National Audit Office

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

HC 191
SESSION 2012-13

5 JULY 2012

Department of Health

Securing the future financial sustainability of the NHS

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National Audit Office

Department of Health

Securing the future financial sustainability of the NHS

Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 4 July 2012

This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

Amyas Morse
Comptroller and Auditor General
National Audit Office

3 July 2012

HC 191 London: The Stationery Office £16.00

This report looks at the financial sustainability of NHS commissioners, and the NHS trusts and NHS foundation trusts that provide community, secondary and tertiary health care services.

Printed in the UK for the Stationery Office Limited on behalf of the Controller of Her Majesty's Stationery Office

2500871 07/12 PRCS

Contents

Key facts 4

Summary 5

Part One
Indicators of the financial health of the NHS 14

Part Two
Financial support to providers and commissioners 23

Part Three
Risks to the future financial sustainability of local health economies 32

Appendix One
Methodology 41

An additional methodology paper can be found on our website at www.nao.org.uk/nhs-sustainability-2012

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This report can be found on the National Audit Office website at www.nao.org.uk/nhs-sustainability-2012

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Key facts

£2.1bn

total surplus in SHAs, PCTs, NHS foundation trusts and NHS trusts in 2011-12

£1bn

cash given to NHS trusts and NHS foundation trusts in the form of public dividend capital between 2006-07 and 2011-12

34

the total number of NHS trusts (10), NHS foundation trusts (21) and PCTs (3) which reported a deficit in 2011-12

£1.6 billion	total net surplus reported by SHAs and PCTs
£444 million	total net surplus among NHS foundation trusts, including trusts which achieved foundation status during the year
21	NHS foundation trusts in deficit in 2011-12
122	NHS foundation trusts in surplus in 2011-12
£40 million	total net surplus of NHS trusts
10	NHS trusts in deficit in 2011-12
97	NHS trusts in surplus in 2011-12

Summary

1 Between 2011-12 and 2014-15 there will be very little real terms growth in spending on the NHS. The NHS must make up to £20 billion efficiency savings to meet the forecast growth in demand for health services over this period. NHS trusts and NHS foundation trusts face downward pressure on their income with 4 per cent efficiencies built into national tariffs and financial penalties if they do not meet performance standards.

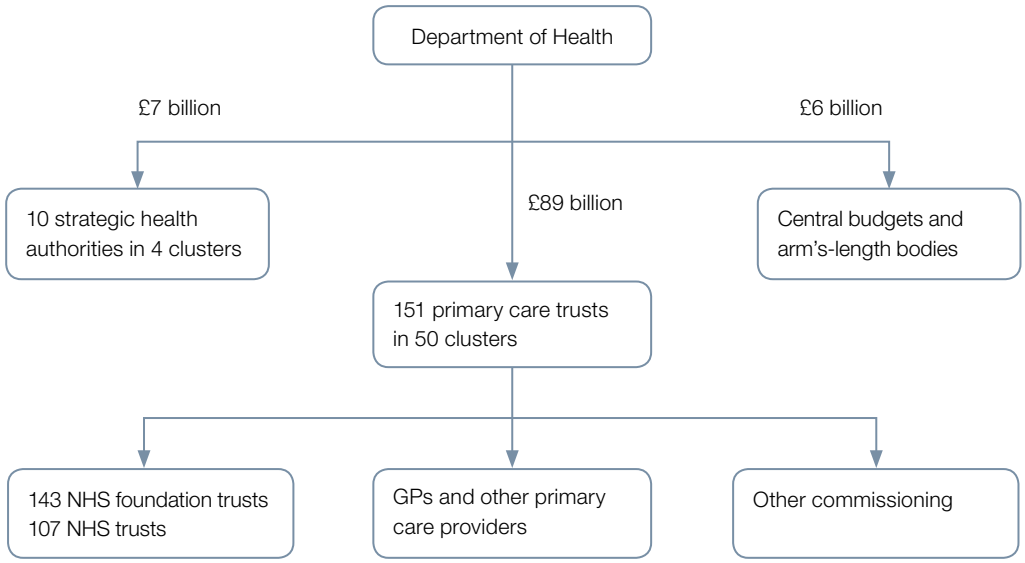
2 **Figure 1** overleaf shows, in a simplified way, how the Department of Health (the Department) funds primary care trusts (PCTs) in England to commission health care services from GPs, hospitals and other providers for their local populations. In 2011-12, as part of the transitional arrangements to implement the Health and Social Care Act 2012, the Department grouped 151 PCTs in England into 50 clusters. There are ten strategic health authorities (SHAs), grouped into four clusters, which performance manage PCTs for the Department. As at 31 March 2012, most tertiary, secondary and community services are provided through 107 NHS trusts and 143 NHS foundation trusts. SHAs also performance manage NHS trusts, while Monitor, an independent regulator, oversees NHS foundation trusts.

3 Implementing measures introduced by the Health and Social Care Act will mean substantial changes to how NHS services are commissioned. PCT clusters managed up to 90 per cent of the NHS revenue budget in 2011-12. Newly created clinical commissioning groups will have their own budgets from 2013-14. From that point the clinical commissioning groups will take over many of the PCTs' commissioning responsibilities. The NHS Commissioning Board will become responsible for commissioning all primary care, overseeing clinical commissioning groups and commissioning specialist services. PCTs and SHAs will cease to exist.

4 This report looks at the financial sustainability of NHS commissioners, and the NHS trusts and NHS foundation trusts that provide community, secondary and tertiary health care services. If NHS organisations are financially unsustainable this could impact on service delivery and quality. The indicators we used were whether NHS bodies achieved surplus or deficit, what financial support they needed, and measures of debt and liquidity. We examined trends in performance and actions that bodies in the most challenged health economies have taken to address financial difficulties as a way of assessing risks to their future financial sustainability. We have identified risks likely to impact on NHS bodies, but have not made detailed projections of the likely future performance of NHS bodies.

Figure 1
Funding for the NHS in England

The Department of Health funds PCTs to commission healthcare services from GPs, hospitals and other providers



NOTES

1 Figures shown are based on 2011-12 plan and rounded to the nearest £ billion.

2 At the start of the financial year there were 115 NHS trusts and 137 NHS foundation trusts. At 31 March 2012 there were 107 NHS trusts and 143 NHS foundation trusts.

Source: Department of Health

5 In the medium to long term, achieving financially sustainable health care for local communities is likely to mean changes to where, and how, people access services. Some local commissioners and providers are already developing and consulting on plans to do this. It is important that assumptions about the financial sustainability of providers and commissioners which NHS organisations build into their financial plans take full account of the impact of any financial support received in the past.

Key findings

Indicators of the financial health of the NHS

6 SHAs, PCTs, NHS trusts and NHS foundation trusts reported a combined overall surplus of £2.1 billion in 2011-12. The total revenue allocation for the NHS for 2011-12 was £102 billion. The allocation to SHAs and PCTs for them to commission services was £96 billion.

7 There is a large gap between the strongest and weakest organisations in the NHS. Within the overall surplus there is some financial distress, particularly in a number of provider organisations. This is particularly marked in London. Two trusts, South London Healthcare NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust, reported a combined deficit of £115 million. The Royal Marsden NHS Foundation Trust reported a surplus of £20 million. **Figure 2** shows that there were 377 NHS bodies which reported a surplus in 2011-12, and 34 in deficit.

8 In 2011-12 SHAs collectively reported a surplus of £1.06 billion, 51 per cent of the total NHS surplus. Some SHAs have proportionately much higher surpluses than others. The total net surplus for all PCTs rose from £476 million in 2010-11 to £523 million in 2011-12. Of all PCTs, 148 out of 151 reported a surplus in 2011-12. The three that did not are parts of the NHS North Central London cluster, which had a combined deficit of £49 million.

Figure 2
Surpluses and deficits reported by NHS bodies in 2011-12

There were 377 NHS bodies which reported a surplus, and 34 in deficit

	In (deficit)		In surplus		Total	
	Number	(£m)	Number	(£m)	Number	(£m)
Strategic health authorities	0	–	10	1,061	10	1,061
Primary care trusts	3	(49)	148	571	151	523
NHS foundation trusts	21	(130)	116	558	137	428
NHS trusts	10	(177)	97	217	107	40
NHS trusts that became NHS foundation trusts part way through the year	0	–	6	16	6	16
Total	**34**	**(356)**	**377**	**2,424**	**411**	**2,068**

NOTES

1 Six NHS trusts became foundation trusts in the course of the 2011-12 financial year. We have included The Hillingdon Hospitals NHS Foundation Trust, which achieved foundation status on 1 April 2011, in figures for NHS foundation trusts for the whole year. The £16 million surplus shown is reported by the Department as £5 million for the period in which they were NHS trusts, and by Monitor as £11 million for the period in which they were NHS foundation trusts.

2 Totals may not sum due to rounding.

3 Limitations in the data mean that figures for NHS trusts and NHS foundation trusts have to be calculated in slightly different ways. The methodology appendix explains how we have calculated these figures.

Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health

9 In 2011-12, NHS foundation trusts reported an average surplus of £3.1 million, compared with £2.9 million in 2010-11. NHS foundation trusts, as self-governing institutions, do not have a statutory duty to make a specific surplus in any single year. In 2011-12, 21 NHS foundation trusts finished the year in deficit, an increase from 19 in 2010-11, and had a combined deficit of £130 million. At the end of the year, NHS foundation trusts taken together had a total of £4.0 billion of cash and cash equivalents, £2.2 billion other current assets, and £4.7 billion current liabilities, altogether representing total net current assets of £1.5 billion. Case examples in this study, such as Peterborough and Stamford NHS Foundation Trust, however, show that some NHS foundation trusts are also facing severe challenges.

10 There is a small group of NHS trusts in long-term financial difficulty. By the end of 2011-12, ten trusts reported a combined deficit totalling £177 million, compared with the total £217 million surplus reported by the other 97 trusts.

Financial support given to commissioners and providers

11 The vast majority of PCTs, NHS trusts and NHS foundation trusts reported a surplus in 2011-12. Among those, 51 of the NHS trusts and NHS foundation trusts reported a surplus of less than £1 million. Any assessment of the underlying financial sustainability of the NHS, however, must also recognise that SHAs and PCTs agreed non-recurrent funding to some trusts: direct financial support to increase income; and other non-recurrent funding, including support for transitional costs or business changes. In addition, the Department provided injections of cash to some trusts, in the form of public dividend capital, to strengthen the balance sheet, provide working capital or cover cash shortages resulting from deficits. All financial support is intended to help maintain services for patients, and is conditional on plans for recovery to a more sustainable position.

Direct financial support

12 Without direct financial help some NHS trusts, NHS foundation trusts, and PCTs may not have broken even, would have reported larger deficits, or had smaller surpluses. Had this support not been made available, some of those organisations may have been able to reduce their expenditure further. We estimate that SHAs and PCTs provided £151 million in additional revenue to NHS trusts and £10 million to NHS foundation trusts. **Figure 3** shows that, without 'one-off' direct support, an additional 15 NHS trusts may have posted deficits in 2011-12. We also identified seven PCTs that may have reported a deficit had they not received additional resource allocations directly from their SHA, or benefitted from reallocations between PCTs within the same cluster, totalling £89 million.

Figure 3
Financial support to PCTs, NHS foundation trusts and NHS trusts

Without 'one-off' direct support, an additional 15 NHS trusts may have posted deficits in 2011-12

Change in financial position excluding the effect of direct financial support	Number of bodies which may have moved from surplus to deficit (number)	Potential increase in deficit (£m)	Potential reduction in surplus (£m)
Primary care trusts	7	(82)	(7)
NHS foundation trusts	0	(6)	(4)
NHS trusts	15	(132)	(19)
NHS trusts that became NHS foundation trusts partway through the year	0	0	0
Total	**22**	**(221)**	**(30)**

NOTE
1 Totals may not sum due to rounding.

Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health, and information provided to the National Audit Office by strategic health authorities and primary care trusts

Other non-recurrent funding

13 It is difficult to identify the full extent of one-off funding PCTs are giving NHS trusts and NHS foundation trusts. We found that SHAs were aware of most, but not all, of these agreements. To identify the nature and extent of non-recurrent funding, we undertook a census of PCT clusters. Because this was a census of PCTs, rather than provider trusts, it may be more likely to highlight examples where commissioners may be supporting providers, rather than the other way round, and it relies on commissioners' rather than providers' views of what the purpose of additional funding was.

14 We estimate, based on our census of PCTs, that SHAs and PCTs gave NHS trusts and NHS foundation trusts other non-recurrent funding to help them break even, or cover non-recurrent costs, which in 2011-12 totalled at least £274 million. We cannot identify the extent to which, had commissioners not been able to provide additional funding, trusts could have avoided non-recurrent costs. Facing the same costs, however, without this financial help another 16 NHS trusts and 11 NHS foundation trusts may not have broken even. This sort of funding included:

- funding explicitly to relieve financial pressures, including transitional support (£147 million); and
- funding to help implement business changes (£127 million).

Public dividend capital

15 Four NHS foundation trusts and 17 NHS trusts have received public dividend capital totalling just over £1 billion between 2006-07 and 2011-12, to provide working capital (cash). The Department gives revenue public dividend capital to ensure they have sufficient cash to pay creditors and staff. Public dividend capital is not accounted for as income, so does not affect whether a trust reports a surplus or deficit. South London Healthcare NHS Trust, and its predecessors, have needed a total of £356 million public dividend capital support over the last six years, and not paid any back. Public dividend capital issued to NHS trusts and NHS foundation trusts by the Department in 2011-12 totalled £253 million, a sharp increase from the £76 million public dividend capital paid in 2010-11.

Risks to the future sustainability of local health economies

16 The relationships that commissioners and SHAs have with providers in need of financial support, and the level of support offered, vary across the country. Some PCTs have had limited ability to support providers because of pressure on their own financial resources.

17 Only two PCTs now have historic debt from overspending in previous years. The total amount of outstanding debt at the end of March 2012, for these two commissioners, was £21 million. The Department expects existing PCT clusters to have cleared all legacy debts during 2011-12 and 2012-13, so as not to pass liabilities to the new clinical commissioning groups.

18 NHS foundation trust margins are being squeezed. A key measure of underlying financial performance is the 'earnings before interest, tax, depreciation and amortisation' (EBITDA) margin. The EBITDA margin fell from an average of 7.8 per cent in the first quarter of 2008-09 to 6.1 per cent at the end of 2011-12. Monitor scored three NHS foundation trusts with a financial risk rating of 1 and six with a rating of 2. The average financial risk rating has dropped from 4.1 in the first quarter of 2008-09 to 3.4 in 2011-12.

19 At the end of the 2011-12 financial year, Monitor, the financial regulator of NHS foundation trusts, assessed 11 out of 143 NHS foundation trusts as in significant breach of their terms of authorisation wholly or partly for financial reasons. Monitor scores foundation trusts on a five-point scale, and judges a rating of 3 (or higher) to be the minimum acceptable level of financial performance. This does not map directly on to snapshot financial risk ratings.

20 NHS foundation trusts in difficulty may need the Department to provide working capital because commercial banks withdraw facilities. One of the terms under which commercial banks may provide working capital facilities is that NHS foundation trusts maintain a Monitor risk rating of 3. Trusts rated 1 or 2, however, are likely to be those most in need of cash support.

21 The Department has given working capital loans to NHS trusts and NHS foundation trusts, and as at 31 March 2012 there was £236 million outstanding. Trusts have taken out loans to improve their liquidity, sometimes because of a poor cash position. The Department will only issue loans when it is confident trusts will be able to repay them from future surpluses, and interest is charged on the outstanding balance.

22 Some PCTs have agreed to make advance payment of amounts due to trusts under contracts during the year. Some trusts have needed to do this to help them manage cashflow, and allow them to pay creditors.

23 In addition, PCTs waived fines for providers, for example for failing to achieve acquired infection targets; or made local agreements for the amount paid to providers for emergency admissions and readmissions. The PCTs we spoke to explained that rather than levy penalties, they expected trusts to use the money saved to improve their performance in these areas. Commissioners also agreed payments to reflect increased work where measures to reduce referrals or emergency admissions had not been in place.

24 Among NHS trusts aspiring to NHS foundation trust status there are around 40 trusts that remain on course, but a larger group which are failing to meet milestones and are postponing application dates. At the end of September 2011, there were 19 trusts due to submit their foundation trust application to the Department before the end of 2011-12. At the end of March 2012, ten of these were rated as 'red risk' because of the danger that they will not stay on the forecast trajectory towards foundation trust status. A further nine with later application dates are also 'red risks'. Our report in October last year, *Achievement of foundation trust status by NHS hospital trusts*, showed that at least 20 NHS trusts were not financially sustainable in their current form.

25 It is not yet clear whether clinical commissioning groups and the NHS Commissioning Board will agree to provide financial support to providers, in the way that SHAs and PCTs have done.

26 Of the primary care trust clusters responding to our census, 51 per cent said they were very or quite concerned about the financial sustainability of their providers. The challenges faced by any one trust are determined by local circumstances. PCTs and SHAs that we spoke to highlighted a common set of problems from their perspective:

- Provider trusts will have to achieve higher levels of efficiencies than they have previously managed.
- In the past, some large annual increases in income have allowed provider trusts to stay in surplus by growing income rather than focusing on cost reduction, but the potential to do this is now limited.
- Contractual rules are now making it much more difficult for providers to improve their finances by increasing activity.
- Some hospitals cannot afford private finance initiative commitments, or commitments limit the scope to reduce services. Some trusts will face increased pressure as the amount of tapered private finance initiative support they receive, agreed as part of the original business case, reduces. Based on responses to our census of PCTs, we estimate that this totalled at least £61 million in 2011-12. The Department has announced that six NHS trusts and one NHS foundation trust will receive central support to offset the cost of 'unaffordable' private finance initiative schemes, from 2012-13 onwards.
- Commissioners must improve their financial position and make efficiencies, which reduces their ability to manage the local health economy to support providers (although local policy on this varies).

27 No NHS trust or NHS foundation trust has yet been placed in a 'failure regime'. The Health and Social Care (Community Health and Standards) Act 2003 gave Monitor the power to replace members of NHS foundation trust boards, which it has used on occasion, or dissolve an NHS foundation trust, which it has not. Amendments in the Health Act 2009 created the option for the Secretary of State to appoint a special administrator to take over a failing NHS trust.

Conclusion on value for money

28 Funding for the NHS will not substantially increase, in real terms, over the next three years. The NHS delivered a surplus of £2.1 billion in 2011-12 but within this there is significant variation in financial performance. At the moment some organisations in difficulty have been given additional financial support through both direct financial support and additional non-recurrent funding. It is hard to see that this approach will be a sustainable way of reconciling growing demand with the scale of efficiency gains required within the NHS. Without major change affecting some providers the financial pressure on them will only get more severe.

29 For value for money to be delivered in future, two things are required: first, careful management of the risks created by transition to a new commissioning model; and second, a coherent and transparent financial support mechanism is needed which outlines when trusts should be supported, or allowed to fail.

Recommendations

a **The Department should implement a framework for local health economies to ensure that non-recurrent support to financially weak providers or commissioners is transparent.** This should be incorporated into the standard reporting mechanisms being developed for the new health system. At present, the extent to which PCTs and providers are reliant on one-off financial support, particularly through additional non-recurrent funding, is not always visible.

b **The Department, in line with the new Health and Social Care Act (2012), should publish guidance on assistance to both NHS trusts and NHS foundation trusts around both the provision of non-recurrent support and issuance of public dividend capital.** The Department should also decide when providing public dividend capital to NHS trusts or NHS foundation trusts, in what circumstances, if ever, it will expect repayment.

c **The Department will need to make available additional working capital for NHS trusts in the pipeline if they are all to have sufficient liquidity to become an NHS foundation trust. The Department should also introduce a central working capital fund that NHS foundation trusts can access as an alternative to commercial facilities.** This would reduce the costs that NHS foundation trusts pay for commercial working capital facilities, and prevent NHS foundation trusts from having their working capital facilities withdrawn when they have financial difficulties.

d **The Department should explain how it will ensure the financial stability of local providers should clinical commissioning groups get into financial difficulty.** Clinical commissioning groups will be progressively authorised to take on commissioning responsibilities for NHS trusts and NHS foundation trusts from late 2012. In a few areas they will face a difficult financial situation at both provider and commissioner level.

e **The Department should use, where appropriate, the failure regime measures currently available to it for those NHS trusts in the pipeline that cannot achieve foundation trust status.** Some providers may be too financially weak to be viable as merger partners and other alternatives to long-term financial support need to be found.

f **Monitor should publish detailed guidelines explaining how, in practice, the failure regime for NHS foundation trusts which are not sustainable long term will be activated and executed.** The Health and Social Care Act 2012 introduces a failure regime for NHS foundation trusts, giving Monitor the opportunity to address the small number of NHS foundation trusts that have spent years in significant breach of their terms of authorisation because of their finances.

Part One

Indicators of the financial health of the NHS

How the NHS is funded

1.1 This study looks at the financial sustainability of the NHS commissioners and providers of acute, community and mental health care in England.

1.2 Under current arrangements, primary care trusts (PCTs) commission health care services for their communities with money from the Department of Health (the Department). There are 151 PCTs, grouped into 50 clusters. The Department will abolish PCTs on 31 March 2013, when most commissioning responsibility will transfer to newly created clinical commissioning groups.

1.3 Acute, mental health and community services are provided under contract by:

- NHS foundation trusts, which are accountable to Parliament and overseen by an independent regulator, Monitor. At 31 March 2012 there were 143 NHS foundation trusts. They have a greater level of managerial and financial freedom than NHS trusts; and
- NHS trusts, which are under the direction of the Secretary of State for Health. At 31 March 2012 there were 107 NHS trusts.

1.4 PCTs and NHS trusts are performance managed by ten strategic health authorities (SHAs), grouped into four clusters. Like PCTs, SHAs will be abolished as part of the changes to the health service introduced by the Health and Social Care Act 2012.

1.5 The Government requires all NHS trusts to become NHS foundation trusts, or become part of an existing NHS foundation trust, within timescales agreed by the Department. To do so they must satisfy Monitor that, among other things, they meet key financial criteria which are:

- credibly projecting a sustainable net income surplus by the third year of foundation trust status; and
- achieving a minimum financial risk rating of 3 (out of 5) at authorisation and based on financial projections for the first full year as a foundation trust. The four key criteria for determining this are: achieving the plan; underlying performance; financial efficiency; and liquidity.

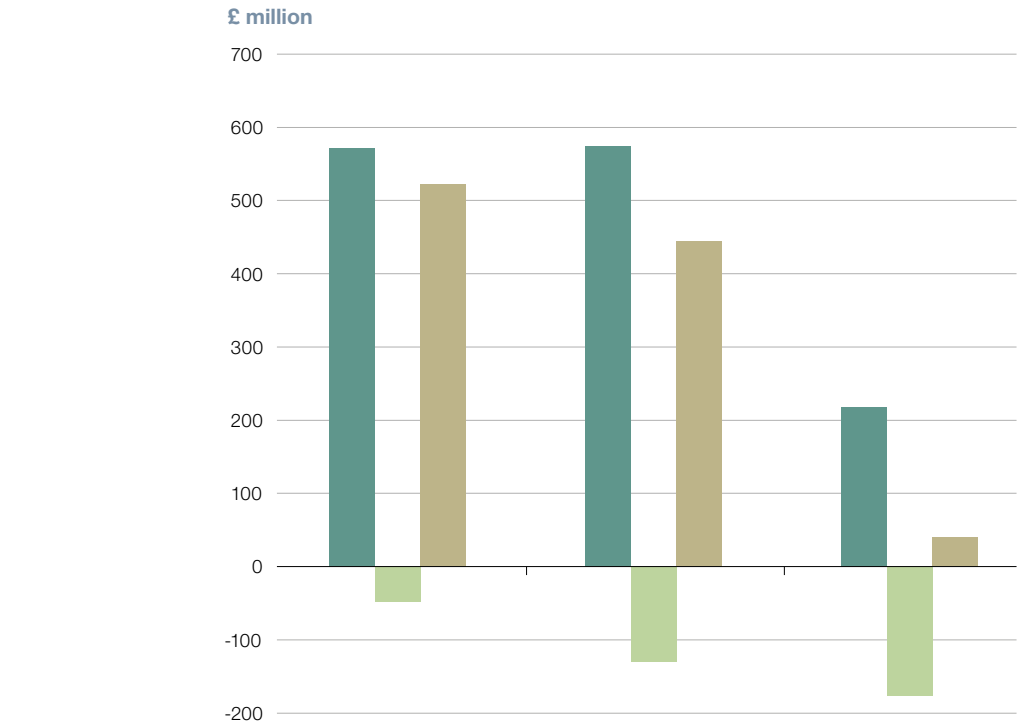
1.6 In 2011-12 the Department of Health allocated £89 billion to PCTs, primarily to commission services from NHS trusts, NHS foundation trusts and primary care providers. Taken together, SHAs, PCTs, NHS trusts and NHS foundation trusts reported an underspend of £2.1 billion in 2011-12.

Financial results for NHS commissioners and providers in 2011-12

1.7 **Figure 4** shows that most NHS foundation trusts, NHS trusts, and PCTs reported a surplus in 2011-12, but a minority reported deficits.

Figure 4
Total surpluses and deficits for PCTs, NHS foundation trusts and NHS trusts in 2011-12

Most NHS foundation trusts, NHS trusts and PCTs reported a surplus, but a minority reported deficits



	PCTs		NHS foundation trusts		NHS trusts	
	(£m)	(Num)	(£m)	(Num)	(£m)	(Num)
Total surplus	571	148	574	122	217	97
Total deficit	-49	3	-130	21	-177	10
Overall position	523	151	444	143	40	107

NOTES

1 Figures for NHS foundation trusts include six NHS trusts that became foundation trusts during the year.

2 Totals may not sum due to rounding.

Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health

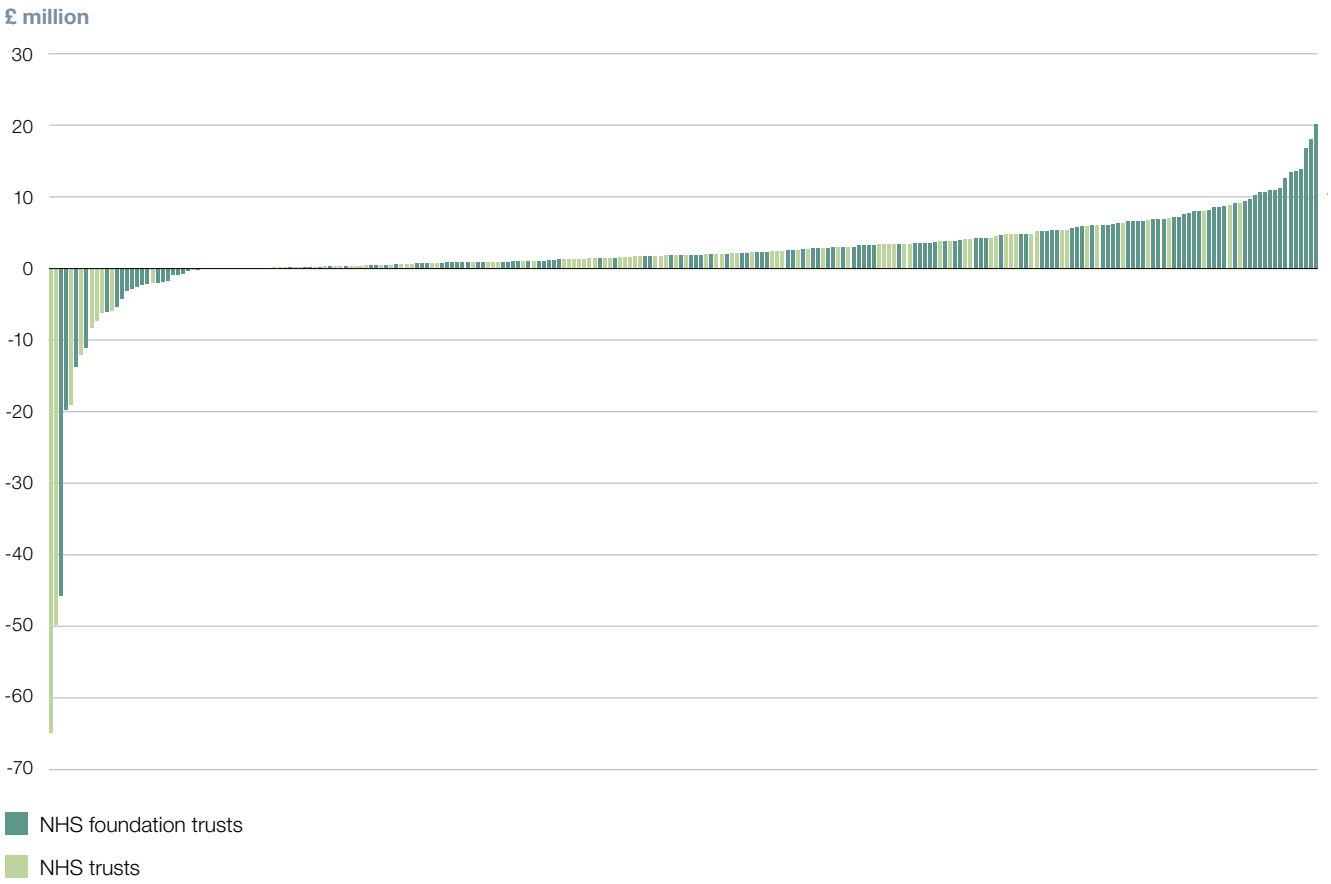
1.8 Among providers, most trusts are in surplus but a small, and growing, number of trusts, both NHS foundation trusts and NHS trusts, have disproportionately large deficits (**Figure 5**). Among trusts in deficit, the average individual deficit in 1997-98 was less than £1 million. In 2011-12 it was £9.9 million, including NHS foundation trusts. There was a larger group of 51 trusts which reported a surplus of less than £1 million. The trusts with the largest surpluses were all NHS foundation trusts.

1.9 Trusts that are superficially similar, or share catchment areas, may have strongly contrasting financial positions, as illustrated by the case example in **Figure 6**. There is no straightforward predictor of which types of trusts will be in surplus and which in deficit.

Figure 5

Surpluses and deficits NHS trusts and NHS foundation trusts reported in 2011-12

A minority of trusts, among which were NHS foundation trusts as well as NHS trusts, did not break even in 2011-12



Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health

Figure 6

Case example: Frimley Park Hospital NHS Foundation Trust and Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Trusts that have much in common, including catchment areas, may have strongly contrasting financial positions

The two trusts have partly overlapping catchment populations (in Berkshire), in an area where patients have considerable choice of provider. They are both long-established medium-sized acute NHS foundation trusts. Neither have private finance initiative schemes.

However, the two trusts have very different financial positions and financial performance histories.

	Frimley Park Hospital NHS Foundation Trust	Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Headline financial results	The trust's operating income in 2011-12 was £260 million. Before becoming an NHS foundation trust in 2005, the trust recorded a deficit in five of the previous seven years. However, since then the trust has generated financial surpluses: £6.4 million in 2009-10, £7.6 million in 2010-11, and £6.2 million for 2011-12.	The trust's operating income in 2011-12 was £222 million. Monitor placed the trust in significant breach of its terms of authorisation as an NHS foundation trust in July 2009 on the grounds that the trust was failing to exercise its functions effectively, efficiently and economically. Post-authorisation surpluses had relied on year-end adjustments, non-trading items and over-performance. Since then the trust reported a deficit of £9.9 million (excluding impairments) in 2009-10, a deficit of £13.2 million in 2010-11 and a deficit of £13.9 million for 2011-12.
Underlying financial status	The trust has healthy cash reserves, with a cash balance of £41 million at the end of 2010-11 and £39 million at the end of 2011-12. The trust is funding building a new Accident and Emergency Centre from cash reserves at a capital cost of £21 million. The trust has achieved £10 million cost improvement plans in 2010-11 (3.2 per cent) and 2011-12 (3.4 per cent). It has plans for a further £10 million of cost improvement savings in 2012-13.	The trust received cash and working capital loans of £18 million in 2010-11 as it could not access commercial loan facilities. In 2011-12 the Department gave the trust £4 million of public dividend capital to strengthen its balance sheet. The Department issued a further £15 million public dividend capital in April 2012, for the trust to partially repay existing loans to the Department and fund essential capital expenditure and operating deficits over the short term. Efficiencies of approximately 7 per cent are required in the next two financial years.
Factors which may be impacting on performance	High patient throughput on a single, highly utilised site. Diversity of income (15 per cent non-NHS income, including private income, a contract with the Ministry of Defence and other sources of income). Three main commissioners, two of which are significantly financially challenged, where the trust has amended the standard contract to share risk by adding activity caps and floors. A stable board, and long established executives. Strong coding of hospital activity, contracting and quality of information, which helps to ensure the trust recovers full payment for all its work. Chief Executive is involved in appointing all clinicians. Good clinical engagement in management.	The trust runs two hospitals, one on an old and widely laid out site which is expensive to run, and four other outpatient clinics. One main commissioner, which was in receipt of financial support from the SHA until 2011-12. High turnover among executive and non-executive board members in 2009-10. Poor quality coding of hospital activity and information, undermining the trust's negotiating position with commissioners (recently improved).

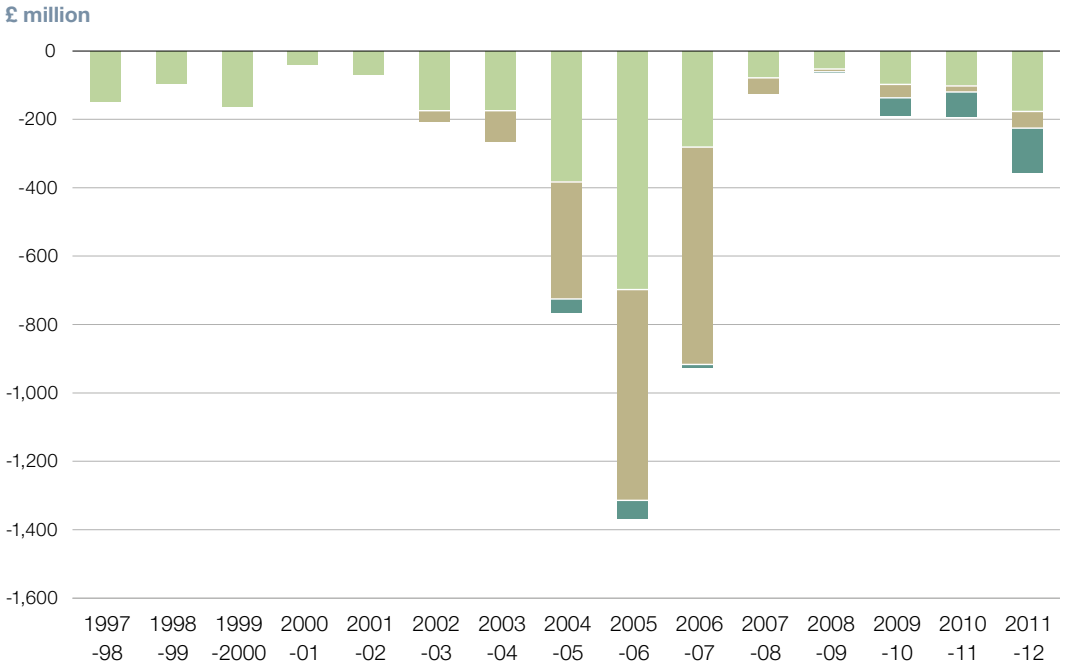
Source: National Audit Office

Financial performance of the NHS in recent years

1.10 The Department established a policy of maintaining strong financial management in response to the financial problems of the NHS in the mid-2000s. **Figure 7** shows that, for those organisations in deficit, by 2011-12 the total deficits among PCTs and NHS trusts were very much lower than they had been in the middle of the last decade. All SHAs return large surpluses.

Figure 7
Annual trust deficits 1997-98 to 2011-12

By 2011-12 the total deficits among PCTs and NHS trusts were very much lower than they had been in the middle of the last decade



	1997 -98	1998 -99	1999 -2000	2000 -01	2001 -02	2002 -03	2003 -04	2004 -05	2005 -06	2006 -07	2007 -08	2008 -09	2009 -10	2010 -11	2011 -12
Foundation trusts								-41	-54	-9	0	-4	-53	-70	-130
PCTs						-30	-91	-342	-616	-636	-45	-8	-39	-18	-49
NHS trusts	-148	-95	-163	-41	-69	-176	-175	-383	-696	-281	-79	-53	-98	-102	-177

NOTES

1 PCTs were created from 2000-01.

2 NHS foundation trust 2010-11 figures were restated due to a change in accounting treatment of donated assets.

3 NHS foundation trust figures in 2004-05 and 2005-06 are after public dividend capital (PDC) dividend. NHS foundation trust figures from 2007-08 onwards are after PDC dividend and before impairments.

Source: National Audit Office analysis of data from Monitor and the Department of Health

1.11 In addition to in-year deficits, two PCTs still have accumulated debts from overspending in previous years. The Department expects existing PCT clusters to have cleared all historic debts during 2011-12 and 2012-13, so as not to pass legacy debt to the new clinical commissioning groups. Only the Peterborough PCT and Cambridgeshire PCT have any outstanding legacy debt at the end of 2011-12. Peterborough's outstanding legacy debt was £13 million, and Cambridgeshire's was £8 million. There remains a risk, however, that some PCTs will incur new legacy debt if they end the 2012-13 financial year in deficit.

Patterns of financial sustainability across local health economies

Relationships between funders and providers across the English regions

1.12 **Figure 8** overleaf shows that deficits and surpluses within NHS organisations vary geographically across England.

1.13 In 2011-12, the Department required PCTs to spend two per cent of their recurrent allocations on non-recurrent expenditure to help pay for, among other things, the one-off costs of transferring responsibilities to clinical commissioning groups. SHAs reviewed and agreed in advance the business cases PCTs developed to use these funds. This requirement continues in 2012-13.

1.14 London represents the extremes of financial health and financial unsustainability within the NHS. In 2011-12 NHS trusts in London reported a combined net deficit of £98 million. Seven of the ten NHS trusts in deficit are in London, and just two trusts, South London Healthcare and Barking, Havering and Redbridge University Hospitals NHS Trust, reported a combined deficit of £115 million. The trust reporting the largest surplus nationally is also in London. The Royal Marsden NHS Foundation Trust reported a surplus of £20 million.

1.15 The total net surplus for all PCTs rose from £476 million in 2010-11 to £523 million in 2011-12. Overall, PCTs in London reported a surplus but, at the same time, the only three PCTs in England to report a deficit in 2011-12 are in the North Central London cluster: Barnet, Enfield and Haringey, with a combined deficit of £49 million. NHS North Central London finance reports make clear that the main reason for these deficits is that these PCTs paid trusts for undertaking more activity than provided for under their contracts. This was after the three PCTs had received £123 million of external support from the SHA through the Challenged Trusts Board by the end of 2010-11 to address underlying deficits.

Figure 8

Surpluses or deficits reported by SHAs, PCTs and provider trusts by region in 2011-12

Deficits and surpluses within NHS organisations vary geographically across England

Region	SHAs (10 in 4 clusters)		PCTs (151 in 50 clusters)		SHA and PCT totals		NHS trusts (107)		NHS foundation trusts (143)	
	Surplus (£m)	% of RRL	Net surplus (£m)	% of RRL	Net surplus (£m)	% of RRL	Net surplus /deficit (£m)	% of turnover	Net surplus /deficit (£m)	% of turnover
North East	59.3	17.1	5.1	0.1	64.4	1.2	–	–	73.2	1.9
North West	215.1	23.1	52.0	0.4	267.1	1.9	28.5	0.9	101.6	1.6
Yorkshire and The Humber	118.2	17.3	70.3	0.7	188.5	1.8	-5.1	-0.2	50.4	1.2
East Midlands	45.1	10.3	44.8	0.6	89.9	1.1	24.0	0.7	7.1	0.5
West Midlands	37.5	6.7	54.0	0.6	91.5	0.9	32.7	0.8	8.8	0.3
East of England	94.8	14.4	9.6	0.1	104.4	1.1	11.5	0.5	0.4	0.0
London	255.7	12.9	186.7	1.2	442.4	2.6	-97.8	-1.2	136.5	2.2
South East Coast	62.1	17.7	23.8	0.3	85.9	1.1	4.0	0.2	19.0	0.7
South Central	54.8	14.2	17.3	0.3	72.1	1.1	12.1	0.7	-2.0	-0.1
South West	117.8	23.2	59.0	0.7	176.8	1.9	29.7	1.4	49.1	1.3
NHS Direct							0.5	0.3		
Total	**1,060.5**		**522.8**		**1,583.0**		**40.2**		**444.1**	

NOTES

1 Totals may not sum due to rounding.

2 The total for NHS foundation trusts includes six NHS trusts that became NHS foundation trusts during the year.

3 There are no NHS trusts in the North East.

4 SHAs' and PCTs' surplus or deficit is relative to their Revenue Resource Limit (RRL) budget. Turnover is based on operating income. To make data for NHS foundation trusts comparable with that for NHS trusts, for NHS foundation trusts operating income excludes reversals, profit and loss on disposals, and amortisation of private finance initiative deferred credits.

5 NHS Direct provides a telephone service for people in England giving access to advice and information, and commissioned services to other parts of the NHS including out-of-hours support for GPs and dental services and telephone support for patients.

Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health

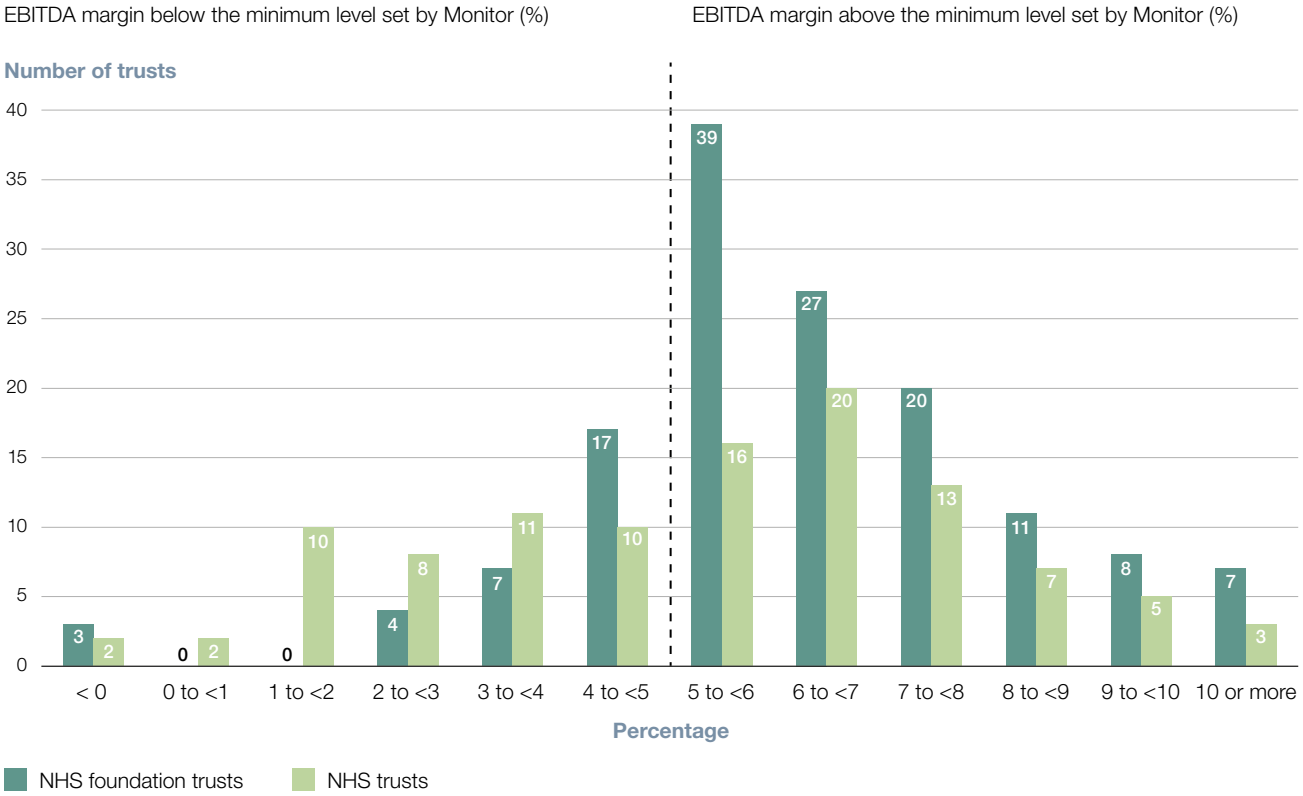
Key measures of financial health

Earnings before interest, tax, depreciation and amortisation

1.16 Monitor reports the financial performance of NHS foundation trusts using a measure called EBITDA – earnings before interest, tax, depreciation and amortisation. Expressed as percentage of income (EBITDA margin) it is a good measure of underlying financial performance. Monitor uses the EBITDA margin as a proxy for operating efficiency. Among NHS foundation trusts, EBITDA margin fell from an average of 7.8 per cent in the first quarter of 2008-09 to 6.7 per cent in 2010-11 and 6.1 per cent at the end of 2011-12. For NHS trusts the fall is greater, from 6.0 per cent in 2010-11 to 5.3 per cent at the end of 2011-12. **Figure 9** shows that in 2011-12 43 NHS trusts in the pipeline to become NHS foundation trusts did not meet the 5 per cent margin normally expected for authorisation, while 31 NHS foundation trusts would no longer meet that threshold if applying now.

Figure 9
EBITDA margins trusts achieved in 2011-12

Forty-three NHS trusts in the pipeline to become foundation trusts did not meet the 5 per cent minimum requirement for authorisation, while 31 NHS foundation trusts would no longer meet that requirement if applying now



NOTES

1 Limitations in the data mean that figures for NHS trusts and NHS foundation trusts have to be calculated in slightly different ways. The methodology appendix explains how we have calculated these figures.

2 An element of the reduction in EBITDA margin between 2010-11 and 2011-12 may be due to assets not transferring to providers under the Transforming Community Services programme.

Source: National Audit Office analysis of audited trust financial data from the Department of Health and unaudited data from Monitor

Net current assets, including cash

1.17 **Figure 10** shows that at the end of March 2012 NHS foundation trusts held net current assets totalling £1.5 billion. NHS trusts were in a much weaker position, increasing the risk that some of them will need injections of cash to pay creditors. At the end of 2011-12 NHS trusts held £209 million, and NHS foundation trusts £27 million, of outstanding working capital loans from the Department. In addition they may have long-term borrowings because of investing in private finance initiative schemes, through borrowings to fund other investments, or historic deficit from previous years.

Figure 10
Net current assets in NHS trusts and NHS foundation trusts

At the end of March 2012 NHS foundation trusts held net current assets totalling £1.5 billion. NHS trusts were in a much weaker position

	Current assets (£bn)		Current liabilities (£bn)	Net current assets (£bn)
	Cash and cash equivalents	Other current assets		
NHS trusts	1.16	1.91	-3.31	-0.24
NHS foundation trusts	3.95	2.20	-4.65	1.49
Total	**5.11**	**4.11**	**-7.96**	**1.25**

NOTES
1 Figures as at 31 March 2012.
2 Current assets and current liabilities include balances between trusts (figures are therefore reported gross).
3 Figures do not sum due to rounding.

Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health

Part Two

Financial support to providers and commissioners

2.1 At the end of 2011-12, ten NHS trusts, three PCTs and 21 NHS foundation trusts reported a deficit. These numbers may have been higher had providers and commissioners not also received additional financial support:

- SHAs and PCTs may give providers explicit one-off funding, either to offset non-recurrent costs arising in the year, or to make good a shortfall between income and expenditure. A small number of PCTs have also needed direct financial support.
- Local PCTs have also given providers other non-recurrent funding including, for example, help to support transitional costs or business change.
- The Department may directly give trusts cash, in the form of public dividend capital.

2.2 Some of the additional funding SHAs and PCTs provided helped NHS trusts and NHS foundation trusts meet exceptional costs arising in the year. It is not possible to identify whether, had this funding not been available, trusts would have been able to defer or avoid this expenditure. Pressure on resources available to commissioners to help support non-recurrent costs, however, is likely to increase rather than decrease. Without direct financial support and other non-recurrent funding, another 31 NHS trusts, 11 NHS foundation trusts and seven PCTs may have been in deficit instead of surplus. Had this support not been made available, some of those organisations may have been able to compensate for lower income by reducing their expenditure. All financial support is intended to help maintain services for patients, and is conditional on plans for recovery to a more sustainable position.

Direct financial support

Support to commissioners

2.3 Some commissioners cannot give additional support to providers because they themselves are struggling to stay within their own resource limit. According to SHAs and PCTs responding to our census, there were seven PCTs which may have been in deficit without direct financial support. SHAs increased PCTs' resource allocations, and some PCT clusters reallocated resources between PCTs within the cluster. The total value of this direct support in 2011-12 was £89 million.

Support to providers

2.4 The NHS trust sector reported a surplus of £40 million in 2011-12, but this may have been reduced to an overall net deficit without direct financial support. In total, SHAs and PCTs gave NHS foundation trusts £10 million, and NHS trusts £151 million, direct one-off financial support in 2011-12. There are a few provider trusts, however, which have needed 'one-off' support repeatedly to cover shortfalls between income and expenditure. **Figure 11** illustrates one NHS trust that reported a surplus but received additional financial support.

The impact of direct support

2.5 Without one-off direct support, an additional 15 NHS trusts may have posted deficits in 2011-12. **Figure 12** on pages 26 and 27 shows the potential impact of additional support to NHS trusts and NHS foundation trusts regionally. Without additional direct support, in the East of England region the number of trusts in deficit in 2011-12 may have increased from four to seven. In the South Central region there may have been five trusts in deficit rather than two.

Other non-recurrent funding

2.6 It is very difficult to identify the full extent of one-off funding commissioners and providers agreed, or the purposes for which it is actually used. We conducted a census of PCT clusters, and asked them what financial help they received from SHAs and gave trusts. Out of the 50 clusters, 45 responded. Of PCT clusters, 69 per cent said they provided some additional funding to their main providers in 2011-12.

2.7 We estimate, from the census of PCTs, that NHS trusts and NHS foundation trusts received additional non-recurrent funding through PCTs totalling around £274 million in 2011-12. Trusts received £147 million transitional support to relieve financial pressure and support non-recurrent costs during the year, and £127 million to help implement business change. Without this financial help an additional 16 NHS trusts and 11 NHS foundation trusts may have been in deficit.

Figure 11
Case example: Portsmouth Hospitals NHS Trust

The trust reported a surplus but received additional financial support

Background

Portsmouth Hospitals NHS Trust is a large acute hospital trust providing services to a population of around 0.6 million in Portsmouth, South East Hampshire and beyond.

Foundation trust application date: March 2013

Financial situation

In 2008-09 the trust was in surplus (£0.16 million), in deficit in 2009-10 (-£14.9 million), in surplus in 2010-11 (£0.16 million) and in surplus in 2011-12 (£0.15 million).

Issues facing future sustainability/risk

- The trust appears to be in a balanced break-even financial position. However the trust had £10 million of support built into the original contract baseline value for 2011-12 via the PCT as part of contract financial capping arrangements. These arrangements were agreed prior to agreement on activity to be delivered and the actual priced contract valuation which would have lessened the value of support required considerably to around £3.5 million. It will potentially receive a further £3.7 million in 2012-13 in the event that activity reduces in order to recognise stranded (empty space) fixed costs.
- The trust has operated a private finance initiative scheme since 2009-10. This has increased fixed costs by £24 million per year. The Department's review of trusts with private finance initiative schemes identified Portsmouth's scheme as representing a significant but not insurmountable financial challenge and concluded that, with local health-care partner support, they should achieve foundation trust status.
- The format of long-term local health-care partner support is uncertain.
- The trust has a contract cap system in place in 2011-12 with their lead commissioner. Demand and thus activity levels continued to rise. The trust quickly breached the activity cap, and has been in on-going discussions with commissioners to increase their payment. For 2012-13 the trust's contracts broadly reflect national 'payment by results' rules.
- The trust delivered a £25 million internal cost-improvement programme. Approximately £6 million of this has been delivered on a non-recurrent basis, which effectively adds to the annual efficiency target the trust faces in 2012-13.

The 2010-11 audit letter issued an 'except for' value-for-money conclusion because:

- local demand management schemes aimed to reduce the trust's activity and income;
- due to the current private finance initiative scheme the trust has a significant level of fixed costs that will be difficult to reduce in the short term; and
- the trust needs to achieve a high level of savings to break even, which is viewed as difficult to achieve without external support.

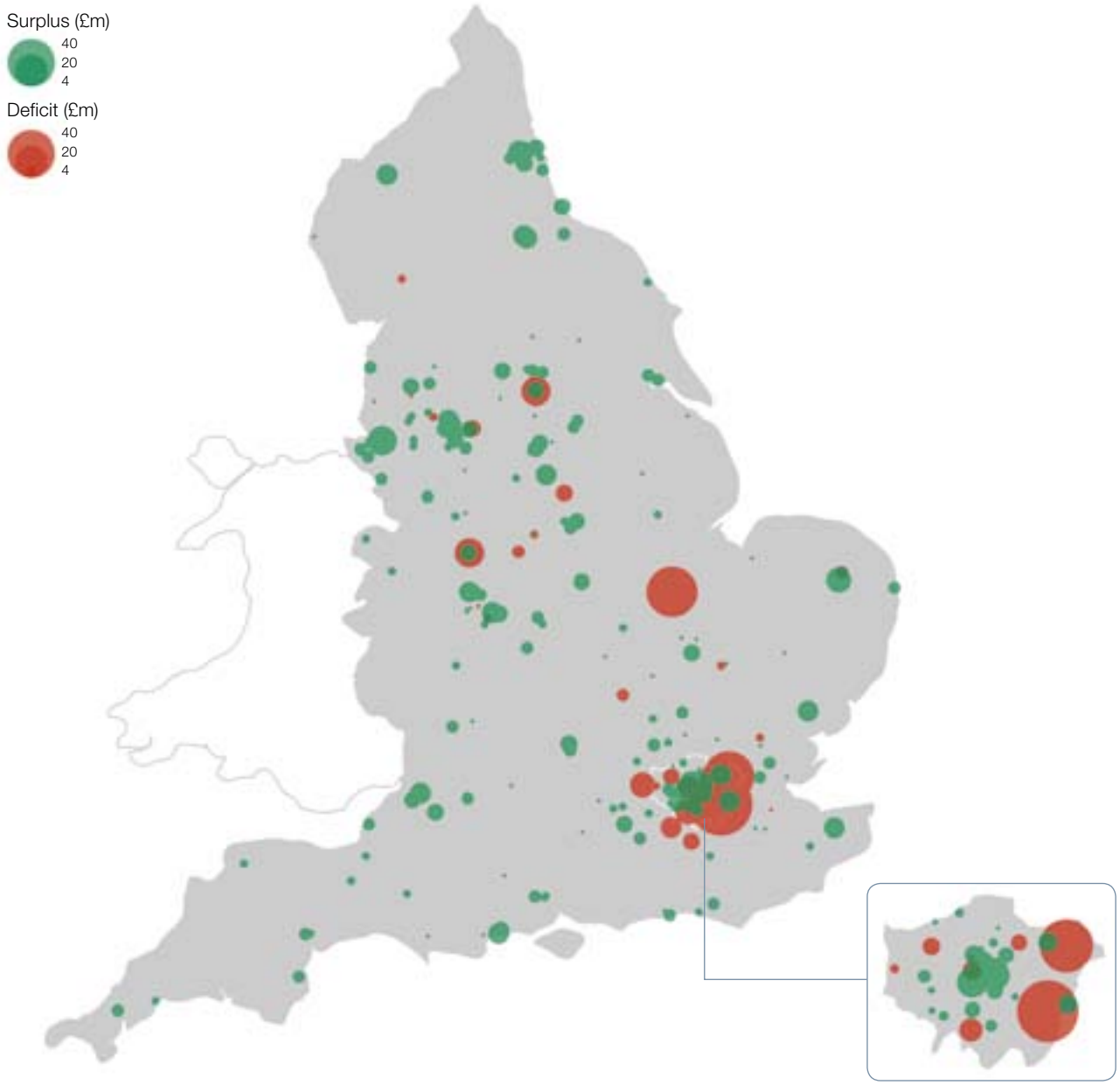
Source: Portsmouth Hospitals NHS Trust data and National Audit Office interviews

Figure 12

The potential impact of direct support on surpluses and deficits in NHS trusts and NHS foundation trusts

The impact of additional support to provider trusts varies across the country and in London

2011-12 reported surpluses and deficits



NOTES

1 Green shows surplus, red shows deficit. The size of surplus or deficit is represented by the size of the dot.

2 Surplus/deficit is based on audited data. Direct support is based on information provided to the National Audit Office by strategic health authorities and primary care trusts.

Source: National Audit Office analysis of audited trust financial data from Monitor and the Department of Health, and information provided to the National Audit Office by strategic health authorities and primary care trusts

2011-12 positions with direct support removed

2.8 A commissioning PCT and provider trust also have scope to use flexibility allowed in the terms of their contracts. NHS standard contracts lay down when and how PCTs will reimburse NHS trusts and NHS foundation trusts for providing treatment services. This will typically include clauses covering reimbursement for treatment in excess of contracted activity, sums that depend on achieving quality improvements, and fines and penalties for under-performance. Based on the census of PCTs, in 2011-12:

- twenty-two per cent of PCT clusters levied fines below the contracted rate or waived them altogether;
- nine per cent of PCT clusters paid providers above the national rate for excess emergency admissions;
- around one-fifth of PCT clusters paid for emergency readmission within 30 days; and
- seventeen per cent also allowed providers to keep the part of their contract payment linked to specific performance improvements, even if providers did not achieve these improvements.

2.9 **Figure 13** gives an example of the difference that these agreements can make.

Figure 13
Case example: Bedford Hospital NHS Trust

A commissioning PCT and NHS trust can make local agreements about payments for services

Background

Bedford Hospital NHS Trust is a small district general hospital and provides a range of services to over 270,000 people living predominantly in north and mid Bedfordshire.

Financial situation

The trust is in surplus year-on-year: in 2008-09 (£2.1 million), 2009-10 (£0.6 million) and 2010-11 (£0.3 million). In 2011-12 the trust delivered a surplus of £0.2 million.

The trust's contract with its lead PCT included penalty provisions that, for example, the PCT would not pay for follow-up attendances in excess of an agreed threshold, or for discharge summaries issued outside of agreed tolerances. Strictly applying all these provisions would have resulted in the trust receiving £4 million less income under its contract than the value it finally agreed with its lead PCT. The trust and its lead PCT agreed a fixed payment instead, and waived the penalties. In return, the trust took the risk that if it had to carry out more elective operations than expected in order to meet waiting time targets, the PCT would not pay any extra for this additional work.

Looking ahead, Bedford needs to show that it is financially viable without non-recurrent support to achieve foundation trust status. It had been rated green on the Department's foundation trust pipeline risk register against an agreed date for submitting their foundation trust application to the Department in October 2012. Bedford is, however, working with the Midlands and East SHA to explore a wide range of governance options including foundation trust status.

The Midlands and East SHA supported Bedfordshire PCT with £2 million of support as part of the above contractual agreement.

Source: Bedford Hospital NHS Trust data and National Audit Office interviews

Working capital

2.10 A major source of support for some trusts in financial difficulties is providing additional public dividend capital which directly strengthens their balance sheet. Public dividend capital represents the Department of Health's investment in the public assets of NHS bodies. Public dividend capital is the equivalent of share capital, so a trust's public dividend capital will only increase with an injection of cash to either purchase assets or support working capital.

2.11 Some of the public dividend capital issued is to support operational cash requirements. This is designed to help trusts maintain the amount of working capital they need when they would not be able to access a working capital loan.[1]

2.12 Increasingly, the Department and SHAs have looked to prevent trusts becoming more indebted. In extreme cases, the Department has provided additional cash (as public dividend capital) to cover shortfalls arising from trusts' in-year deficits, preventing them having to borrow more money while they seek long-term solutions. NHS London's Challenged Trust Board provides money to help trusts offset their historic deficits when there is evidence of long-term viability.

2.13 The Department announced in April 2005 that, "After 2005-06 the Department is planning not to issue new public dividend capital to NHS trusts or NHS foundation trusts. Instead, it will issue interest-bearing debt with real rates of interest and repayment of principal."[2] **Figure 14** overleaf shows that, from 2006-07 onwards, the Department nonetheless issued £1 billion public dividend capital to 21 trusts, of which just under £160 million has been repaid.

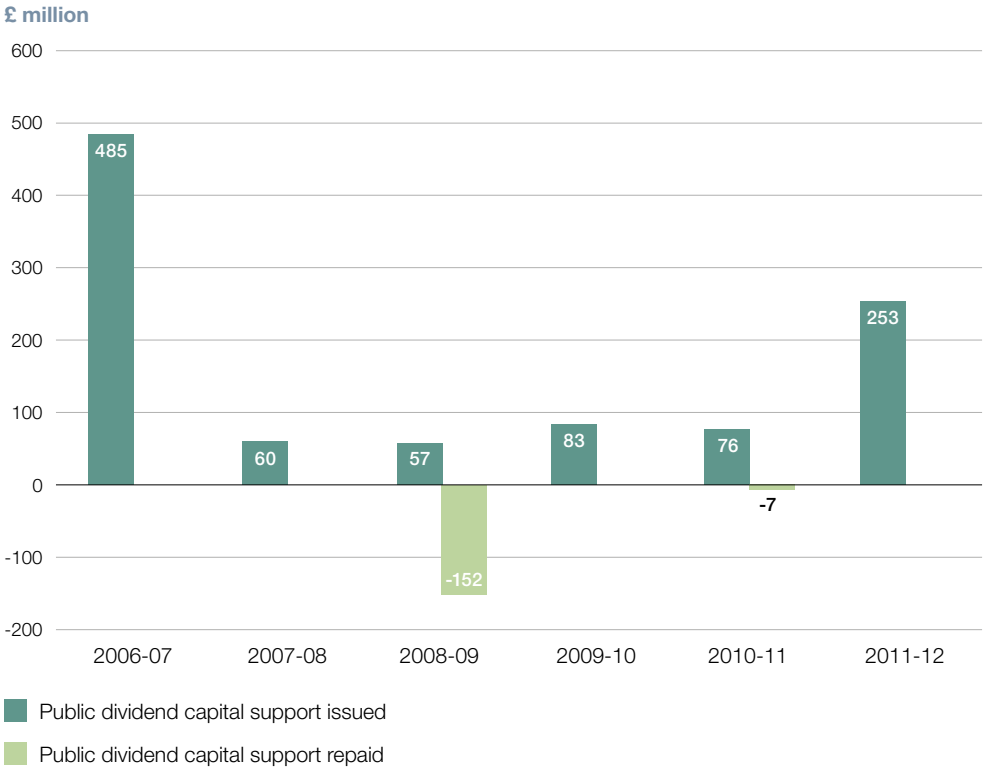
2.14 **Figure 15** on page 31 shows that 11 trusts received a total of £253 million public dividend capital in 2011-12. Among these, between 2006-07 and 2011-12, the Department issued a total of £356 million to South London Healthcare NHS Trust and its predecessor bodies, and £195 million to Barking, Havering and Redbridge University Hospitals NHS Trust. The Department anticipates that NHS trusts and NHS foundation trusts are likely to need around £300 million public dividend capital in 2012-13.

1 www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/20110808_NHSPerformance.pdf
2 Letter from the Department of Health for action by directors of finance, dated 19 April 2005, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131714

Figure 14

Revenue public dividend capital issued to, and repaid by, trusts

The Department has issued £1 billion public dividend capital to 21 trusts, of which just under £160 million has been repaid



NOTES

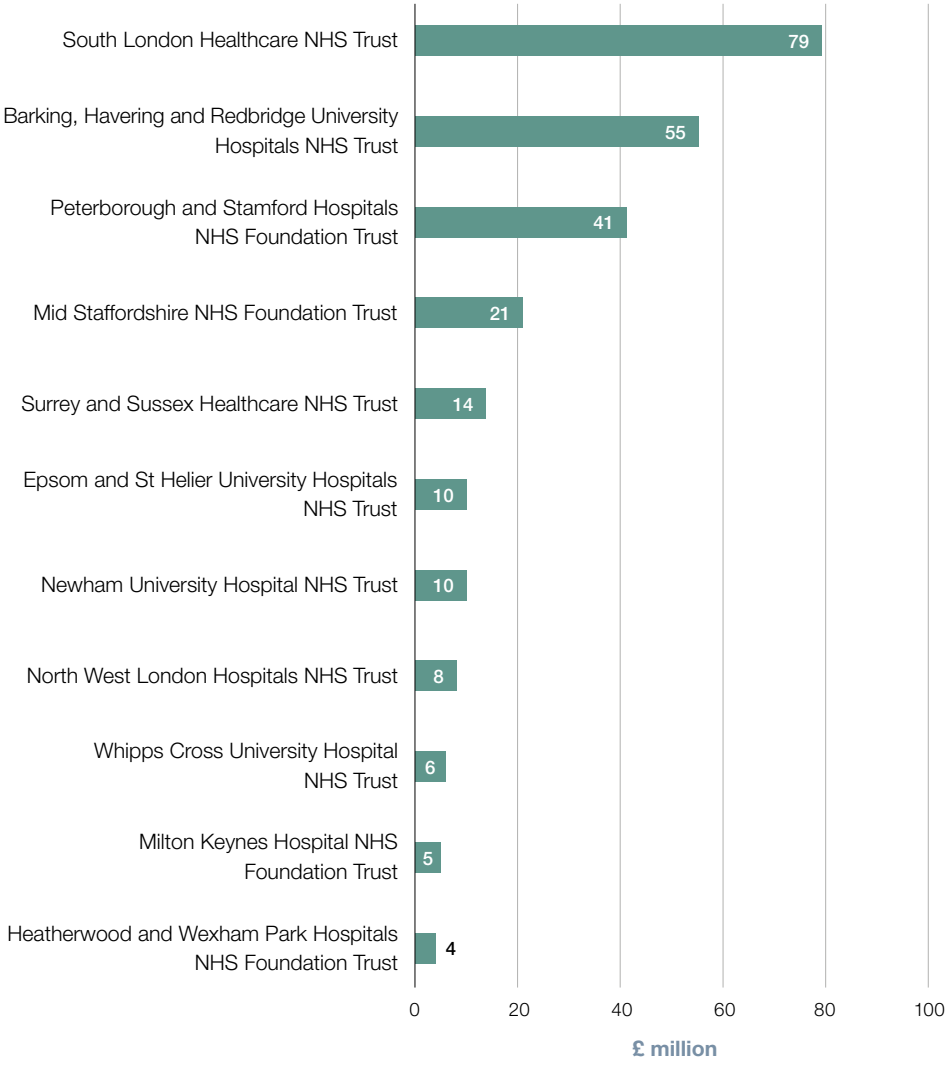
1 The Department issued public dividend capital to 13 trusts in 2006-07 in lieu of loans due to their inability to make repayments.

2 Two trusts, Royal Cornwall Hospitals NHS Trust and Weston Area NHS Trust, have fully repaid their public dividend capital. Six more have partially repaid public dividend capital issued to them.

Source: Department of Health

Figure 15
Recipients of public dividend capital in 2011-12

The Department issued 11 trusts a total of £253 million public dividend capital in 2011-12



Source: Department of Health

Part Three

Risks to the future financial sustainability of local health economies

Financial pressures on commissioners

3.1 The NHS *Operating Framework* makes clear that, "it is a requirement that no PCT or SHA will plan for a deficit in 2012-13. PCTs carrying legacy debt into 2012-13 must clear it."[3]

3.2 In 2012-13, as in 2011-12, PCTs have to set aside 2 per cent of their recurrent resource allocations for spending on non-recurrent activities only. SHAs are required to agree the business cases for this spending. Part of this money is expected to be used to fund the one-off costs of transition to the new health system. A significant element is expected to be used to develop measures to help achieve the NHS 'Quality, Innovation, Productivity and Prevention' initiative, including service redesign costs. It has also proved an important source of additional funding for providers in some areas.

3.3 In the local health economies we visited we found examples of clinical commissioning groups already trying to reduce cost by reducing the number of patients referred to hospitals. For example, some clinical commissioning groups were trying to identify constituent GP practices whose referral rates were in excess of their peers. Downward pressure on referrals, when reflected in contracts between clinical commissioning groups and providers, can be expected to have an increasing downward impact on hospital activity levels.

The financial environment for providers

3.4 In April 2012 Monitor published an updated set of financial assumptions, which it uses to assess applicant trusts for foundation trust status, and for risk rating some investments and transactions undertaken by existing NHS foundation trusts. To be authorised as NHS foundation trusts, applicants must show that, unless there are exceptional circumstances, the trust can generate a sustainable net income surplus by year three of their financial projections, and maintain a reasonable cash position. The Department expects all NHS trusts to achieve NHS foundation trust status, either alone or after merging with another NHS trust or NHS foundation trust.

3 Department of Health, *The Operating Framework for the NHS in England 2012-13*, November 2011, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

3.5 **Figure 16** shows Monitor's assessment that the efficiency pressure on providers could reach 5.0 per cent for the next two to three years and, in a more pessimistic scenario, could be up to 5.5 per cent.[4] In addition, for acute trusts the impact of potential adjustments to tariff could increase the efficiency requirement by a further 2 per cent (non-recurrently). This figure will depend on local circumstances and actions being taken by the trust. Monitor's advice to all trusts, however, was that "to ensure quality is not compromised, it will be important for trusts to look at new ways of working and new ways of delivering services as they seek to address these challenges".[5]

3.6 Work by McKinsey and Company for the Department looked at efficiencies achieved in public and private hospital sectors in different countries, and found that year-on-year savings of much more than 5 per cent had not been achieved elsewhere. Of PCT clusters responding to our census, 51 per cent told us they were very or quite concerned about the future financial sustainability of their local providers.[6]

Figure 16
Monitor's financial assumptions for the period 2012-13 to 2016-17

Monitor's assumptions are that, in a more pessimistic 'downside' scenario, trusts could face recurrent efficiency pressures of up to 5.5 per cent a year for the next two to three years

Monitor's assessment of efficiency requirements in acute and non-acute sectors	Recurrent efficiency requirement (%)				
	2012-13	2013-14	2014-15	2015-16	2016-17
Acute trusts					
Monitor's estimate of the expected pressures and risks to providers' income and costs	4.5	5.0	5.0	4.2	4.2
Monitor's more pessimistic 'downside' estimate of the expected pressures and risks	5.25	5.5	5.5	5.0	5.0
Non-acute trusts					
Monitor's estimate of the expected pressures and risks to providers' income and costs	4.5	5.0	5.0	4.2	4.2
Monitor's more pessimistic 'downside' estimate of the expected pressures and risks	5.0	5.5	5.5	4.7	4.7

Source: Update to Monitor's financial assumptions, April 2012

4 The 5.5 per cent efficiency requirement is partly related to the national tariff for most acute services.
5 Monitor's letter to NHS foundation trusts and applicants, Update to Monitor's financial assumptions, April 2012, available at: www.monitor-nhsft.gov.uk/information-nhs-foundation-trusts/correspondence-foundation-trusts.
6 We defined 'financial sustainability' as: long-term financial viability without additional non-recurrent funding and the ability to break-even given current assumptions on trends in income and costs for providers.

3.7 Monitor assesses financial risk for each NHS foundation trust every three months. Monitor's 2012-13 *Compliance Framework* specifies that, "if an NHS foundation trust has a financial risk rating of 2 or less, or if the assessment of its committed working capital facilities and overall cash position indicate that it is at serious risk of not being able to continue providing mandatory services, Monitor will consider escalating the trust for consideration of whether it is in significant breach".[7]

3.8 A small but growing number of NHS foundation trusts are in financial difficulty. Monitor first placed an NHS foundation trust in significant breach of the terms of their authorisation wholly or partly because of financial reasons in April 2009. By April 2010 Monitor had placed five trusts in breach because of financial risk. This had increased to 11 trusts at 31 March 2012. Monitor's average financial risk rating for NHS foundation trusts fell from 4.1 in 2008-09 to 3.4 in 2011-12.

Downward pressure on income

3.9 Many trusts have benefited financially in recent years from year-on-year increases in activity. The corresponding increases in income have reduced the pressure on them to reduce costs. Trying to reduce demand for hospital services is now a major part of efforts to reduce costs in the NHS. However, it was still normal in 2011-12 for trusts' operating income to exceed plans. In total, NHS trusts and NHS foundation trusts received £3.2 billion more in operational income than planned in 2011-12. The median variance in income above plan was 3.3 per cent for NHS foundation trusts and 4.0 per cent for NHS trusts.

3.10 It is no longer realistic, however, for trusts to rely on income to cover rising costs. In cash terms, the median trust was only £0.3 million better off in 2011-12. This is because the median increase in expenditure of 3.66 per cent almost matched the increase in income of 3.70 per cent. **Figure 17** shows that there are, however, some big differences between 'winners and losers'.

3.11 Based on our case study visits, some PCTs reduced the amount of work they commissioned from providers in contracts for 2011-12. The PCTs we visited told us that this was one of the ways they had responded to the national drive, as part of the NHS 'Quality, Innovation, Productivity and Prevention' initiative, to achieve savings by reducing demand for hospital services and providing more care outside hospitals.

3.12 However, our discussions with commissioners and providers indicate that these reduced activity levels were not always set in consultation with providers, or were not agreed until part way through the year. Measures to reduce activity were not always in place at the start of the contract period, which meant that GPs did not reduce the number of elective referrals to hospitals they made. In some areas there have also been continued increases in emergency admissions. Since hospital capacity was unchanged, activity did not reduce. Most commissioners that we spoke to had therefore been sympathetic to provider claims for additional payments to reflect the increased work.

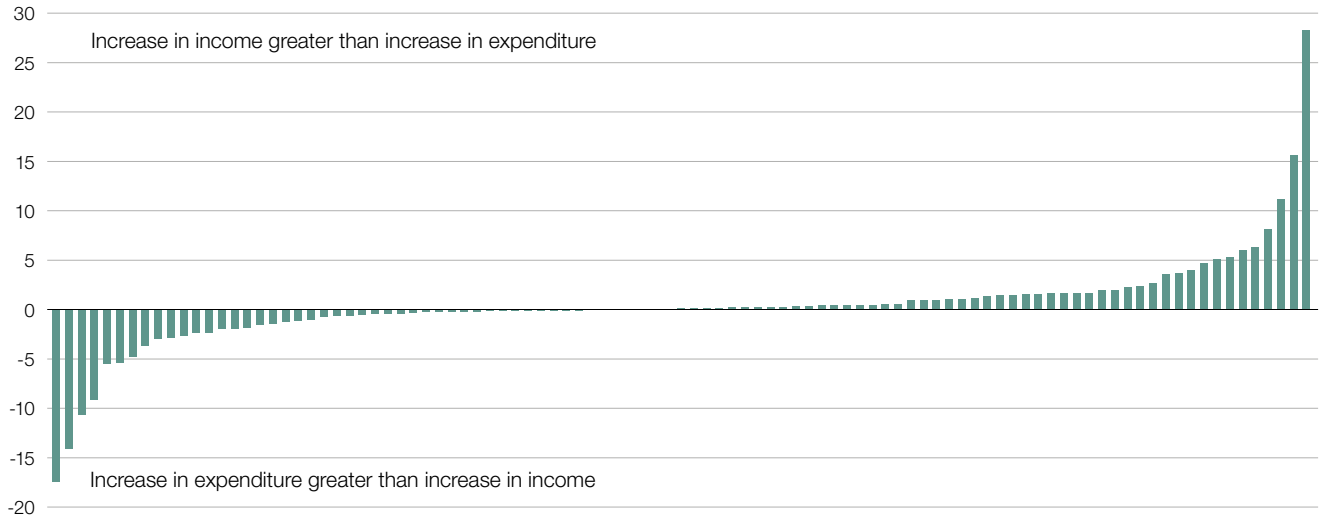
7 Monitor, *Compliance Framework 2012-13,* available at: www.monitor-nhsft.gov.uk/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-framework-

Figure 17

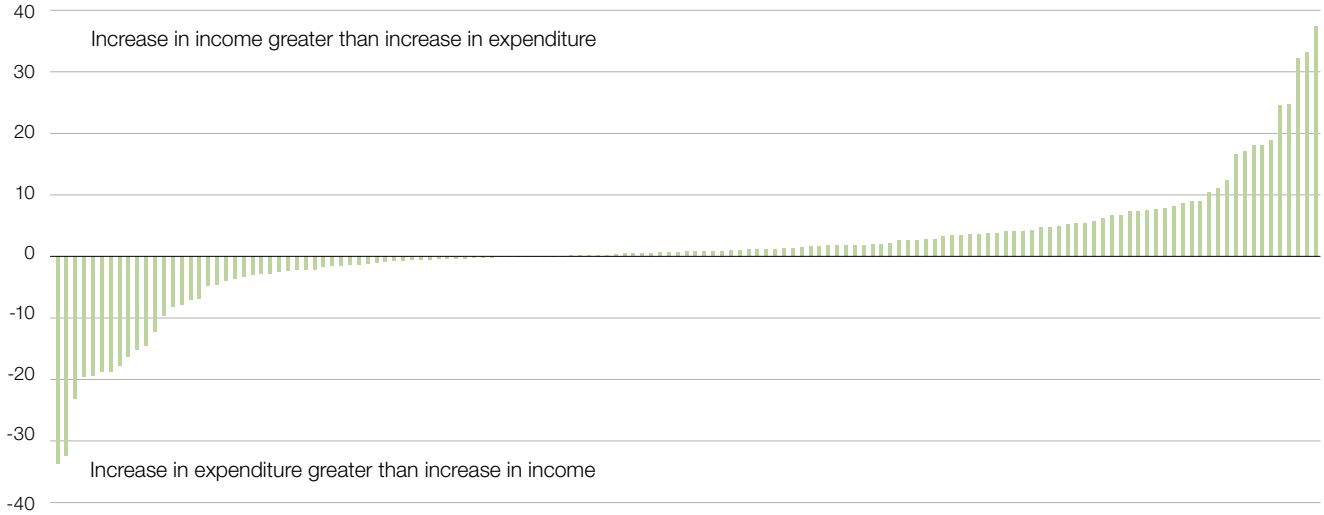
Unplanned variances in income and spending in 2011-12 for NHS trusts and NHS foundation trusts

There are some big differences between 'winners and losers'

NHS trusts (£m)



Foundation trusts (£m)



NOTES

1 To make data for NHS foundation trusts comparable with that for NHS trusts, for NHS foundation trusts operating income excludes reversals, profit and loss on disposals, and amortisation of private finance initiative deferred credits. Expenditure is shown excluding impairments.

2 Three community trusts did not have plan data and are excluded.

3 Five acute NHS trusts (Mid Yorkshire Hospitals NHS Trust, Mid Essex Hospital Services NHS Trust, North Middlesex University Hospital NHS Trust, University Hospital of North Staffordshire NHS Trust and Barts and the London NHS Trust) are excluded from the figure above because they are significant outliers, at least partly due to their treatment of impairments.

4 Outturn income and expenditure are audited. Planned income and expenditure figures are not audited.

5 Some NHS trusts had additional income and expenditure in 2011-12 from community services functions transferring from PCTs. This was not reflected in the original plans while the accounting treatment (merger or acquisition) was being finalised. This may result in some inflation of NHS trust income and expenditure compared to planned income and expenditure but if, as would normally be expected, the income and expenditure are broadly in balance, this would not impact on the net movement shown in this figure. NHS foundation trusts typically included the additional income and expenditure expected from transferring community services functions in their annual plan.

Source: National Audit Office analysis of audited and unaudited trust financial data from Monitor and the Department of Health

3.13 The Department has set demanding savings targets for 2012-13, with the emphasis increasingly on redesigning clinical services.[8] The Department reduced prices for tariff procedures by 1.5 per cent. Procedures priced on the basis of 'best practice', increasing pressure on hospitals to match savings achieved by the most efficient include 0.3 per cent embedded in tariff prices. Any savings that trusts did not achieve in 2011-12 will have to be rolled forward into planned savings for 2012-13. There continues to be a minimum annual efficiency requirement of 4 per cent, which is built in to tariff prices.

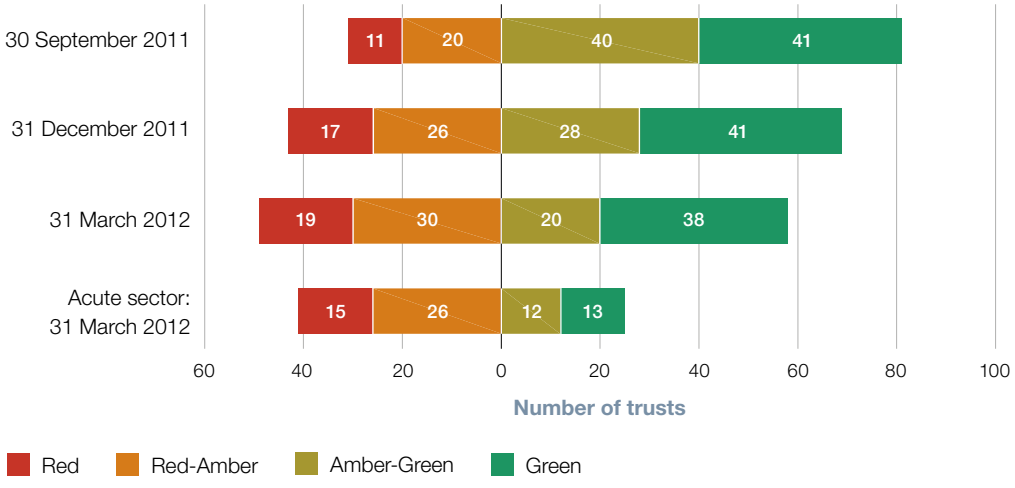
The most difficult challenges

Slippage in the NHS foundation trust 'pipeline'

3.14 At the end of September 2011 there were 19 trusts due to submit their NHS foundation trust application to the Department before the end of 2011-12. At the end of March 2012 ten of these were rated as 'red risk' because of the danger that they will not stay on their forecast trajectory towards foundation trust status. More widely, at the end of March 2012 there were 19 NHS trusts that SHAs rated as 'red risk'. The Department has also escalated 16 NHS trusts to oversee closely, because they were rated as red for three consecutive months. This may be for a number of reasons, but in some cases it is because improvements in financial performance are not being achieved in line with agreed milestones (**Figure 18**). Although 36 per cent of NHS trusts are rated green, the proportion drops to 20 per cent for acute trusts only.

Figure 18
SHAs' risk ratings of NHS trusts' progress towards foundation status

There are 19 trusts which SHAs rate as 'red risk' because they have been unable to stay on the forecast trajectory towards foundation trust status



NOTE

1 SHAs agree ratings with the Department's directorate of provider delivery.

Source: Department of Health

8 Department of Health, *The Operating Framework for the NHS in England 2012-13,* November 2011, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

3.15 We highlighted in our report *Achievement of Foundation Trust status by NHS hospital trusts* that there are particularly complex problems for NHS trusts in London.[9] Two providers, South London Healthcare NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust, account for 65 per cent of the total £177 million deficit among NHS trusts. In these local health economies there is no single, or simple, solution (**Figure 19**).

Liquidity

3.16 To assess whether trusts are able to pay their creditors, Monitor measures whether they have sufficient liquid reserves to cover a minimum of 15 days' operating expenses. Monitor calls this a 'liquidity risk rating of 3'.

3.17 We estimate that 26 NHS trusts are unable to meet Monitor's criteria without additional support. The total working capital requirement they need is £184 million, based on 2011-12 figures.

Figure 19
Case example: South London Healthcare NHS Trust

Some providers face a mixture of problems, for which there is no single, or simple, solution

South London Healthcare NHS Trust was formed on 1 April 2009 by merging Bromley Hospitals NHS Trust, Queen Mary Sidcup NHS Trust and Queen Elizabeth Hospital NHS Trust. At the time these trusts had a combined deficit of £21.3 million. They were three of the six NHS trusts that reported a deficit in 2008-09.

The deficit of the new trust was £42 million in 2009-10; £41 million in 2010-11; and in 2011-12 has increased further to £65 million. In 2011-12 it achieved £20 million of its £30 million savings target.

South London Healthcare NHS Trust and its predecessor bodies were given £356 million of revenue public dividend capital support since 2006-07, none of which has been paid back. Despite this additional support, the trust's financial position has got steadily worse.

Despite its financial difficulties it has not been judged by the Department to be one of the trusts "not financially viable in its current form".

South London Healthcare NHS Trust has three private finance initiative schemes, two of which were assessed by McKinsey & Co for the Department of Health as contributing to South London Healthcare NHS Trust's financial problems. South London Healthcare NHS Trust is expecting to receive some £20 million of recurrent support from the Department for its private finance initiative schemes. One of the criteria for receiving private finance initiative support is that the trust must show that it can be financially viable.

Current senior finance staff have found very poor quality financial data and finance process issues.

In March 2012, key players in the local health economy were brought together to carry out a simulation to help determine a model of future viability for South London Healthcare NHS Trust.

Source: National Audit Office

9 Comptroller and Auditor General, *Achievement of foundation trust status by NHS hospital trusts.* Session 2010–12, HC 1516, National Audit Office, October 2011.

3.18 Some commissioners gave trusts payments due under their contract in advance during the year, to help them manage short-term liquidity pressure. NHS foundation trusts in difficulty may also need the Department to provide additional working capital when commercial arrangements are withdrawn. As part of the terms of their authorisation, all NHS foundation trusts can have a working capital facility arranged with a commercial bank. We found that one of the terms under which commercial banks provide this facility is that NHS foundation trusts maintain a Monitor risk rating of 3. NHS foundation trusts rated 1 or 2, however, are likely to be most in need of cash support.

Private finance initiative commitments

3.19 Historic private finance initiative debt creates substantial pressures for some trusts. Based on responses to our census of PCTs, trusts received some £61 million of tapered private finance initiative support in 2011-12, in line with plans in the business cases for private finance initiative funded development. Because these payments gradually reduce, provider trusts must be able to manage without this support at the end of the taper. Long-term commitments under private finance initiative agreements can also limit the scope hospitals have to reconfigure services across different sites.

3.20 The Department has reviewed the financial plans of 22 NHS trusts with significant private finance initiative schemes, and concluded that in six cases the trusts' plans are not viable without some level of central support. The Department announced in February 2012 that it would make a total of £1.5 billion available to six NHS trusts and one NHS foundation trust, spread over the remaining life of the private finance initiative agreements, to help them meet Monitor's financial assessment criteria for foundation status. This support equates to approximately £60 million a year across the seven trusts, over a 25-year period. One NHS foundation trust, Peterborough and Stamford NHS Foundation Trust, told us that they believed forecasts in the business case for a private finance initiative scheme had proved over-optimistic, and that this had contributed to financial problems. **Figure 20** shows that Peterborough and Stamford NHS Foundation Trust reported a deficit of £1.5 million in 2010-11, but £45.8 million in 2011-12. The local health economy attributes approximately half of this amount to an unaffordable private finance initiative investment.

Mergers or changes to services

3.21 There are a number of NHS trusts that have recognised that they are not financially viable in their current form. In our report *Achievement of Foundation Trust status by NHS hospital trusts* we reported that 20 trusts could not achieve foundation trust status in their present form. Of these, 15 have become, or are in the process of becoming, part of an existing foundation trust, merging with other applicant trusts to become a new organisation or, in one case, franchised. This leaves at least five trusts whose future is unclear:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Surrey and Sussex Healthcare NHS Trust

- Epsom and St Helier University Hospitals NHS Trust
- Weston Area Health NHS Trust. The Department concluded that the trust is not viable over the long term in its current form. The trust will develop in 2012-13 a plan for its future.
- George Eliot Hospital NHS Trust

3.22 Some providers are seen as sustainable in the short term but not the long term. In some areas work is already being done looking at future sustainability, and programmes of mergers, reorganisation of services and acquisitions are going ahead.

Figure 20
Case example: Peterborough and Stamford NHS Foundation Trust

The trust told us that they believed forecasts in the business case for a private finance initiative scheme had proved over-optimistic, and that this had contributed to financial problems

Background

Peterborough and Stamford NHS Foundation Trust is a medium-sized district general hospital. It operates across two sites, Peterborough City Hospital and Stamford Hospital. The trust relocated in October 2010 from two sites in Peterborough to the new Peterborough City Hospital building financed through private finance initiative investment.

Financial situation

In 2009-10 the trust reported an underlying surplus of £0.6 million, in 2010-11 a deficit of £1.5 million, and in 2011-12 a deficit of £45.8 million.

The trust's lead commissioners, Peterborough and Cambridgeshire PCTs (who now operate as a single cluster) are the only two PCTs continuing to have historic debts (of £21 million) at the end of 2011-12.

Issues facing future sustainability/risk

In October 2011 Monitor found Peterborough and Stamford NHS Foundation Trust in significant breach of its terms of authorisation.

Towards the end of 2011-12, the Department provided the trust with £41.2 million of public dividend capital support.

On the basis of what the trust told us Peterborough is considered to have three main problems:

The private finance initiative scheme is unaffordable. The trust requires a long-term structural solution and is being considered for the recurrent private finance initiative support that the Department are planning to provide.

The lead PCT cluster is financially challenged and has not been able to pay for all the activity the trust is providing. Demand management schemes are not succeeding in reducing emergency activity, putting additional financial pressure on the trust.

The trust has consistently been unable to deliver cost improvement plans.

Source: National Audit Office

Managed failure

3.23 The Committee of Public Accounts has previously expressed concerns about the Department lacking a formal 'failure' regime to manage NHS foundation trusts in severe financial difficulties, to ensure continuity of care and to protect taxpayers' interests.[10] The Health and Social Care (Community Health and Standards) Act 2003 gave Monitor the power to replace members of NHS foundation trust boards, which it has used on occasion, or dissolve the NHS foundation trust, which it has not. Dissolution would transfer the property and liabilities of an NHS foundation trust, without triggering a process to resolve the issues that led to dissolution. The regulations allowing for an insolvency regime under the Insolvency Act 1986 have not been introduced.

3.24 Amendments in the Health Act 2009 created the option to appoint a special administrator to take over a failing NHS trust. These provisions have to date not been used. Rather than introduce new provisions for dealing with failing NHS trusts in the Health and Social Care Act 2012, the Department intends to make use of the existing provisions. That legal framework will remain in place until NHS trusts are abolished. The Health Act 2009 also allowed Monitor to 'de-authorise' NHS foundation trusts and for the Secretary of State to appoint a special administrator to take over such failing NHS foundation trusts. The 2012 Act removed the option of 'de-authorisation' but would now allow Monitor to appoint a special administrator while maintaining the organisation as an NHS foundation trust. This will happen if Monitor, "is satisfied that an NHS foundation trust is, or is likely to become, unable to pay its debts". The administrator will then ensure that services deemed essential by commissioners are maintained while all parties agree on a long-term solution to recommend to Monitor, and ultimately the Secretary of State.

3.25 When the 2009 Health Act created the option of appointing a special administrator to run a failing trust, it also covered NHS trusts. As with NHS foundation trusts, this was never used. In future, the Department expects that the NHS Trust Development Authority will address cases as they arise.

10 House of Commons Committee of Public Accounts, *National Health Service Landscape Review,* Thirty-third Report of Session 2010–12, HC 764, 27 April 2011.

Appendix One

Methodology

Our methodology was designed to obtain an overview of the financial sustainability of NHS commissioners, and the NHS trusts and NHS foundation trusts, which ensure access to secondary and tertiary health care services. Our methodology involved structured interviews with key stakeholders; a census of PCT clusters; analysis of underlying financial information; and visits to eight trusts and eight PCT clusters. The trusts we selected were chosen to help us understand how trusts are approaching financial sustainability. They do not represent the population as a whole.

The main elements of our fieldwork took place between January and May 2012.

Detailed methods

Methods	Purpose
Interviews with officials Semi-structured interviews with key stakeholders from the Department of Health and Monitor.	To understand: • the Department's perspective on NHS financial sustainability; and • Monitor's perspective on NHS financial sustainability.
Analysis of trust financial data • Indicators of financial sustainability based on the tests Monitor applies to applicants for foundation trust status. • Comparison of other key measures (including income, spending, debt and liquidity over time). • Income and spending against plan. • Surplus/deficit: Surplus and deficit figures for NHS foundation trusts used in the report are the net surplus or deficit before net impairments. This treatment matches the way Monitor report in their annual review of NHS foundation trust consolidated accounts.	Numerical review of financial sustainability across population of NHS bodies, present and historical: • To compare performance and trends in financial performance and sustainability. • To consider how the 2011-12 data compare with 2010-11 and earlier data. • To look at collective and individual direction of travel. Source: Audited financial data and quarterly data returns from all NHS bodies (except NHS foundation trusts) to the Department of Health and quarterly financial data returns from all NHS foundation trusts to Monitor.

Methods	Purpose
Analysis of trust financial data *continued*	
Surplus and deficit figures for NHS trusts used in the report are the net surplus or deficit before net impairments and adjustments for IFRIC 12 donated assets. This treatment matches how the Department reports surplus and deficit figures for NHS trusts. • Debt. • Earnings before interest, tax, depreciation and amortisation (EBITDA). EBITDA figures for NHS foundation trusts are calculated from unaudited quarterly returns. EBITDA figures for NHS trusts are calculated from audited financial data.	
Census of all 50 PCT clusters	
• Census of all 50 PCT clusters. • The response rate was 45 of 50 (90 per cent of PCT clusters). • The financial data from our census was unaudited data. Some of the variations in information collected may be due to differences in interpretation by PCTs responding to the census. Census questionnaires were developed with input from the Department and piloted. Reviews where signed off by finance directors. Where possible we checked responses to other evidence, including public board papers.	To understand: • how much additional support is provided to trusts and the different routes this support takes; • the sustainability of trusts without additional support; and • PCT clusters' views on sustainability of their trusts.
Analysis of Department of Health financial data	
• Analysis of additional support for trusts that strategic health authorities recorded in 2011-12. • Analysis of the public dividend capital that the Department has provided to trusts since 2006-07. • Analysis of the working capital loans and capital investment loans that the Department has provided to NHS trusts and NHS foundation trusts.	To understand: • how much additional support is provided to trusts and the different routes this support takes; and • the sustainability of trusts without additional support.

Methods	Purpose
Structured interviews with strategic health authorities • Structured interviews with the finance directors of the four strategic health authority clusters and heads of finance for underlying strategic health authorities as appropriate.	To understand the strategic health authority perspective on: • the financial health of the trusts in its region; • the additional support these trusts have received; • the key issues impacting each trust; • the progress of the trusts to foundation trust status; and • the financial health of the foundation trusts in its region.
Visits to primary care trust clusters We carried out semi-structured interviews face-to-face with senior managers at eight primary care trust clusters: • Peterborough and Cambridgeshire Cluster • Greater Manchester Cluster • NHS South of Tyne and Wear • Bedfordshire and Luton Cluster • South East London Cluster • South West London Cluster • Southampton, Hampshire, Isle of Wight and Portsmouth Cluster • NHS Berkshire Cluster	To understand: • NHS bodies' financial performance, both collectively and individually, against key measures of financial sustainability including outturn surplus or deficit against forecast and year-to-date position, debt and liquidity; • how much ground there is to be covered by challenged organisations, and the distance between the most and least financially resilient bodies; • the actions that can be taken by SHAs to support trusts and PCTs, and how far organisations have received non-recurrent financial support; and • the key risks and obstacles, primarily for trusts and PCTs, to achieving financial sustainability.
Visits to NHS trusts We carried out semi-structured interviews face-to-face with senior managers at eight trusts: • Heatherwood and Wexham Park Hospitals NHS Foundation Trust • Frimley Park Hospital NHS Foundation Trust • South London Healthcare NHS Trust • South West London & St George's Mental Health NHS Trust • Peterborough and Stamford Hospital NHS Foundation Trust • Bedford Hospital NHS Trust • South Tyneside NHS Foundation Trust • Portsmouth Hospitals NHS Trust	To understand: • NHS bodies' financial performance, both collectively and individually, against key measures of financial sustainability including outturn surplus or deficit against forecast and year-to-date position, debt and liquidity; • how much ground there is to be covered by challenged organisations, and the distance between the most and least financially resilient bodies; • the actions that can be taken by SHAs to support trusts and PCTs, and how far organisations have received non-recurrent financial support; and • the key risks and obstacles, primarily for trusts and PCTs, to achieving financial sustainability.

Design and Production by
NAO Communications
DP Ref: 009875-001

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ISBN 978-0-10-297720-2

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