



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

The financial sustainability of NHS bodies

Summary

1 This is our third report on the financial sustainability of NHS bodies. Key tests of financial sustainability include changes in the surplus or deficit of the NHS as a whole, spending by NHS bodies as a proportion of their funding, and the number and scale of organisations in financial distress. In the medium to long term, the health service must be financially sustainable for it to provide sustainable services for patients.

2 The Health and Social Care Act 2012 changed the way the NHS was funded in 2013-14. Before then, strategic health authorities and primary care trusts allocated funds to healthcare providers. Most funds are now allocated by GP-led clinical commissioning groups.

3 In 2013-14, against a tight budget settlement, the government protected NHS funding. The Department of Health (the Department) allocated £95.2 billion to NHS England in 2013-14 to pay for NHS services. The largest proportion was spent by 211 clinical commissioning groups to buy services from 98 NHS trusts, NHS Direct and 147 NHS foundation trusts. NHS England directly commissioned £13.4 billion of specialised treatment, such as organ transplants and new drug therapies. These services tend to involve low volumes and high costs. NHS England also commissioned £11.3 billion of primary care services.

4 This report focuses on the NHS trusts and foundation trusts that provide community, mental health, acute and specialist health services. We also look at the financial performance of NHS England and the clinical commissioning groups that purchase those services. The report does not look in detail at primary care, social care, public health or other similar services. We set out our audit approach in Appendix One and our evidence base in Appendix Two. Technical notes explaining how we have treated some of the financial data are in Appendix Three.

Key findings

Trends in the financial performance of NHS bodies

5 In 2013-14 NHS bodies achieved a net surplus of £722 million, made up of an £813 million underspend by commissioners and a £91 million net deficit by NHS trusts and foundation trusts. This is one-third of the £2.1 billion net surplus that strategic health authorities, primary care trusts, NHS trusts and foundation trusts achieved in 2012-13. At the end of 2012-13 commissioners' cumulative surplus stood at £1.2 billion. In 2013-14 commissioners needed to use £400 million of their brought-forward surplus, reducing it to £813 million (paragraphs 1.5 and 1.6).

6 More NHS trusts and foundation trusts reported deficits in 2013-14 than in 2012-13. Comparing the two years, 18 NHS trusts and 26 foundation trusts moved from reporting a surplus in 2012-13 to a deficit in 2013-14. The gross deficit for all trusts increased from £297.2 million in 2012-13 to £743.3 million in 2013-14. The average deficit decreased from £11.9 million to £11.6 million. Foundation trusts have more financial freedom than NHS trusts, and a short-term deficit is not necessarily evidence of financial weakness. However, only 5 foundation trusts moved from a deficit in 2012-13 to a surplus in 2013-14 (paragraphs 1.7 to 1.9).

7 Trusts in surplus in 2013-14 were likely to have a lower surplus than they had in 2012-13. The number of NHS trusts and foundation trusts with a surplus fell from 222 in 2012-13 to 182 in 2013-14 and, for those trusts, their average surplus fell from £4.0 million to £3.6 million (paragraph 1.7).

8 The average earnings before interest, tax, depreciation and amortisation (EBITDA) margin for NHS trusts and foundation trusts has fallen over the past 4 years. The EBITDA margin is a key measure of the financial health of NHS trusts and foundation trusts. Monitor (the statutory regulator for NHS foundation trusts) uses, as a guide, 5% as one threshold to test whether an NHS trust is financially strong enough to be licensed as a foundation trust. The average EBITDA margin for NHS trusts fell from 5.4% in 2012-13 to 4.2% in 2013-14. For existing foundation trusts, the average EBITDA margin fell from 5.7% to 5.0%. By the end of 2013-14, 70 foundation trusts (48%) had fallen below the 5% threshold (paragraphs 1.10 and 1.11).

9 Financial risk in NHS trusts and foundation trusts is increasing. Monitor and the NHS Trust Development Authority (NHS TDA) use various measures, including financial and continuity of service ratings, to assess the risk to services among provider bodies. At the end of 2013-14 Monitor gave 20 acute foundation trusts (24% of the acute sector) continuity of service risk ratings of 1 or 2 on a 4-point scale (meaning that these trusts are of the most concern). The NHS TDA rated more than half the NHS trusts – 55 of 98 – as having ‘formal action required’, ‘material issues’ that had already been identified, or ‘concerns requiring investigation’ (paragraphs 1.17 to 1.20).

10 Based on forecasts at 30 June 2014, NHS trusts were forecasting a net deficit in 2014-15 of £404 million and foundation trusts a net deficit of £108 million. This compares with initial plans of a net deficit of £425 million for NHS trusts, and £20 million for foundation trusts. The deterioration in foundation trusts’ forecast position is consistent with their 2013-14 performance. In 2013-14, 19 foundation trusts originally planned a deficit but 41 were in deficit by the year end (paragraph 1.6).

Pressures on the financial sustainability of NHS bodies

11 Providers and commissioners in financial difficulty have not matched pressures on funding with equivalent reductions in expenditure. Between 2012-13 and 2013-14 total spending by trusts increased by 4.3%, while income increased by only 3.5%. The difference between changes in income and expenditure was greater for trusts in deficit (-1.9%) than in surplus (-0.3%). A few NHS trusts and foundation trusts reported large surpluses. However, 20 NHS trusts and 9 foundation trusts reported deficits of more than £10 million or more than 5% of their income in 2013-14. In 2013-14 providers were required to deliver 4% efficiency savings and this requirement is expected to continue for the next 4 years. Monitor, NHS England and the NHS TDA plan to make more transparent the additional income providers are paid over and above nationally set prices. This will help show whether providers are achieving real efficiency savings, or relying on increasing their income to break even. If providers do not achieve efficiency savings while remaining within locally agreed contracts and nationally set prices, their financial performance will worsen (paragraphs 2.2 to 2.5).

12 Despite payment for emergency admissions at a 30% marginal rate, demand continues to increase. Trusts are paid at a marginal rate of 30% of the full tariff for all emergency admissions above a baseline set from the number of admissions in 2008-09. The Department introduced this payment method to discourage unnecessary emergency admissions. We reported in October 2013 that emergency admissions had increased in 62% of trusts since the introduction of the marginal rate for emergency admissions. Case study trusts told us that demand is increasing, and it is not always possible to discharge patients into the community in a timely way. All the acute trusts we spoke to told us that payment for emergency admissions did not meet their costs. In practice, payment at the marginal rate may not give commissioners strong enough incentives to make alternative community care available. Increasing demand for emergency admissions will also reduce the resources commissioners have to invest in alternative primary or community care (paragraph 2.7).

13 NHS England underspent by £279 million compared with its original plan but, within this net total, it overspent £377 million on directly commissioned specialised services. The overspend was partly due to over-ambitious planning assumptions when responsibility for these services transferred from strategic health authorities. NHS England offset this pressure through use of its reserves (paragraph 2.8).

14 The clinical commissioning groups with the largest deficits are those with the widest gap between their target funding allocation and the income they received. Forty-nine clinical commissioning groups performed less well than originally planned: 12 of these had forecast a surplus but ended the year in deficit. The local auditor of clinical commissioning groups referred 19 bodies in deficit to the Secretary of State for spending more than their authorised resource limit. Nineteen of the 20 clinical commissioning groups with the tightest financial positions had received less than their target funding allocation (by 5.0% on average). Eighteen of the 20 clinical commissioning groups with the largest surpluses had received more than their target funding allocation (by 8.8% on average) (paragraphs 2.9 and 2.10).

15 Despite diversity in local health economies, some common features of the cost base for providers help explain their performance. As an example of local variation, the balance between providers' fixed and variable costs differs between trusts depending on locally negotiated arrangements such as property services and maintenance contracts (paragraph 2.12). Our analysis nonetheless shows:

- The surplus or deficit of an NHS trust or foundation trust is not explained by the financial strength of the clinical commissioning group that gives a provider the largest funding (paragraph 2.11).
- Historic private finance initiative (PFI) debt can make it more difficult to change the way estates and buildings are used. Among organisations with PFI commitments, those with the highest capital charges, as a proportion of their income, were the most likely to report weak financial results in 2013-14 (paragraphs 2.16 and 2.17).
- Some trusts have increased their spending on temporary or locum staff to tackle staff shortages or maintain clinical standards. Four of our 8 case study trusts had done this. Total spending on temporary staff increased by 23% between 2012-13 and 2013-14 (paragraph 2.19).
- Trusts with the best performance in achieving the 4-hour target to admit, transfer or discharge patients from A&E departments are likely to have a higher surplus than others. However, clinical performance does not generally explain financial performance (paragraphs 2.20 and 2.21).

Managing financial risks

16 NHS trusts and foundation trusts under financial stress continue to rely on cash support from the Department. In 2013-14 the Department issued £511 million cash support to 21 NHS trusts and 10 foundation trusts in the form of revenue-based public dividend capital (PDC). This is an increase of £248 million compared with 2012-13. The Department provides revenue-based PDC so that organisations in difficulty have the cash they need to pay creditors and staff. Since 2006-07, the Department has issued a total of £1.8 billion revenue-based PDC, of which £160 million has been repaid (paragraph 3.6 and 3.8).

17 Financial plans submitted by commissioners and providers covering the 2 years 2014-15 and 2015-16 have had to be revised and 2015-16 plans are not yet finalised. Commissioners and providers submitted 2-year operational plans in April 2014. The NHS TDA, Monitor and NHS England did not expect these plans to change. However, in the 5-year plans (covering 2014-15 to 2018-19) submitted at the end of June 2014, more than 50% of foundation trusts changed their 2-year plans, with most of the changes made to their 2015-16 forecasts. Between April and June 2014 nearly 75% of NHS trusts refreshed their plans, although only 8 made material changes to their forecasts. There remains considerable uncertainty about the impact on 2015-16 plans of initiatives such as the Better Care Fund, which both the Department and NHS England expect to reduce demand for acute hospital services. We will revisit this planning process for commissioners and providers in 2015, when relevant data will be more stable (paragraphs 3.17 to 3.19).

18 Trusts are expecting to receive more income than commissioners are expecting to spend on healthcare services. Data are not complete but, in August 2014, income forecasts exceeded planned commissioning spending by an estimated £404 million for 2014-15. Based on provisional figures, the gap for 2015-16 was £2.2 billion, potentially rising to £8.7 billion by 2018-19. These assumptions are consistent with evidence from our case studies, in which we found trusts were not confident that commissioners would be able to reduce demand for healthcare. Trusts forecasting deficits are assuming that the Department will continue to provide cash support (paragraphs 3.20 and 3.21).

19 Relationships between local bodies are not mature, and it is not clear where responsibility for strategic change will lie. Commissioners and providers told us the new structure felt fragmented, particularly at regional level. Senior staff we interviewed in NHS trusts and foundation trusts thought no organisation was responsible for taking a strategic view across the whole local health economy, but they were trying to bring about the transformational changes needed. Providers felt the patient services they offered would be at risk in the event of a failure by the system to plan effectively, and recognised the importance of working with clinical commissioning groups. Havering Clinical Commissioning Group, for example, told us it is working with 2 local clinical commissioning groups to coordinate strategic change and reconfigure services across the local health economy (paragraphs 2.22 and 3.23 to 3.25).

Conclusion on value for money

20 Headline measures of financial sustainability worsened between 2012-13 and 2013-14, largely due to growing financial stress in the NHS trusts and foundation trusts that provide hospital, mental health and community services. The total net surplus of NHS commissioners and providers was lower in 2013-14 than in 2012-13. NHS England expects clinical commissioning groups to achieve a surplus, but 19 of them did not do so. Among NHS trusts and foundation trusts, the average EBITDA margin was lower, more of them were in deficit and those not in deficit reported a lower average surplus. An increasing proportion were assessed by regulatory bodies as high risk.

21 These trends are not sustainable. An increasing number of providers and commissioners are in financial difficulty. Some NHS bodies have not made large enough cost savings, or contained the increasing demand for services within their available funding, whilst meeting quality and access targets. Parts of the NHS are achieving efficiencies by reconfiguring services to best meet patients' needs within available resources. However, commissioners' and providers' plans for 2014-15 and 2015-16 were delayed and 2015-16 plans are not yet stable. As in previous years, the Department provided cash support to the most challenged organisations in 2013-14 and some bodies are still planning that cash support will continue to be available. Until the Department explains how it will work with NHS England, NHS TDA and Monitor to address underlying financial pressures, quickly and without recourse to annual cash support, we cannot be confident that value for money, in terms of financial and service sustainability, will be achieved over the next 5 years.

Recommendations

22 The Department should work with regulators and oversight bodies to strengthen processes for testing and aligning the assumptions of commissioners and providers. The NHS faces challenges in meeting demand within resource limits. Unless there is alignment between the assumptions the Department, Monitor, NHS TDA and NHS England make about key factors such as activity growth, income, spending plans and productivity then this will increase uncertainty and financial risk. As part of the annual planning process, oversight bodies need to understand the assumptions commissioners and providers have included in setting contracts in order to assess the risk associated with achieving them. This will help avoid pressures being dealt with in an unplanned or uncoordinated way.

23 Monitor, the NHS TDA and NHS England should make more transparent use of the 1–2 and 3–5-year forecasts to improve understanding of financial sustainability across the NHS. This should help the Department assess whether overall spending within the NHS is likely to be in line with available resources and what levels of ongoing cash support may be needed by challenged organisations as part of any reconfiguration or financial recovery plan. It should also encourage better informed strategic decision-making in local health economies.

24 The Department and oversight bodies should strengthen the support they provide to help NHS commissioners and providers review and redesign services more quickly. This may involve providing more guidance and advice, identifying the incentives and capability needed to implement changes and working with local partners to make the case for change. The NHS is coming to the end of its first 5-year efficiency challenge, but some commissioners and providers are only now carrying out strategic service reviews.

25 The Department should consider, as an alternative to short-term in-year funding to financially distressed bodies, tapered financial support for investment or restructuring matched to clear plans over a longer period and with a clear end point. Providing non-recurrent support to bodies in financial distress may be necessary in the short term to ensure safe services to patients. However, some providers are becoming increasingly reliant on extra in-year financial support. Because this funding would not otherwise be available to them, it risks creating disincentives and delays to finding sustainable solutions that would represent better value for money in the long term.

26 NHS England and Monitor, in their review of how urgent and emergency care should be paid for in future, should assess the financial impact of any changes on trusts and commissioners. A number of acute providers cited the payment structure for emergency admissions as a factor contributing to their challenged financial positions. The review and future payment system should consider all parts of the healthcare system, including commissioners, primary and community care, so that responsibility and incentives across the system are shared.

27 NHS England should reinforce to clinical commissioning groups the requirement that they set out in planning documents how they have considered the impact of their decisions on other parts of the local health economy. There are examples of clinical commissioning groups starting to do this. But the Committee of Public Accounts has previously raised concerns whether devolved commissioning decisions would take a sufficiently strategic and joined-up approach to meet patient needs. NHS England should promote best practice. It should also be prepared to challenge more robustly commissioners' plans that do not clearly consider the impact on the wider health economy and explain how competing demands for limited resources from different providers and commissioners will be resolved.

28 The Department should work with oversight bodies to collect consistent financial data from providers. Trusts do not collect and record cost data consistently enough or in enough detail for systematic analysis. This limits the ability of providers and oversight bodies to undertake in-depth time series analysis, modelling, efficiency assessments and benchmarking.