available before their bids were considered again.
- In March 2017, the government also announced an additional £100 million in capital to support facilities at emergency departments for general practitioners. NHS England has directed this funding to those trusts with the greatest challenge in creating these facilities.
- In November 2017, the government announced an extra £3.5 billion of capital investment for estates transformation and improvement schemes over the next four years, including £2.6 billion to help partnerships deliver transformation plans. The government hopes this will allow the NHS to generate at least a further £3.3 billion from the sale of surplus land and buildings. The government has announced the first 8% of capital funding to 12 of the highest-quality schemes.
- Between 2015-16 and 2019-20, NHS England is investing £1 billion in general practice infrastructure, including facilities and technology.

**3.16** From 2017-18, NHS England plans to target separate transformation funding for mental health, cancer, diabetes and technology (totalling £808 million), at those partnerships making the most progress. NHS England is providing early accountable care systems with an allocated pot of transformation funding rather than requiring them to bid for separate streams attached to particular priorities.

### Aligned incentives

**3.17** The partnerships we visited told us that the current national tariff payment system does not help them achieve their strategic aims of reducing hospital activity and sharing financial risk, and that they were exploring alternative payment systems. Block contracts and risk-sharing arrangements increased from 29% of the total value of contracts in 2016-17 to 37% in 2017-18. However, incentives are not always aligned for each trust. In 2017-18, 41% of trusts held different types of contracts with clinical commissioning groups in the same footprint area. In addition, commissioners have been given conflicting messages on the current payment system, with NHS England giving commissioners a clear steer to explore other payment systems to help manage demand, while NHS Improvement has encouraged trusts to use payment by results to maximise their income.

**3.18** To encourage local systems to share financial risk, NHS England and NHS Improvement are encouraging partnerships to work towards a shared system control total. In principle, organisations within the same system will be able to adjust their financial control totals to reflect relative pressures and performance, as long as they meet an aggregate control total. From 2017-18, clinical commissioning groups in London have been operating under a commissioner control total within each partnership, and the early accountable care systems have been exploring how this might work in practice across commissioners and trusts. However, some partnerships we spoke to outlined the challenge of making these work in a challenging financial environment.

**3.19** Partnerships, and their member organisations, face a tension between achieving short-term in-year financial balance and making progress on long-term transformation. **Figure 18** on pages 46 and 47 shows the challenge that some partnerships face in making their planned in-year savings, before they have even made any additional effort to reduce spending in the long term. For 28 of 44 footprints, planned savings in 2017-18 are in excess of savings achieved in 2016-17 for both the commissioner and trust sectors. While developing preventative services was a strong feature of all the plans we examined, most partnerships we visited noted that they had made insufficient progress so far. Their need to make short-term immediate savings meant they were often overlooking investment in preventative services.

## Regulation

**3.20** There is a tension between NHS England, which is accountable for the performance of clinical commissioning groups, and NHS Improvement, which is accountable for the performance of trusts. To reduce this tension the two organisations are working more closely to oversee and support partnerships. Local partnerships and organisations that we visited noted that they now seem more aligned. Examples include:

- a number of key posts, including regional directors shared between NHS England and NHS Improvement;
- a single point of contact across the two organisations for the first accountable care systems; and
- establishing a joint programme board coordination unit and regional programme management offices to track and oversee delivery across the partnerships.

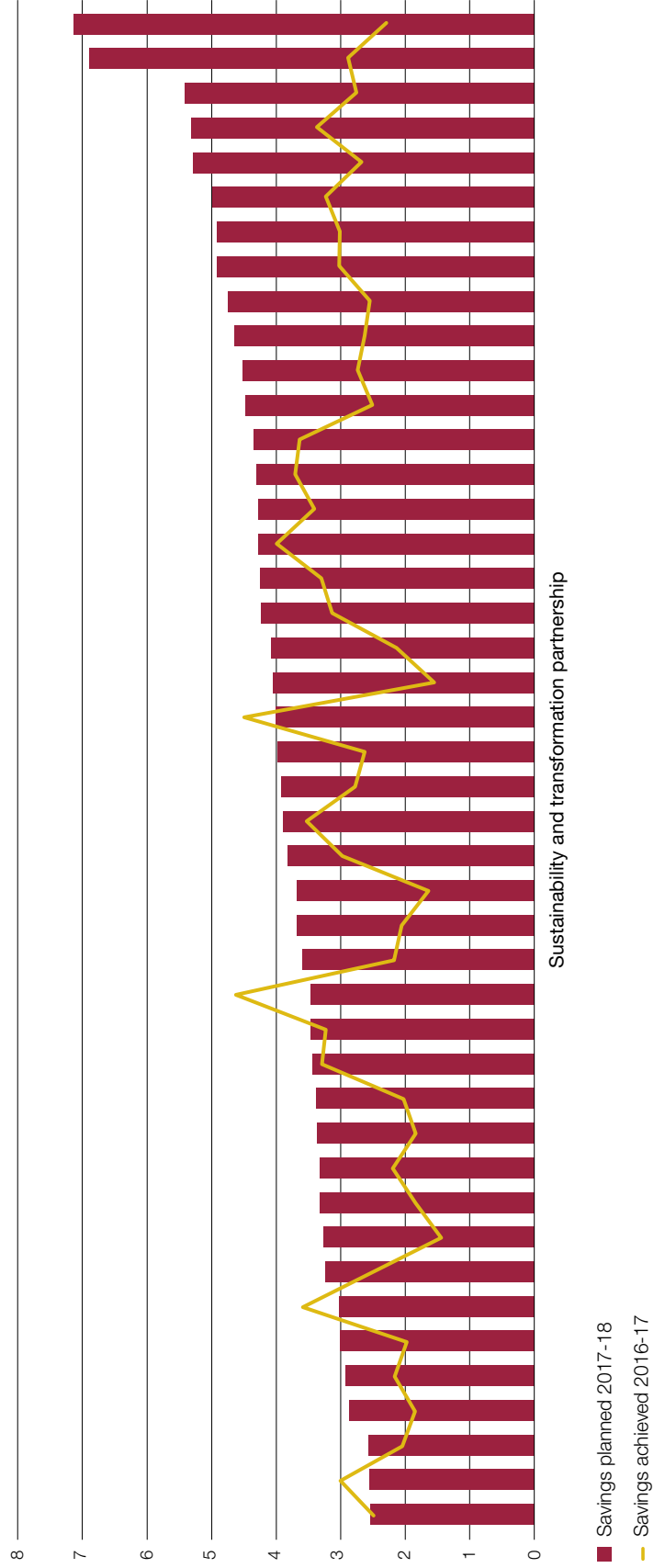
**3.21** Completing the plans, performance returns and progress reports required by NHS England and NHS Improvement uses considerable management capacity. Partnerships cited issues that potentially took capacity away from transformation work, such as the number of returns these organisations require, the size and frequency of these returns and duplicated efforts to complete similar returns for different regulatory teams.

**Figure 18** Clinical commissioning group and trust savings by sustainability and transformation partnership, 2016-17 and 2017-18

Planned savings in 2017-18 far exceed those achieved in 2016-17 in a number of partnerships

**Clinical commissioning group savings**

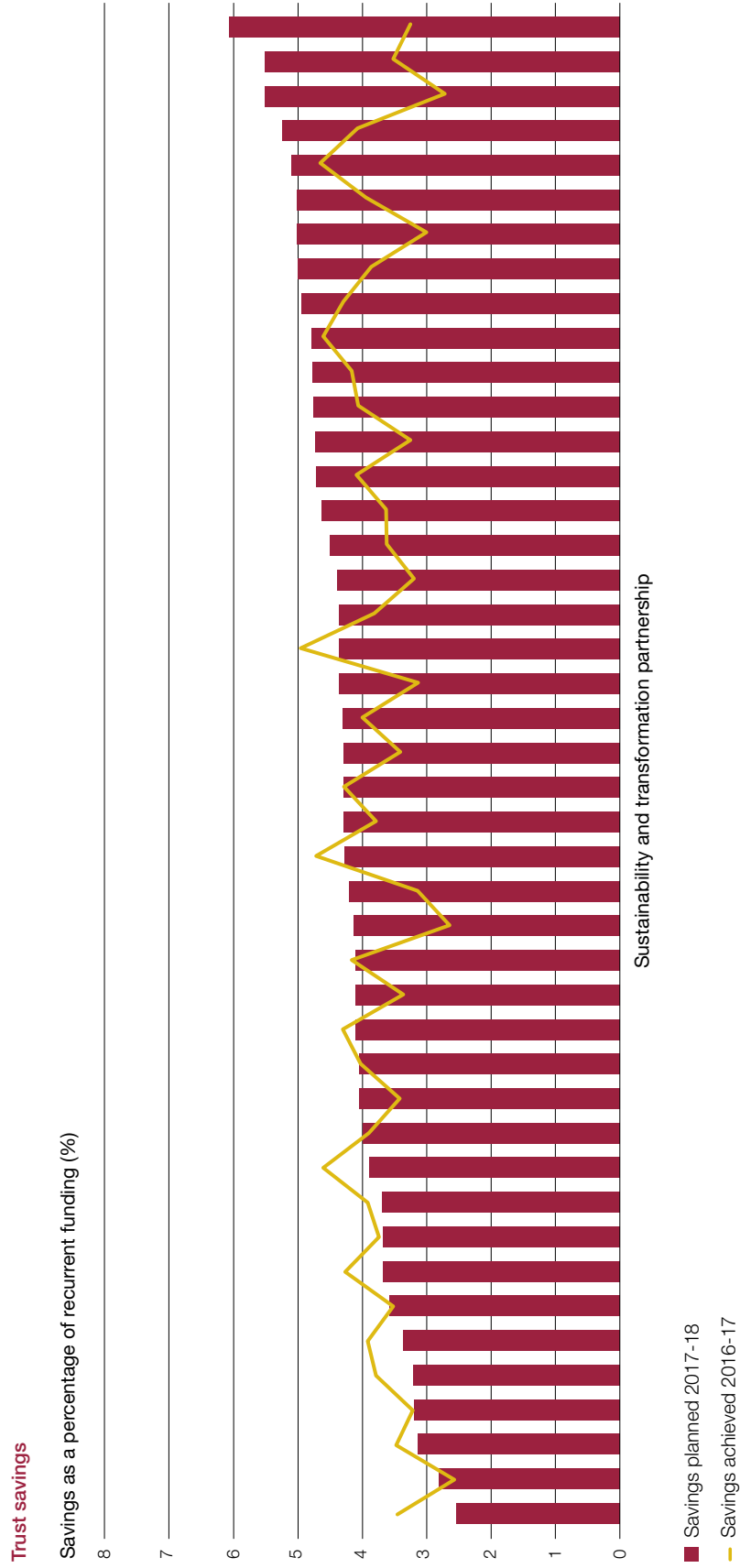
Savings as a percentage of recurrent funding (%)





**Figure 18 continued**  
 Clinical commissioning group and trust savings by sustainability and transformation partnership, 2016-17 and 2017-18

Planned savings in 2017-18 far exceed those achieved in 2016-17 in a number of partnerships



**Note**

1 For clinical commissioning groups, the savings percentage for each footprint has been calculated as the total quality, innovation, productivity and prevention savings (planned or achieved) divided by the total recurrent allocations for 2015-16 and 2016-17 for the groups within the footprint. For trusts, it is the total cost improvement programme savings (planned or achieved) divided by the total spending by the trusts within the footprint.

Source: National Audit Office analysis of NHS England and NHS Improvement data

# Appendix One

## Our audit approach

**1** This report examines the progress the Department of Health and Social Care (the Department), NHS England and NHS Improvement have made towards achieving financial balance. We reviewed:

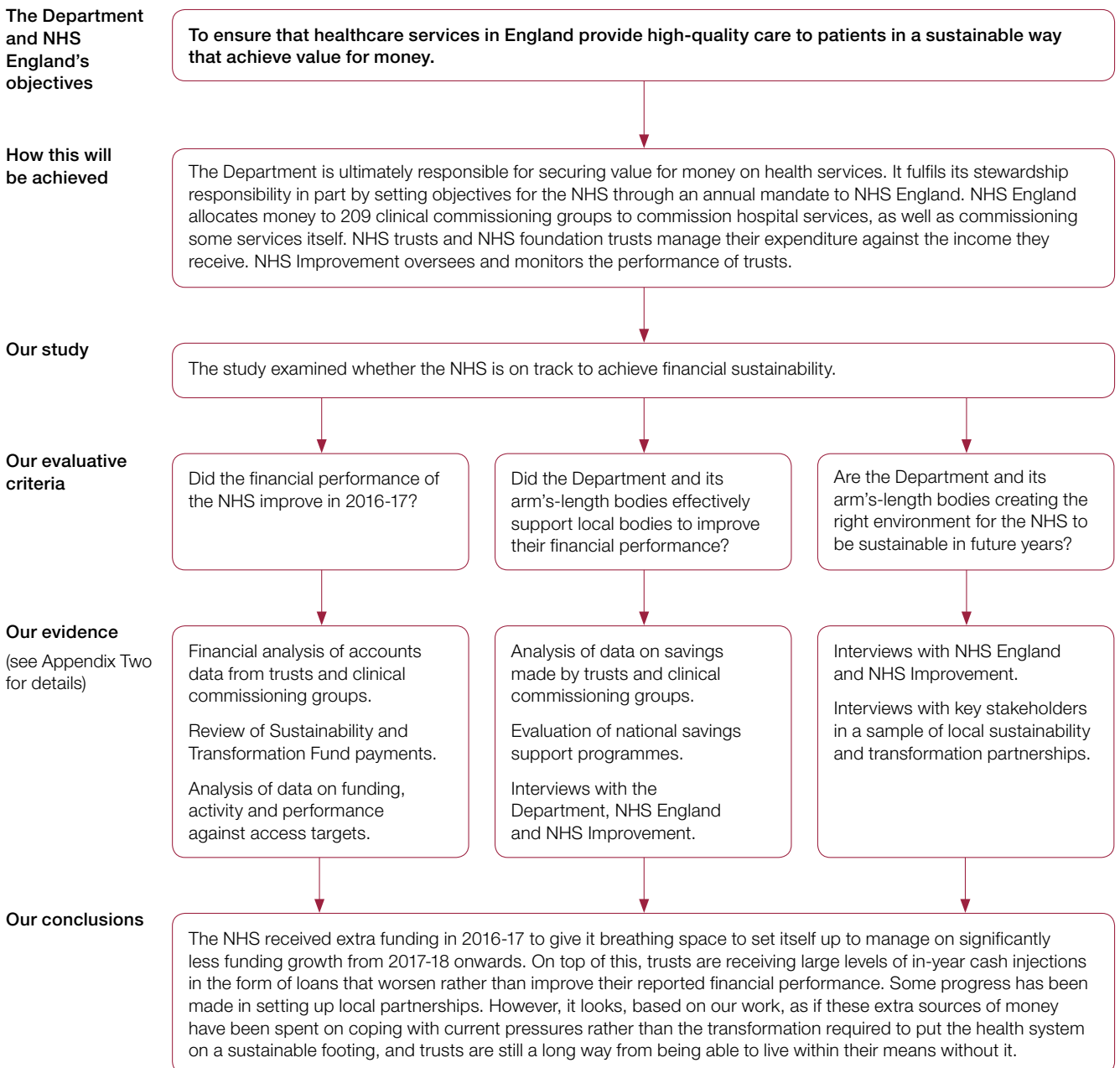
- the headline financial performance of the NHS overall;
- how the Department, NHS England and NHS Improvement have supported local commissioners and trusts to make savings and efficiencies; and
- the support they have given to help local NHS bodies work better in partnership.

**2** In reviewing these issues, we applied an analytical framework with evaluative criteria that consider what arrangements would be optimal for moving the NHS towards financial sustainability. By 'optimal', we mean the most desirable possible, while acknowledging expressed or implied constraints. A constraint in this context is the funding settlement to the Department.

**3** Our audit approach is summarised in **Figure 19**. Our evidence base is described in Appendix Two.

**Figure 19**

## Our audit approach



# Appendix Two

## Our evidence base

**1** We reached our independent conclusions on whether the NHS is on track to achieve financial sustainability after analysing evidence we collected between June and October 2017. Our audit approach is outlined in Appendix One.

**2 We analysed financial and performance data. Financial data came from NHS accounts and data provided by the Department of Health and Social Care (the Department), NHS England and NHS Improvement.** Data analysis included:

- the overall financial position of the NHS in 2016-17;
- a time series analysis of clinical commissioning groups' finances against their planned and actual year-end positions;
- a time series analysis of the financial position of NHS trusts and NHS foundation trusts against surplus/deficit, income, current assets and current liabilities;
- additional financial support compared with 2015-16;
- a time series analysis of NHS activity; and
- a time series analysis of performance against key access targets.

**3 We compared existing financial data on trusts with performance against access targets.** We compared the average financial performance across trusts in 2016-17 with rates of compliance with access standards for accident and emergency, cancer treatment and routine, non-urgent referrals.

**4 We carried out a review of the Sustainability and Transformation Fund in 2016-17.** We assessed:

- the outcomes of the Fund against NHS England and NHS Improvement's stated objectives;
- the distribution of core, incentive and bonus payments to trusts; and
- the impact on trusts' financial positions at the end of the year.

**5 We evaluated the national support programmes that NHS England and NHS Improvement have put in place to help local bodies deliver savings.** We reviewed:

- data on costs and outcomes from each programme, where available;
- planned and achieved financial savings; and
- support, guidance and best practice shared with local bodies.

**6 We analysed data on quality, innovation, productivity and prevention savings made by clinical commissioning groups and cost improvement programme savings made by trusts.** This included:

- trends in achieved savings against planned savings between 2013-14 and 2016-17, and planned savings for 2017-18;
- levels of recurrent and non-recurrent savings and, for trusts, levels of generated income; and
- analysis of savings achieved and planned across sustainability and transformation partnership areas.

**7 We spoke to a range of staff across the Department, NHS England and NHS Improvement.** This was to understand the support that they have given to local bodies to make savings and financial improvements, and the support they are giving to sustainability and transformation partnerships. We spoke to representatives covering topics including capital, financial special measures, the financial improvement programme, new model of care vanguards, urgent and emergency care, RightCare and operational productivity. We also spoke to a selection of staff from NHS England and NHS Improvement's regional offices.

**8 We interviewed and/or consulted a range of stakeholders.** This work was designed to obtain views on: financial pressures and challenges within the NHS; oversight and control by the national bodies; and support given to local bodies and systems. We consulted with the British Medical Association, the Chartered Institute of Public Finance and Accountancy, the Healthcare Financial Management Association, the Health Foundation, The King's Fund, the Local Government Association, NHS Clinical Commissioners, NHS Providers, the Nuffield Trust and the Royal College of Surgeons.

**9 We conducted interviews at a sample of six sustainability and transformation partnerships in August and September 2017.** This work was designed to understand:

- progress in implementing plans to transform services;
- the challenges faced by local systems in building effective partnerships; and
- the support provided by national bodies to tackle these challenges.

We selected our sample of six sustainability and transformation partnerships by considering the following factors:

- a diverse range of relative progress as assessed by NHS England's July 2017 ratings, including two early accountable care systems and three that were part of the capped expenditure process;
- a broad geographic spread across England;
- a range of rural and non-rural partnerships; and
- a range of leaders, including where the partnership lead was from a trust, clinical commissioning group or local authority.

Overall, we met with 79 individuals representing 56 different organisations.

# Appendix Three

## Technical notes

1 In preparing and analysing the data used throughout the report, we have made a number of assumptions and adjustments.

2 Information on NHS trusts and NHS foundation trusts may differ from that reported by NHS Improvement due to the way we have treated trusts that changed their status in-year.

### **Presentation of figures**

3 Except where otherwise noted, figures are presented in nominal terms and have not been adjusted for inflation.

4 Where possible, income and expenditure figures are presented on a basis that is consistent with the underlying trusts' published accounts.

5 Income figures for both NHS trusts and NHS foundation trusts include:

- income from patient care activities; and
- other operating income (including income from the Sustainability and Transformation Fund, training activities, rental income and income from other miscellaneous sources).

6 Expenditure figures for both NHS trusts and NHS foundation trusts include:

- staff costs, except those capitalised as part of the costs of non-current assets;
- operating costs, including purchase of healthcare services from other organisations, expenditure on medical supplies including drugs and other consumables, and transport costs;
- premises costs, including depreciation and amortisation and support services;
- net interest and other finance costs;
- public dividend capital dividends payable;

- other gains and losses, including share of profit or loss of associates and joint arrangements, gains and losses on disposals of assets, and other movements in fair values of assets;
- corporation tax expenses; and
- premiums payable for clinical negligence liabilities.

7 NHS trusts' and NHS foundation trusts' income and expenditure figures have also been adjusted for the effects of organisational changes, to report underlying performance by excluding the effects of one-off transactions, as well as for changes in discount rate, to reflect the impact on trusts which could not have been planned at the start of the year.

### **Adjusting for the effects of organisational changes during 2016-17**

8 This report refers to 154 NHS foundation trusts in existence on 31 March 2017. This figure excludes Mid Staffordshire NHS Foundation Trust, which ceased to provide services on 1 November 2014. Mid Staffordshire NHS Foundation Trust recorded a deficit of £108,000 in 2016-17. The costs relate to the payment of historic liabilities and the overhead costs of the shell company. Our analysis throughout the report does not include any balances relating to Mid Staffordshire NHS Foundation Trust in 2016-17.

9 Two NHS trusts became NHS foundation trusts in 2016-17:

- Mersey Care NHS Trust on 1 May 2016; and
- Wirral Community NHS Trust on 1 May 2016.

10 We have treated these trusts in the totals for NHS foundation trusts. This has the effect of treating them as though they had been a foundation trust all year.

11 Three mergers between trusts occurred in 2016-17:

- Calderstones Partnership NHS Foundation Trust was taken over by Mersey Care NHS Foundation Trust on 1 July 2016;
- Manchester Mental Health and Social Care Trust was taken over by Greater Manchester Mental Health NHS Foundation Trust on 1 January 2017; and
- Birmingham Women's NHS Foundation Trust was taken over by Birmingham Children's Hospital NHS Foundation Trust on 1 February 2017, at which point the trust was renamed Birmingham Women's and Children's NHS Foundation Trust.

12 For all these mergers of trusts, we have totalled the former trusts' income, expenditure and surplus/deficit arising between 1 April 2016 and the date of merger and added it to the income, expenditure and surplus/deficit of the post-transaction trust. This has the effect of treating the merger as if it had occurred on 1 April 2016.



## Adjustments to NHS trusts' figures

**13** NHS trusts' figures are adjusted to report the underlying performance of trusts by excluding the effects of one-off transactions, and to be consistent with figures used by the Department of Health and Social Care (the Department). Figures for NHS trusts' income, expenditure and surplus/deficit are reported:

- before net impairments;
- before the impact of absorption, accounting for bodies that merged or were acquired by other organisations;
- before additional charges associated with bringing private finance initiative (PFI) assets onto the balance sheet due to the introduction of International Financial Report Standards accounting in 2009-10 (IFRIC 12);
- before the impact of changes in accounting for donated assets and government grant reserves;
- before the consolidation of trusts' charitable fund subsidiaries; and
- after the effects of any income support provided by the Department and NHS England.

**14** All figures are presented on a gross basis; no adjustments are made to remove the effects of transactions between NHS trusts and NHS foundation trusts.

## Adjustments to NHS foundation trusts' figures

**15** NHS foundation trusts' figures are adjusted to report the underlying performance of trusts by excluding the effects of one-off transactions, and to be consistent with figures used by the Department and to be on the same basis as NHS Improvement reports them in the NHS Foundation Trusts: Consolidated Accounts. Income, expenditure and surplus/deficits for NHS foundation trusts are reported:

- before net impairments;
- before the impact of absorption accounting for bodies that merged or were acquired by other organisations;
- after additional charges associated with bringing PFI assets onto the balance sheet due to the introduction of IFRS accounting in 2009-10 (IFRIC 12);
- after the impact of changes in accounting for donated assets and government grant reserves;
- before the consolidation of trusts' charitable fund subsidiaries; and
- after the effects of any income support provided by the Department and NHS England.

**16** All figures are presented on a gross basis; no adjustments are made to remove the effects of transactions between NHS trusts and NHS foundation trusts.



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