National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health

The financial sustainability of NHS bodies

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National Audit Office

Department of Health

The financial sustainability of NHS bodies

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

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This report examines whether the current financial performance of NHS trusts, foundation trusts and commissioning bodies is sustainable.

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Contents

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Key facts

£722m

total net cumulative surplus of NHS England and clinical commissioning groups, less total net deficit reported by NHS trusts and foundation trusts in 2013-14

82

of 456 bodies (clinical commissioning groups, NHS trusts and foundation trusts) reported a deficit at the end of 2013-14

-£45m

indicative total net forecast deficit for NHS commissioners and provider bodies in 2014-15, based on plans at 30 June 2014

£813 million	net cumulative surplus of NHS England and clinical commissioning groups in 2013-14
19 (9%)	clinical commissioning groups in deficit at the end of 2013-14
-£91 million	total net deficit of all NHS trusts and foundation trusts in 2013-14
22 out of 98 (22%)	NHS trusts in deficit at the end of 2013-14 (excluding NHS Direct, and South London NHS Trust, which was dissolved on 1 October 2013)
41 out of 147 (28%)	NHS foundation trusts in deficit at the end of 2013-14
£1.8 billion	cash support given to NHS trusts and foundation trusts between 2006-07 and 2013-14 as revenue-based public dividend capital

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.

Part One

Trends in the financial performance of NHS bodies

1.1 In this part of the report we look at trends in the financial performance of NHS bodies and indicators of risk to financial and service sustainability.

NHS funding in 2013-14

1.2 In 2013-14 against a tight budget settlement, the government protected NHS funding.[1] On 1 April 2013, 211 clinical commissioning groups replaced 151 primary care trusts, and assumed responsibility for commissioning most healthcare services from community, secondary and specialist providers. NHS England, through its 27 local area teams, is responsible for commissioning primary care and specialised services. This report focuses on commissioning and providing services through NHS trusts and foundation trusts.

1.3 On 31 March 2013 there were 100 NHS trusts (as well as NHS Direct, which is a national body) and 145 foundation trusts. A new NHS trust, Gloucestershire Care Services, was formed on 1 April 2014. Two NHS trusts became foundation trusts during the year (Kingston Hospital on 1 May 2013 and Western Sussex Hospitals on 1 July 2013). South London NHS Trust transferred all its services to other NHS providers. Following these changes, at 31 March 2014 there were 98 NHS trusts (as well as NHS Direct) and 147 NHS foundation trusts.

1.4 NHS England is accountable to the Department of Health (the Department) for its spending. NHS trusts are subject to assurance by the NHS Trust Development Authority (NHS TDA). NHS foundation trusts are self-governing and have more financial and operational freedom from government than NHS trusts. The independent regulator Monitor oversees NHS foundation trusts.

1 HM Treasury, *Spending round 2013*, June 2013.

NHS spending against resources from the Department

1.5 **Figure 1** overleaf shows that the NHS as a whole ended 2013-14 with a surplus of £722 million, compared with an overall surplus of £2.1 billion in 2012-13. The headline figure includes £400 million drawdown by commissioners of £1.2 billion accumulated surpluses brought forward from 2012-13. The 2013-14 surplus was made up of:

- NHS England spending £29,749 million of the £29,847 million available for its national functions and centrally commissioned services, achieving a cumulative underspend of £98 million;
- Clinical commissioning groups spending £64,650 million of the £65,366 million available for locally commissioned services, resulting in a cumulative underspend of £716 million; and
- NHS trusts and foundation trusts reporting an overall £91 million deficit – a significant decrease from a £592 million surplus in 2012-13. NHS trusts had a net deficit of £216 million in 2013-14 (excluding NHS Direct, which had a deficit of £25 million), and foundation trusts a net surplus of £125 million.

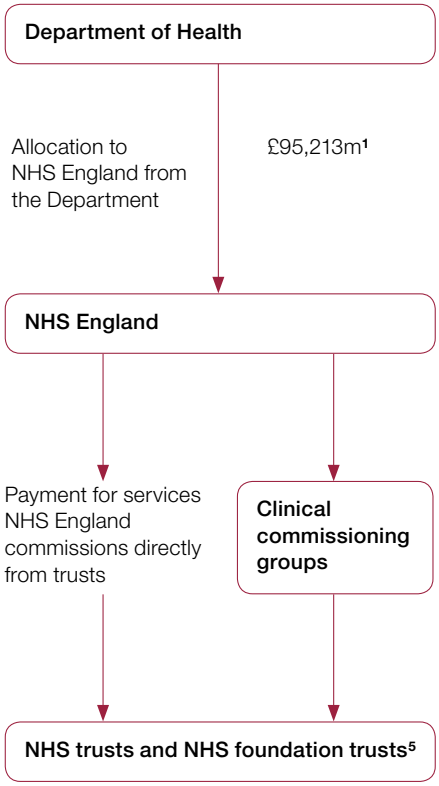
1.6 Based on plans at 30 June 2014, the Department estimated that NHS commissioners and providers together would end the 2014-15 financial year with a £45 million deficit. Because this figure included £400 million drawdown by commissioners of accumulated surpluses from prior years, it understates the financial pressure commissioners are under. Discounting the drawdown, the figure would be equivalent to an in-year deficit of £445 million. NHS trusts initially planned a collective £425 million net deficit in 2014-15. The revised forecast at 30 June 2014 was a net deficit of £404 million. Two-thirds predict that they will achieve a surplus or break even. Forecasts range from a 2.5% surplus to a predicted deficit of up to 11% of total funding. Foundation trusts initially planned a total net deficit of £20 million. At 30 June 2014 their forecast indicative net deficit was £108 million. Foundation trusts' 2013-14 performance showed a similar deterioration between plan and outturn in that 19 foundation trusts originally forecast a deficit, but 41 were in deficit at the year end.

Surpluses and deficits of NHS providers

1.7 The total number of providers in deficit increased from 25 in 2012-13 (10% of all secondary providers) to 64 in 2013-14 (26% of all secondary providers). There were 5 NHS trusts in deficit at the end of 2012-13 and 22 at the end of 2013-14. One of the trusts in deficit at the start of the year, South London Healthcare NHS Trust, was dissolved on 1 October 2013, so making a total of 23 trusts in deficit during 2013-14. The number of foundation trusts in deficit doubled from 20 in 2012-13 to 41 in 2013-14. The gross deficit for NHS trusts and foundation trusts together 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. The number of NHS trusts and foundation trusts with a surplus fell from 222 in 2012-13 to 182 in 2013-14 and their average surplus fell from £4.0 million to £3.6 million.

Figure 1

The summarised financial performance of commissioners and providers against allocations in 2013-14



Allocation used by NHS England for centrally commissioned services, including primary care, specialised services and public health	£29,847m	Underspend[4]	£98m[6]
Allocation to CCGs	£65,366m	Underspend	£716m[6]
Total income[1] for NHS trusts and foundation trusts	£72,620m[3]	Overspend (deficit)	£91m
Net underspend by commissioners and providers			£722m

Notes

1 The core measure for the financial performance of NHS England is its Revenue Departmental Expenditure Limit, which is £95,213 million. The total Mandate revenue budget set by the Department was £95,873 million, and includes other expenditure limits totalling £660 million.

2 NHS trusts and foundation trusts have 'income' as opposed to 'allocations'. This is because they operate on a more commercial basis than NHS England and clinical commissioning groups, which operate within an annual resource limit.

3 NHS trusts and foundation trusts receive income from clinical commissioning groups, NHS England and other sources including services provided to other trusts. The £72,620 million income shown here is the gross income from all these sources.

4 NHS England underspend excludes £133 million of 'legacy' benefit that represents the winding down of primary care trust or strategic health authority closing balance sheets.

5 Amounts for NHS trusts and foundation trusts include South London Healthcare NHS Trust, which dissolved on 1 October 2013. All other data are as at 31 March 2014.

6 The combined underspend of NHS England and clinical commissioning groups was £813 million. Figures may not sum exactly because of rounding differences.

7 Data in the chart exclude figures for NHS Direct.

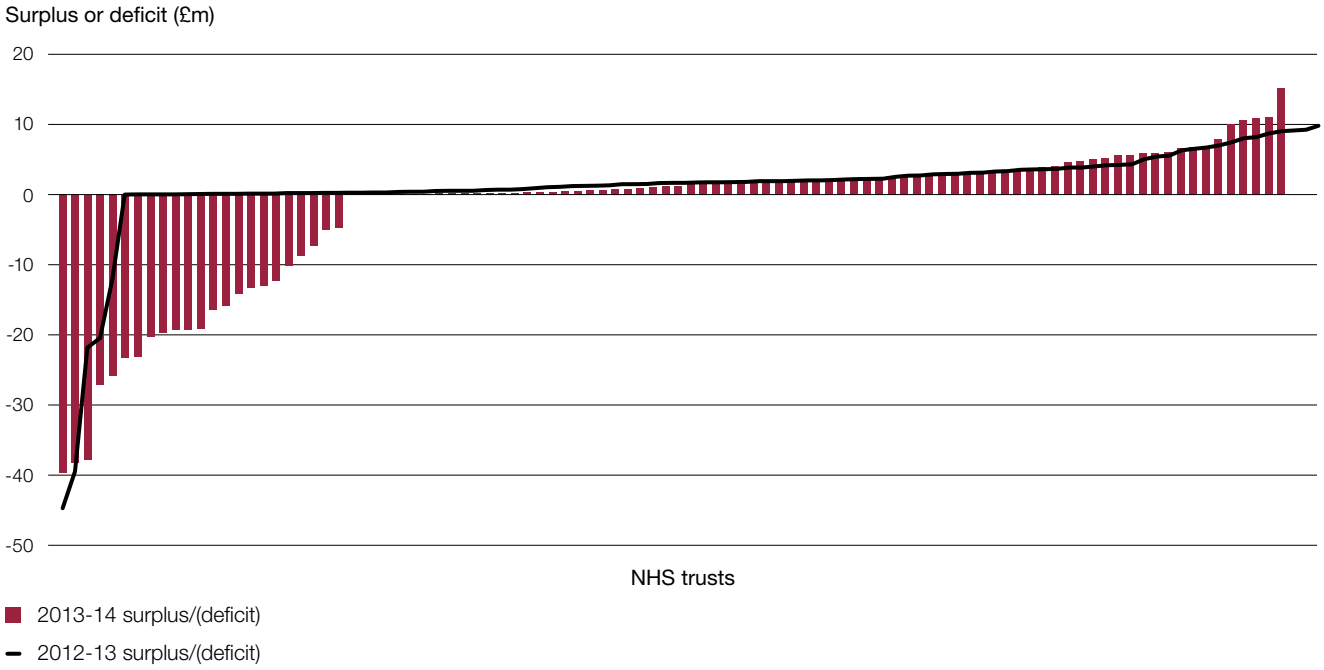
Source: National Audit Office analysis of NHS England, Monitor and NHS TDA data

1.8 **Figure 2** shows that most NHS trusts reported a surplus in 2013-14. However, more NHS trusts were in deficit in 2013-14 than in 2012-13. Between 2012-13 and 2013-14:

- 18 moved from surplus to deficit;
- 5 remained in deficit (including South London Healthcare NHS Trust); and
- none moved from deficit to surplus.

Figure 2
Surpluses and deficits of NHS trusts, 2012-13 and 2013-14

Most NHS trusts reported a surplus in 2013-14, but more NHS trusts were in deficit in 2013-14 than in 2012-13



Notes

1 Data in the chart exclude figures for NHS Direct.

2 NHS trusts that became foundation trusts in-year have been treated as though they were foundation trusts for the whole year.

3 Data include South London Healthcare NHS Trust, which dissolved on 1 October 2013. All other data are as at 31 March 2014.

Source: National Audit Office analysis of Department of Health and NHS Trust Development Authority data

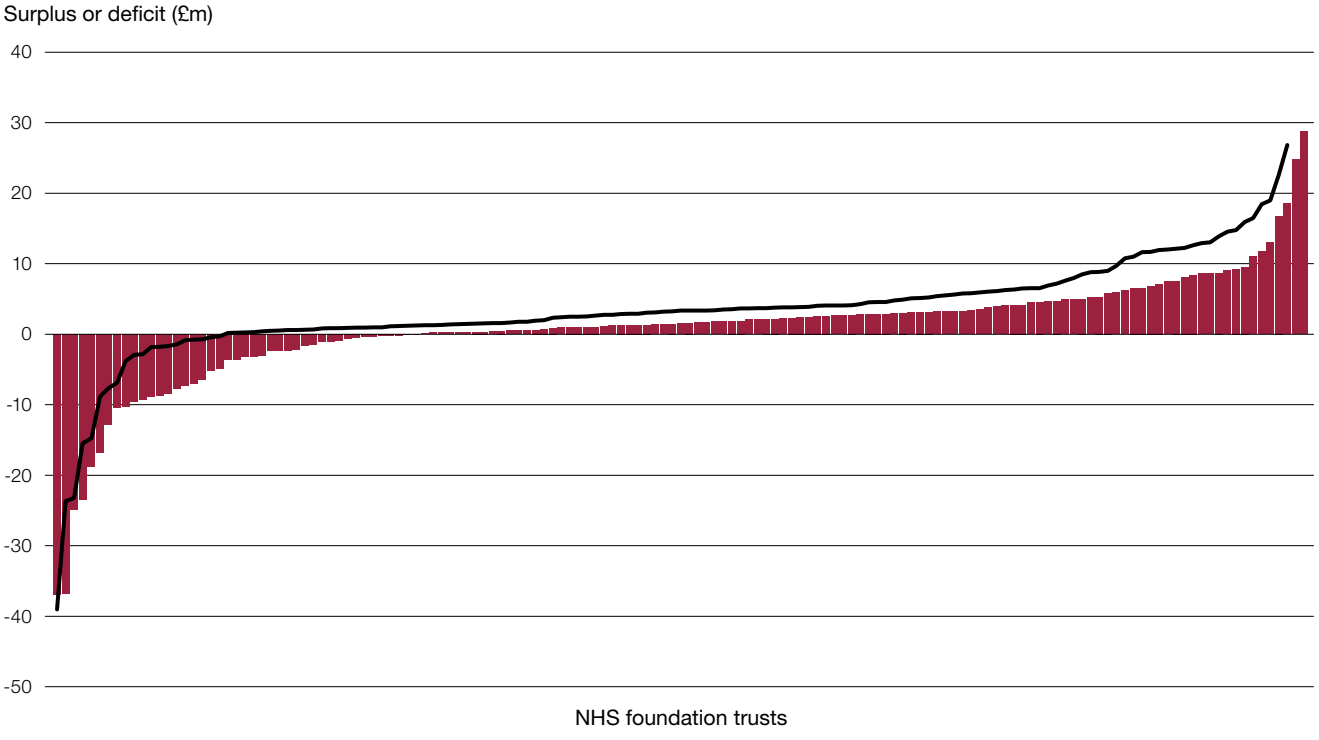
1.9 **Figure 3** shows that NHS foundation trusts tended to have lower surpluses in 2013-14 than in 2012-13, and more were in deficit. Between 2012-13 and 2013-14:

- 26 moved from surplus to deficit;
- 15 remained in deficit; and
- 5 moved from deficit to surplus.

Figure 3

Surpluses and deficits of NHS foundation trusts, 2012-13 and 2013-14

Foundation trusts had lower surpluses in 2013-14 than in 2012-13, and more were in deficit



Note

1 Data in this chart exclude charitable funds transactions.

Source: National Audit Office analysis of Monitor data

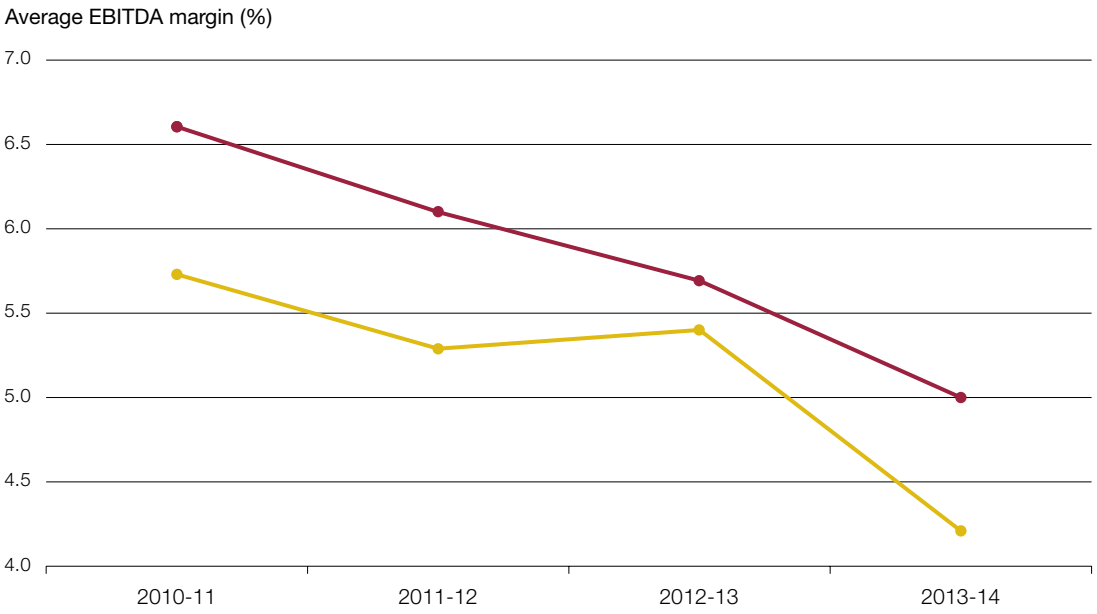
Earnings before interest, tax, depreciation and amortisation as a measure of underlying sustainability

1.10 A measure called the EBITDA margin (earnings before interest, tax, depreciation and amortisation, expressed as a percentage of income) is a good proxy for operating efficiency and an indicator of underlying financial sustainability. **Figure 4** shows that the average EBITDA margin has fallen over the past 4 years, and has been consistently higher for foundation trusts than for NHS trusts.

Figure 4

Average EBITDA margins for NHS trusts and foundation trusts, 2010-11 to 2013-14

The average EBITDA margin has fallen over the past 4 years and has consistently been higher for foundation trusts than NHS trusts



	2010-11	2011-12	2012-13	2013-14
Foundation trusts	6.6	6.1	5.7	5.0
NHS trusts	5.7	5.3	5.4	4.2

Notes

1 Figures for NHS trusts include data for acute, ambulance, community and mental healthcare provider organisations. Data shown here exclude figures for NHS Direct.

2 EBITDA figures for NHS foundation trusts are calculated from unaudited quarterly returns. EBITDA figures for NHS trusts are calculated from audited financial data.

3 When reporting on the sector, Monitor and the NHS TDA calculate EBITDA by dividing total EBITDA for the sector by total revenue for the sector, to adjust for size of the trust. In this report, we calculated a simple average EBITDA margin for all foundation trusts and all NHS trusts.

4 Data include South London Healthcare NHS Trust, which dissolved on 1 October 2013. All other data are as at 31 March 2014.

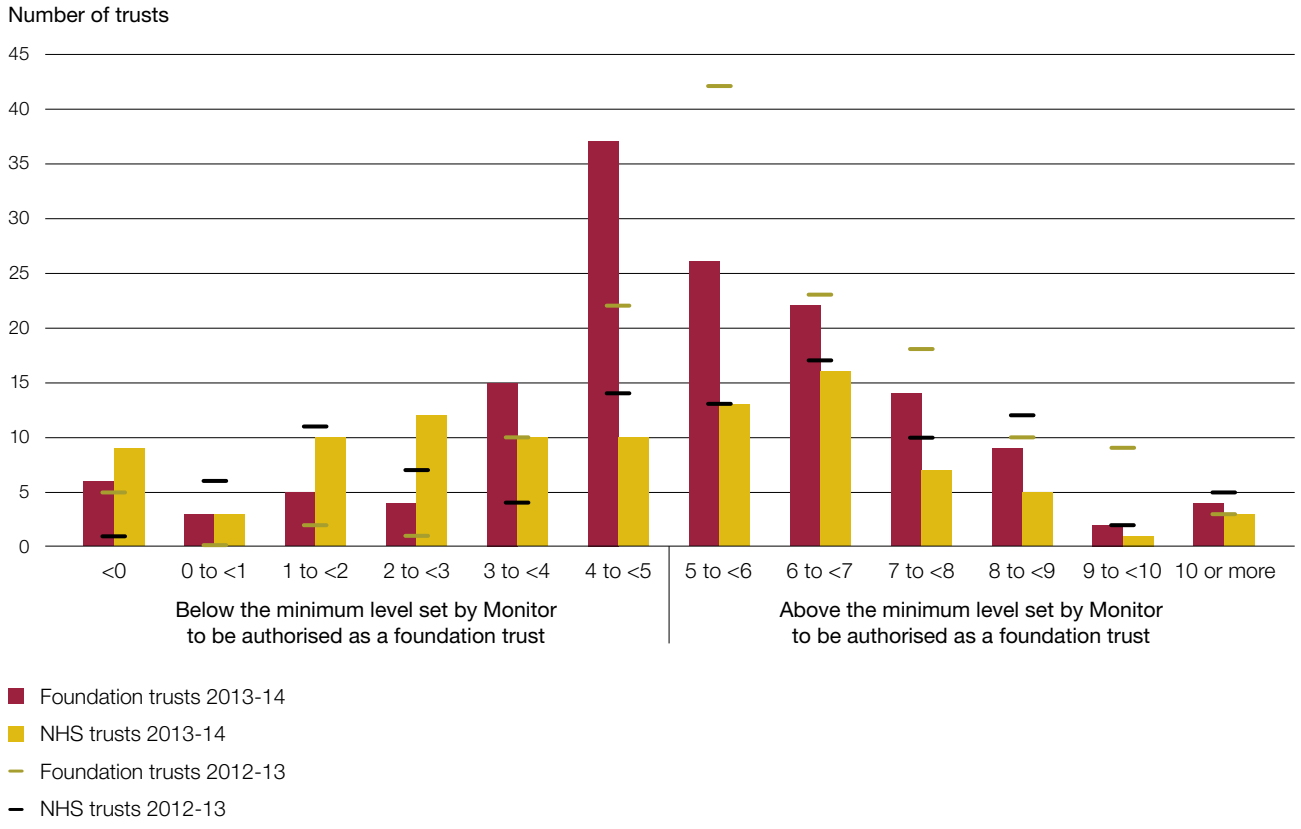
Source: National Audit Office analysis of NHS Trust Development Authority and Monitor data

1.11 The median EBITDA margin for NHS trusts and foundation trusts in 2013-14 was 4.7% and 5.2%, respectively. **Figure 5** shows, however, that there is substantial variation in the EBITDA margins achieved by individual trusts. Monitor uses a threshold of 5% as the minimum EBITDA margin it would normally view as a sustainable level to license a trust as a foundation trust. The numbers of all trusts meeting this threshold fell between 2012-13 and 2013-14. At the end of 2013-14, 70 existing foundation trusts (48%) fell below the 5% threshold.

Figure 5

Distribution of EBITDA margins in NHS trusts and foundation trusts, end of 2013-14, compared with 2012-13

There is substantial variation in the EBITDA margin achieved by individual trusts



Notes

1 NHS Direct is not included.

2 Figures are not adjusted for the potential impact of any non-recurrent financial support trusts may have received.

3 Data include South London Healthcare NHS Trust, which dissolved on 1 October 2013. All other data are as at 31 March 2014.

Source: National Audit Office analysis of NHS Trust Development Authority and Monitor data

Net current assets

1.12 **Figure 6** shows that the net current assets held by NHS trusts and foundation trusts increased from £1.64 billion at the end of 2012-13 to £1.66 billion at the end of 2013-14. NHS trusts were in a weaker position than foundation trusts. NHS trusts had net current liabilities of £0.10 billion, whereas foundation trusts held net current assets totalling £1.76 billion.

1.13 The total cash held by NHS trusts and foundation trusts decreased from £5.84 billion to £5.48 billion. Our case studies found that this was because some trusts were investing cash into capital projects, such as site redevelopment.

Figure 6

Cash and other current assets and liabilities at the end of the financial year, 2012-13 and 2013-14

	2012-13				2013-14			
	Current assets		Current liabilities	Net current assets	Current assets		Current liabilities	Net current assets
	Cash and cash equivalents (£bn)	Other current assets (£bn)	(£bn)	(£bn)	Cash and cash equivalents (£bn)	Other current assets (£bn)	(£bn)	(£bn)
NHS trusts	1.36	1.80	-3.32	-0.15	1.27	2.29	-3.66	-0.10
NHS foundation trusts	4.48	2.37	-5.06	1.79	4.21	3.14	-5.59	1.76
Total	**5.84**	**4.17**	**-8.38**	**1.64**	**5.48**	**5.43**	**-9.25**	**1.66**

Notes

1 Current assets and current liabilities include balances between trusts (figures are gross, not netted off between trusts).

2 Figures do not sum because of rounding differences.

3 Data in this chart exclude charitable funds for NHS foundation trusts.

4 Current assets and liabilities for South London Healthcare NHS Trust, which dissolved on 1 October 2013, are included in the figures of King's College Hospital NHS Foundation Trust, Oxleas NHS Foundation Trust and Lewisham and Greenwich NHS Trust at 31 March 2014, which took on South London Healthcare NHS Trust's services.

5 NHS trusts that became foundation trusts in-year have been treated as though they were foundation trusts for the whole year.

6 Data exclude NHS Direct.

Source: National Audit Office analysis of NHS Trust Development Authority and Monitor data

Dividends payable on public dividend capital

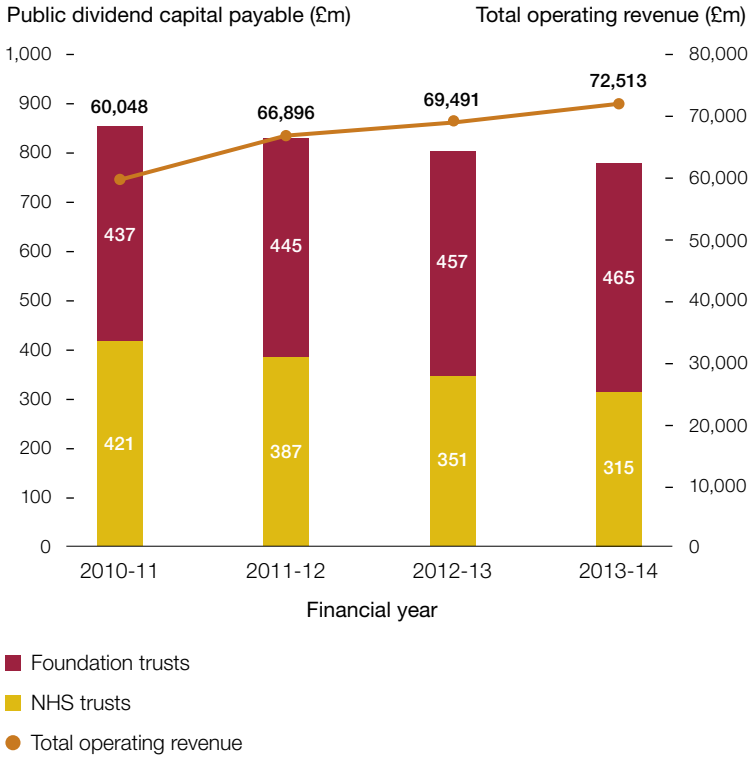
1.14 **Figure 7** shows the value of dividends payable by NHS trusts and foundation trusts on public dividend capital (PDC) investments. All trusts pay annual dividends to the Department based on 3.5% of the value of their average net assets.

1.15 Total operating revenue for NHS trusts and foundation trusts increased by 21% from 2010-11 to 2013-14, while the amount of PDC dividends payable fell by 9%. This may reflect a downward revaluation of assets such as buildings and major equipment. Some trusts with large commitments (for example, buildings funded under the private finance initiative) may have negative asset balances and are not, therefore, required to pay dividends.

Figure 7

Change in dividend payable on PDC and total operating revenue, 2010-11 to 2013-14

Total operating revenue for trusts increased by 21% from 2010-11 to 2013-14, while the amount of PDC dividends payable fell by 9%



Notes

1 The figures reflect the value of dividends payable at the end of the year.

2 The data shown use draft accounts in calculating the public dividend capital in accordance with guidance. In some circumstances (mainly affecting foundation trusts), this figure can change at final accounts stage, but these cases are rare.

3 NHS trusts that became foundation trusts in-year have been treated as though they were foundation trusts for the whole year.

Source: National Audit Office analysis of Department of Health data

1.16 The figure is significant because a downward revaluation of assets allows trusts to reduce the PDC dividends they pay, yet the sector as a whole is showing a worsening financial performance. At the same time, NHS trusts and foundation trusts invested in new capital as a ratio of their depreciation (a source of capital) at 146% and 168% respectively in 2013-14. This means that they may incur future costs for servicing new assets.

Financial risk in NHS providers

1.17 Monitor and the NHS TDA use financial and non-financial measures to assess the risk to services among providers. In 2013-14, performance of most of these measures worsened. This suggests the financial sustainability of provider bodies is not improving.

1.18 **Figure 8** overleaf shows that the percentage of NHS foundation trusts Monitor assessed as having the highest financial and continuity of service risk has been increasing since 2007-08. As a benchmark, Monitor normally expects aspirant trusts to achieve a rating of 3 or more to be licensed as a foundation trust. In 2013-14, 6.8% of existing foundation trusts were in the highest risk category. All 20 trusts with a continuity of service risk of 1 or 2 were acute trusts, representing 24% of the acute sector. By comparison, 100% of ambulance trusts, 94% of specialist trusts and 80% of mental health trusts had a continuity of service risk rating of 4. The planned continuity of service risk rating for 2014-15 shows a further increase in the proportion of foundation trusts with the greatest continuity of service risk.

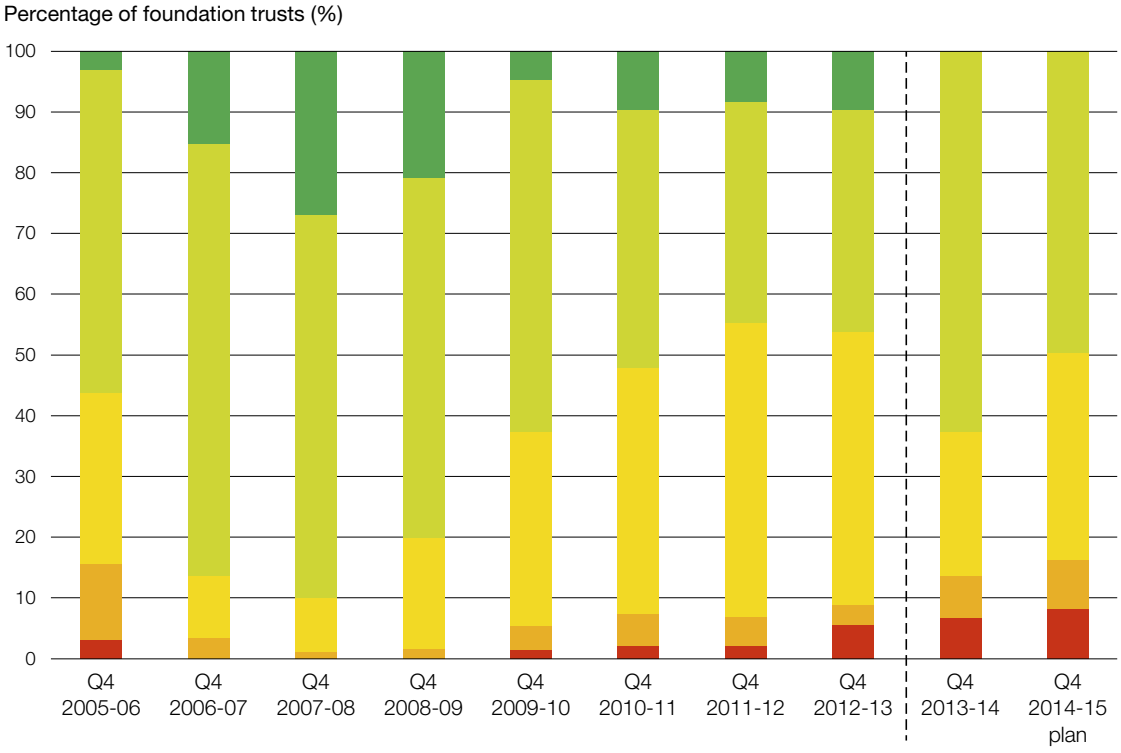
1.19 For NHS trusts, the NHS TDA makes an oversight and escalation risk assessment based on measures of quality, finance and sustainability. The score determines the nature of the interventions and support available to trusts. Sustainability scores are currently decided by a moderation process led by NHS TDA directors of delivery and development. NHS TDA intends to develop a methodology for basing sustainability scores on the outcome of the planning process.

1.20 **Figure 9** on page 23 shows the oversight and escalation scores for NHS trusts. In 2013-14 the number of trusts with no identified concerns worsened, from 18 in the second quarter of 2013-14 to 15 in the fourth quarter. At the end of 2013-14, the NHS TDA rated more than half the trusts – 55 of 98 – as needing formal action, having material issues that had already been identified, or concerns requiring investigation. The planned continuity of service risk rating for 2014-15 shows a further increase in the proportion of NHS trusts with the greatest risk.

Figure 8

Monitor's financial and continuity of service risk ratings for NHS foundation trusts at quarter 4, 2005-06 to 2013-14

The percentage of foundation trusts Monitor assessed as having the highest financial and continuity of service risk has been increasing since 2007-08



	Q4 2005-06	Q4 2006-07	Q4 2007-08	Q4 2008-09	Q4 2009-10	Q4 2010-11	Q4 2011-12	Q4 2012-13	Q4 2013-14	Q4 2014-15 plan
5 (%)	3.1	15.3	27.0	20.9	4.7	9.6	8.4	9.7	0.0	0.0
4 (%)	53.1	71.2	62.9	59.1	58.1	42.6	36.4	36.6	62.6	49.7
3 (%)	28.1	10.2	9.0	18.3	31.8	40.4	48.3	44.8	23.8	34.0
2 (%)	12.5	3.4	1.1	1.7	3.9	5.1	4.9	3.4	6.8	8.2
1 (%)	3.1	0.0	0.0	0.0	1.6	2.2	2.1	5.5	6.8	8.2

Note

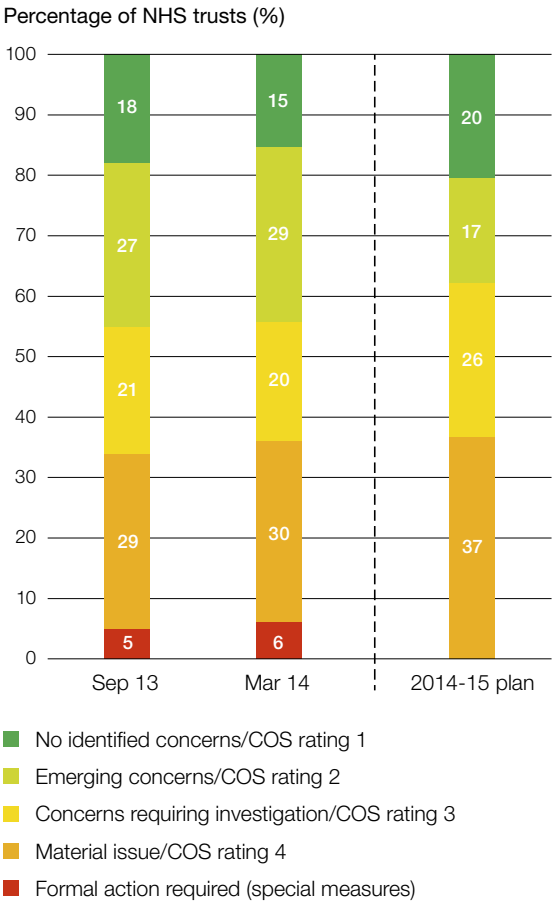
1 2012-13 ratings are not directly comparable with 2013-14 ratings, because Monitor moved to assessing a foundation trust's continuity of service risk rating from a 5-point scale to a 4-point scale.

Source: National Audit Office analysis of Monitor data

Figure 9

NHS TDA's oversight and escalation scores for NHS trusts between quarter 2 2013-14 to quarter 4 2013-14, and 2014-15 forecast continuity of service ratings

Risk ratings for NHS trusts marginally worsened in 2013-14



Notes

1 NHS TDA took on its full functions from 1 April 2013. Before then, strategic health authorities managed oversight of NHS trusts. Oversight and escalation scores are not available before quarter 2 2013-14.

2 NHS TDA uses a 5-point scale to assess oversight and escalation scores, based on NHS trusts' actual performance. The best equivalent for 2014-15 plans is the continuity of service risk rating, which NHS TDA assesses on a 4-point scale. 2014-15 forecast ratings are continuity of service ratings.

3 Data do not include NHS Direct.

Source: National Audit Office analysis of NHS TDA data

Governance risk in NHS foundation trusts

1.21 Governance risk ratings are based on information including:

- the results of Care Quality Commission (CQC) inspections;
- key quality and outcomes metrics;
- governance indicators such as patient and staff satisfaction;
- other third-party reports; and
- the organisation's continuity of service risk rating.

1.22 **Figure 10** shows that the proportion of NHS foundation trusts assigned a red rating for governance risk increased from 3% in 2005-06 to 20% (29 of 147 foundation trusts) in 2013-14. The acute sector has the poorest governance risk profile with 28% currently rated as red.

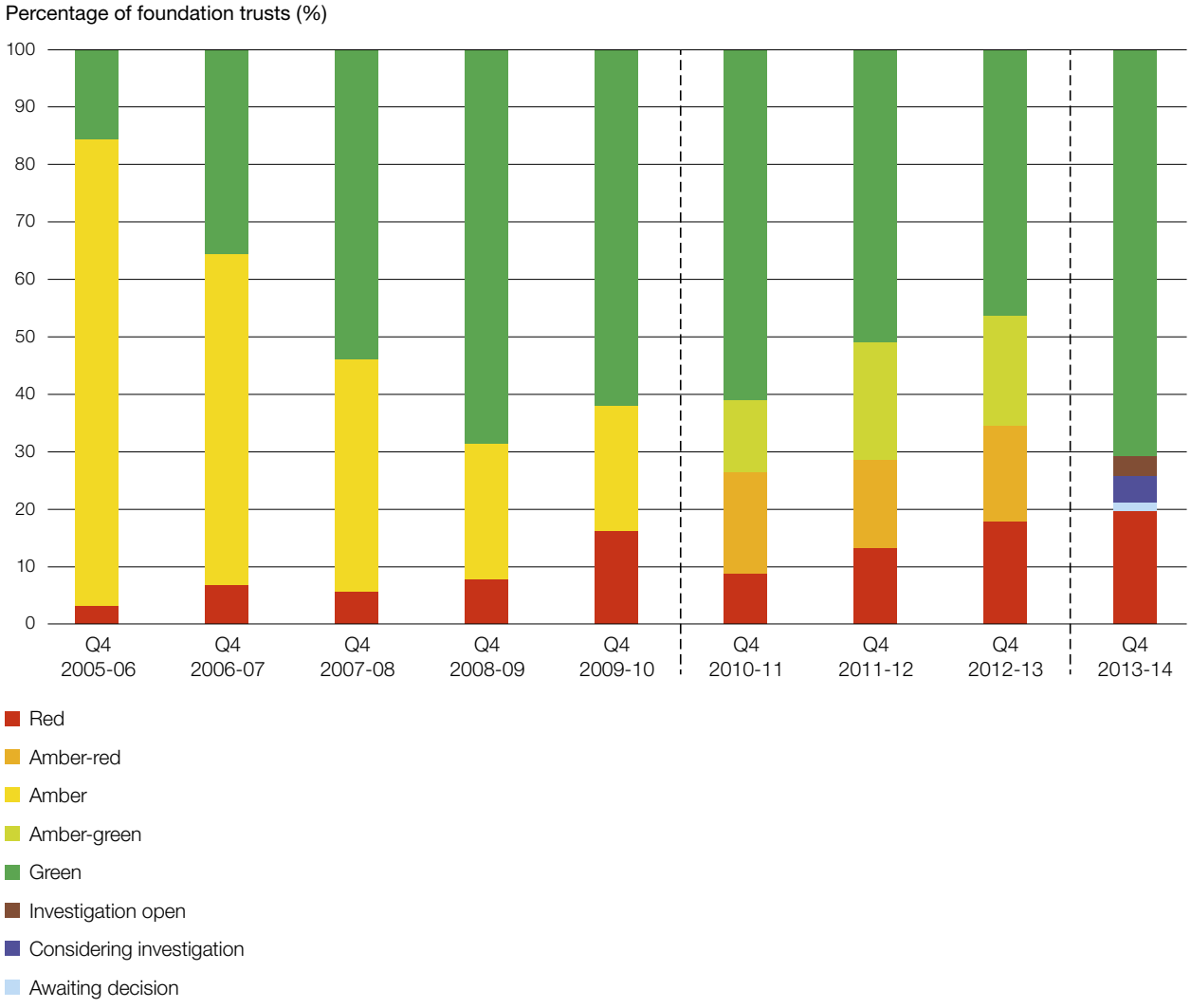
NHS foundation trusts in breach of the terms of their licence

1.23 **Figure 11** on page 26 shows that an increasing proportion of foundation trusts cannot meet the standards Monitor sets. In the fourth quarter of 2013-14, there were 27 trusts (18%) in breach of their licence. Since December 2010, the number has increased in absolute as well as percentage terms.

Figure 10

Monitor's governance risk ratings for NHS foundation trusts at quarter 4, 2005-06 to 2013-14

The proportion of foundation trusts assigned a red rating for governance risk increased from 3% in 2005-06 to 20% in 2013-14



Notes

1 In 2010-11, Monitor moved from a 3-point scale to a 4-point scale, splitting the amber rating into amber-green and amber-red ratings.

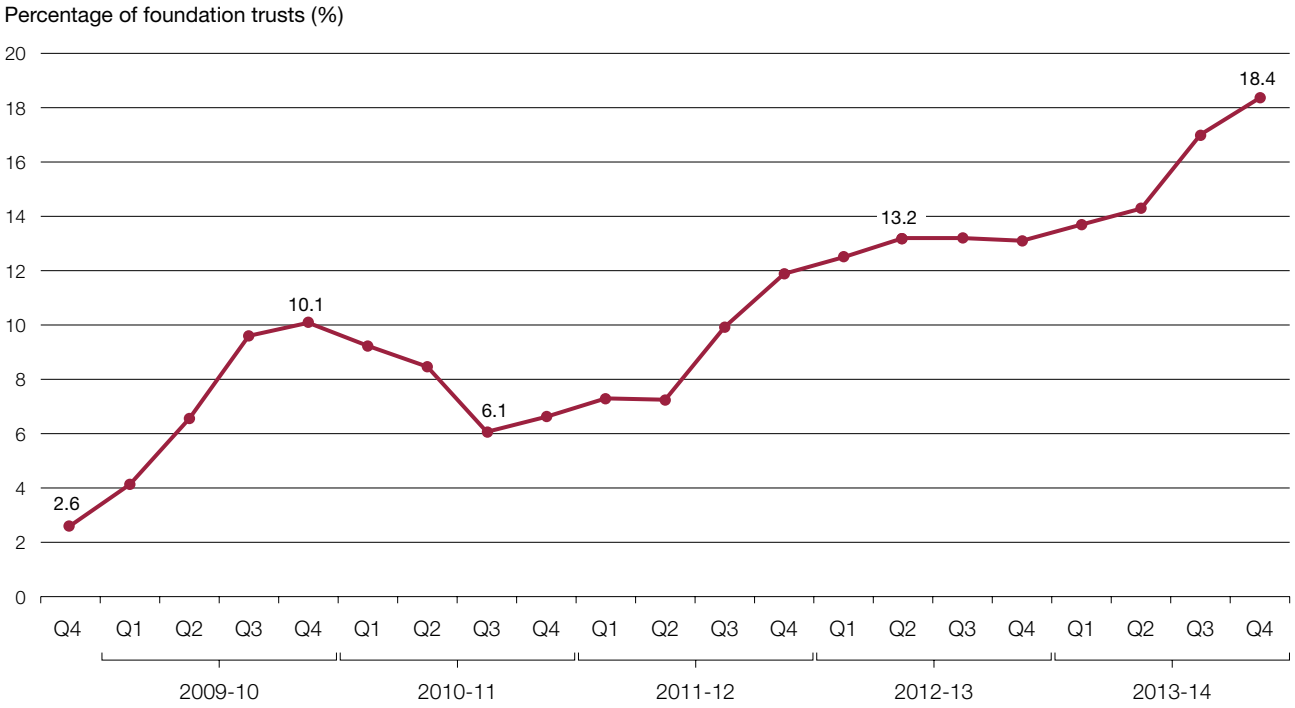
2 In 2013-14, Monitor moved from the 4-point scale to classifying foundation trusts as either 'no evident concerns' (green), 'subject to enforcement action' (red), or 'under review' (with sub-categories as shown above).

Source: National Audit Office analysis of Monitor data

Figure 11

Percentage of foundation trusts in breach (or equivalent) of their terms of authorisation, 2009-10 to 2013-14

An increasing proportion of foundation trusts cannot meet the standards Monitor requires them to achieve



Note

1 The new provider licence replaced the foundation trust authorisation on 1 April 2013, and from this date onwards the term 'significant breach of authorisation' is replaced by 'known or potential breaches of the provider licence'.

Source: National Audit Office analysis of Monitor data

Part Two

Pressures on the financial sustainability of NHS bodies

2.1 In this part of the report we use comparative performance data to help explain the underlying cost and income structures that determine the financial sustainability of NHS bodies.

Providers in financial distress

2.2 A substantial minority of NHS trusts and foundation trusts face severe financial pressures. **Figure 12** on pages 28 and 29 shows that in 2013-14 there were 29 trusts with deficits of more than £10 million or more than 5% of their income.

- Nine (out of 147) were foundation trusts, and 20 (out of 98) were NHS trusts.
- Eleven of these 29 trusts were in deficit both in 2012-13 and 2013-14. Four were NHS trusts (South London; Barking, Havering and Redbridge University Hospitals; North West London Hospitals; and Mid Yorkshire Hospitals).
- Four foundation trusts had deficits of more than £10 million in both 2012-13 and 2013-14 (Peterborough and Stamford; Mid Staffordshire; Sherwood Forest; and Morecambe Bay).
- All but 4 of the 29 trusts are forecasting a deficit in 2014-15.

2.3 Monitor published research in June 2014 that tested whether, for foundation trusts, economies of scale (or other characteristics associated with size), make it more difficult for smaller acute hospitals to perform well.[2] Its analysis found that financial performance worsened as the proportion of work undertaken under the NHS national tariff increased, and that this tended to be higher for smaller providers. However, size only explained a limited amount of the difference in financial performance between hospitals. Monitor found no evidence that smaller acute hospitals performed any worse clinically than larger trusts.

2 Monitor, *Facing the future: smaller acute providers*, June 2014.

Figure 12

Trusts with deficits greater than £10 million or 5% of their income, 2013-14

A large minority of NHS trusts and foundation trusts face severe financial pressure

Trust	Type of trust	Surplus or deficit 2012-13 (£m)	Deficit 2013-14 (£m)	Deficit 2013-14, as percentage of operating income (%)	Planned surplus or deficit 2014-15 (£m)
Peterborough and Stamford Hospitals[1]	FT	-39.0	-36.8	-15.8	-43.3
Mid Staffordshire[1]	FT	-14.7	-24.8	-15.6	n/a[4]
North Cumbria University Hospitals[2]	Non-FT	0.2	-27.1	-11.8	-26.3
Milton Keynes Hospital[1]	FT	-8.8	-16.8	-9.7	-24.9
Princess Alexandra Hospital[2]	Non-FT	0.1	-16.4	-9.2	-11.5
North Essex Partnership[2]	FT	1.8	-10.3	-9.2	11.9
Sherwood Forest Hospitals[1]	FT	-15.5	-23.5	-8.8	-26.4
South London Healthcare[1]	Non-FT	-44.7	-20.7	-8.7	n/a[5]
Barking, Havering and Redbridge University Hospitals[1]	Non-FT	-39.5	-37.8	-8.3	-38.0
Croydon Health Services[2]	Non-FT	0.2	-19.7	-8.0	-17.8
George Eliot Hospital[2]	Non-FT	0.0	-10.2	-8.0	-12.0
Queen Elizabeth Hospital King's Lynn[1]	FT	-0.8	-12.7	-7.7	-14.9
Mid Essex Hospital Services[2]	Non-FT	1.1	-19.3	-7.4	-18.7
University Hospitals Morecambe Bay[1]	FT	-23.2	-18.8	-7.0	-19.0
East Sussex Healthcare[2]	Non-FT	0.5	-23.1	-6.3	-18.5
Royal National Hospital for Rheumatic Diseases[2]	FT	1.0	-1.1	-6.1	-2.2
United Lincolnshire Hospitals[2]	Non-FT	0.1	-25.8	-6.1	-25.2
North West London Hospitals[1]	Non-FT	-20.5	-23.3	-5.6	-21.5
Bedford Hospitals[2]	Non-FT	1.2	-8.7	-5.5	-6.8
University Hospitals of Leicester[2]	Non-FT	0.1	-39.7	-5.1	-40.7
Barnet and Chase Farm Hospitals[2]	Non-FT	0.6	-15.8	-4.7	n/a[6]
West Hertfordshire Hospitals[2]	Non-FT	1.9	-13.4	-4.6	-14.0
Mid Yorkshire Hospitals[1]	Non-FT	-21.8	-19.2	-4.2	-17.1
University Hospital North Staffordshire[2]	Non-FT	0.2	-19.3	-4.1	-16.9

Figure 12 *continued*
Trusts with deficits greater than £10 million or 5% of their income, 2013-14

Trust	Type of trust	Surplus or deficit 2012-13 (£m)	Deficit 2013-14 (£m)	Deficit 2013-14, as percentage of operating income (%)	Planned surplus or deficit 2014-15 (£m)
Worcestershire Acute Hospitals[2]	Non-FT	0.0	-14.2	-4.1	-9.8
Medway[1]	FT	-1.8	-10.4	-4.1	-29.5
Maidstone and Tunbridge Wells[2]	Non-FT	0.1	-12.4	-3.3	-12.3
Plymouth Hospitals[2]	Non-FT	0.0	-13.0	-3.2	-13.0
Barts Health[2]	Non-FT	0.4	-38.3	-3.0	-44.8

Notes
1 Trusts were also in deficit in 2012-13.
2 Trusts were in deficit in 2013-14 but not in 2012-13.
3 Data shown here exclude NHS Direct.
4 Mid Staffordshire NHS Foundation Trust will be dissolved at the end of 2014 and so does not have a planned deficit for 2014-15.
5 On 1 October 2013, South London Healthcare NHS Trust was dissolved and its services were taken over by King's College Hospital NHS Foundation Trust, Oxleas NHS Foundation Trust and Lewisham and Greenwich NHS Trust. The reported position is for the 6 months ending 1 October 2013.
6 On 1 July 2014 Barnet Hospital and Chase Farm Hospital became part of the Royal Free London NHS Foundation Trust.
7 NHS trusts that became foundation trusts in-year have been treated as though they were foundation trusts for the whole year.

Source: National Audit Office analysis of Monitor and NHS Trust Development Authority data and trust board papers

2.4 **Figure 13** overleaf shows that, between 2012-13 and 2013-14, total spending by trusts increased by 4.3%, while income increased by 3.5%. NHS trusts are exhibiting more financial pressure than NHS foundation trusts, as are trusts in deficit compared with those in surplus. Specifically:

- Expenditure increased faster than income for all trusts.
- Both income and expenditure increased at a slower rate for NHS trusts than for foundation trusts.
- The difference between changes in income and expenditure was much greater for trusts in deficit (-1.9%) than for those in surplus (-0.3%).

Figure 13

Changes in income and expenditure for NHS trusts and foundation trusts

	Number of trusts	Change in total operating income, 2012-13 to 2013-14 (%)	Change in total operating expenditure, 2012-13 to 2013-14 (%)	Difference between the change in income and the change in expenditure (%)
NHS foundation trusts	144	4.8	5.2	-0.4
NHS trusts	97	1.7	3.1	-1.4
Trusts that changed status	3	3.5	3.3	0.2
Total	**244**	**3.5**	**4.3**	**-0.8**
Of which:				
Trusts in deficit	63	2.4	4.3	-1.9
Trusts in surplus	178	4.0	4.3	-0.3

Notes

1 There were 3 trusts that changed status:
- West Midlands Ambulance Service NHS Foundation Trust was authorised as a foundation trust on 1 January 2013 and had previously been an NHS trust;
- Kingston Hospital NHS Foundation Trust was authorised as a foundation trust on 1 May 2013 and had previously been an NHS trust; and
- Western Sussex Hospitals NHS Foundation Trust was authorised as a foundation trust on 1 July 2013 and had previously been an NHS trust.

2 The following trusts have been excluded from this figure:
- Gloucestershire Care Services NHS Trust, which was formed on 1 April 2013; and
- South London Healthcare NHS Trust, which was dissolved on 1 October 2013.

3 The numbers of NHS trusts and foundation trusts changed throughout 2013-14. The numbers in this figure are as at 31 March 2014.

4 Income and expenditure shown includes transactions between trusts (figures are gross, not netted off between trusts).

5 Data exclude charitable funds for foundation trusts.

6 Data shown exclude NHS Direct.

Source: National Audit Office analysis of Department of Health data

Providers' income

2.5 Providers receive income for services through a contract for either a fixed-block or variable level of activity. They are required to deliver efficiency savings at a level set within the prices paid by commissioners, which was 4% in 2013-14. In 2014-15 providers must make further savings of 4%. Planning guidance shows efficiency requirements continuing at this level for the next 4 years.[3] Monitor, NHS England and the NHS Trust Development Authority intend to make additional income paid to providers, over and above nationally set service prices, more transparent. They expect this to help clarify whether providers are relying on additional income or making underlying efficiency savings. Until changes are made, failure by provider trusts to deliver efficiency requirements within nationally set prices and locally agreed contracts will cause deterioration in their financial performance.

2.6 Until 2012-13, providers of mental health services typically received payment for a pre-agreed level of work under a fixed-block contract. In contrast, providers of acute services are usually paid according to the volume of patient care services. Mental health providers are moving to an activity-based system. North East London NHS Foundation Trust, a mental health and community services provider, told us that adapting to a new pricing system (cluster currencies) that will come into effect in 2015-16 could pose a risk for the trust. This is because so far the trust has been able to assign only 90% of in-scope service users to the cluster currencies. Until the trust assigns the remaining 10% of in-scope service users appropriately, it may not be able to recover the full cost of that part of its work.

3 Monitor, *Guidance for the Annual Planning Review 2014-15*, December 2013.

2.7 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 emergency admissions in 2008-09.[4] In practice, payment at the marginal rate has not contained the demand for emergency admissions. This can be because alternatives, including enhanced primary care services and discharge from A&E departments into community care, are not available. We reported in October 2013 that emergency admissions had increased in 62% of trusts since the introduction of the marginal rate. In 2012-13, there were 5.3 million emergency admissions to hospitals, representing around 67% of hospital bed days in England, and costing approximately £12.5 billion.[5] All 7 of our case study trusts that were acute trusts told us that this had an adverse impact on their income because demand is rising and they are receiving only marginal payment for increased activity. Based on financial reports from the trusts we visited, we estimate that 1%–3% of their costs are not covered by the income they receive for emergency admissions at the 30% marginal rate. The Foundation Trust Network has estimated, based on a survey of 26 member trusts, that the average amount of income foregone in 2012-13 was £3.2 million. Only one trust, a specialist hospital trust, was consistently reporting a surplus for its non-elective emergency services.[6] In December 2013, Monitor and NHS England reviewed the marginal rate rule and concluded that baseline adjustments should be made when providers faced significant changes in emergency admissions.[7]

National commissioning

2.8 In 2013-14, NHS England, which commissions primary care and specialised services from providers, spent £94,400 million against a planned £94,679 million from its allocated resources, giving a net underspend of £279 million against its plan (**Figure 14**). It overspent £377 million on specialised commissioning, the only significant area to show an overspend against the plan. This was partly because NHS England had made over-ambitious planning assumptions following the transfer of budgets from primary care trusts and strategic health authorities, which were previously responsible for specialised commissioning. In April 2014, it set up a task force which has been working to improve financial controls for specialised commissioning in 2014-15. The task force itself is expected to complete in late autumn 2014, with NHS England continuing its work within a revised structure for specialised commissioning.

4 The marginal rate rule requires that a provider receives payment at 30% of the tariff income once they have exceeded the baseline tariff income value for emergency admissions. The baseline income is calculated by applying the current tariff level to 2008-09 emergency admissions activity. Commissioners are expected to invest the remaining 70% of the tariff income into demand management schemes which prevent inappropriate hospital admissions by improving patient care outside of hospital.

5 Comptroller and Auditor General, *Emergency admissions to hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013.

6 Foundation Trust Network, *Emergency admissions marginal rate review: call for evidence*, June 2013.

7 Monitor and NHS England, *Monitor and NHS England's review of the marginal rate rule*, December 2013.

Figure 14
NHS England's spending, 2013-14

Area	Planned expenditure £m	Actual expenditure £m	Under/(over) spend against plan £m
Clinical commissioning groups	64,751	64,650	101
Social care	859	859	0
Specialised commissioning	13,010	13,387	(377)
Primary care and other direct commissioning[1]	14,071	14,041	30
NHS England administration and central programmes	1,576	1,432	144
Reserves and drawdowns[2]	412	30	382
Financial performance before legacy impacts[3]	**94,679**	**94,400**	**279**

Notes

1 'Other direct commissioning' is made up of military health, health and justice, secondary and community dental care and public health. Primary care commissioning makes up £11,262 million of actual expenditure.

2 The reserves and drawdowns line represents part of the £1,184 million surplus left over from primary care trusts and strategic health authorities in 2012-13. The rest is split among the other lines as allocated by NHS England.

3 Legacy impacts represent the winding down of closing balance sheets from primary care trusts and strategic health authorities of £133 million. These have been excluded as they represent a one-off net correction.

4 Figures may not sum exactly because of rounding differences.

Source: NHS England

Local commissioning

2.9 Forty-nine clinical commissioning groups, which plan and commission local healthcare services, ended the 2013-14 financial year with a less favourable financial position than they had planned. Twelve of these had forecast a surplus for 2013-14, but ended the year in deficit. The overall net position for clinical commissioning groups in 2013-14 was £716 million – £101 million greater than planned. Within this total, the figures ranged from a £33.6 million surplus in NHS Brent Clinical Commissioning Group to a £18.2 million deficit in NHS Croydon Clinical Commissioning Group. In 2013-14, 192 of 211 clinical commissioning groups were in surplus, with a median surplus of £2.4 million. 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.

2.10 We have previously reported evidence that there is a link between clinical commissioning groups' funding, compared with target funding allocations,[8] and their financial position.[9] Distance from target allocations explains around 23% of the variation in clinical commissioning groups' financial position in 2013-14. The analysis showed that, at 31 March 2014:

- The 20 clinical commissioning groups with the tightest financial positions received, on average, 5.0% less than their target funding allocation.[10] Nineteen of these groups received less than their target allocation.
- The 20 clinical commissioning groups with the largest surpluses received, on average, 8.8% more than their target funding allocation. Eighteen of these groups received more than their target allocation.

2.11 The surplus or deficit of the clinical commissioning group that gives a trust the largest funding does not explain the size of the trust's surplus or deficit. **Figure 15** plots the surplus or deficit in NHS trusts and foundation trusts (represented as dots) against clinical commissioning groups (shown as shaded areas). For example, the commissioner in Cumbria had a surplus of between £5 million and £10 million, whereas nearby providers were largely in deficit. The map highlights differences across the country. The North East region, for example, shows greater surpluses than the East region. Commissioners buy services from more than one provider, and most trusts provide services to more than one commissioner. Our more detailed analysis found no causal link, however, between the financial health of providers and that of their clinical commissioning groups.

8 The Department or NHS England calculate a 'target funding allocation' for each local commissioner, which aims to give those local areas with greater healthcare needs a larger share of the available funding. Target funding allocations are intended to represent local areas' fair share of the available funding, rather than the amount of money that might be required to meet their healthcare needs in full.

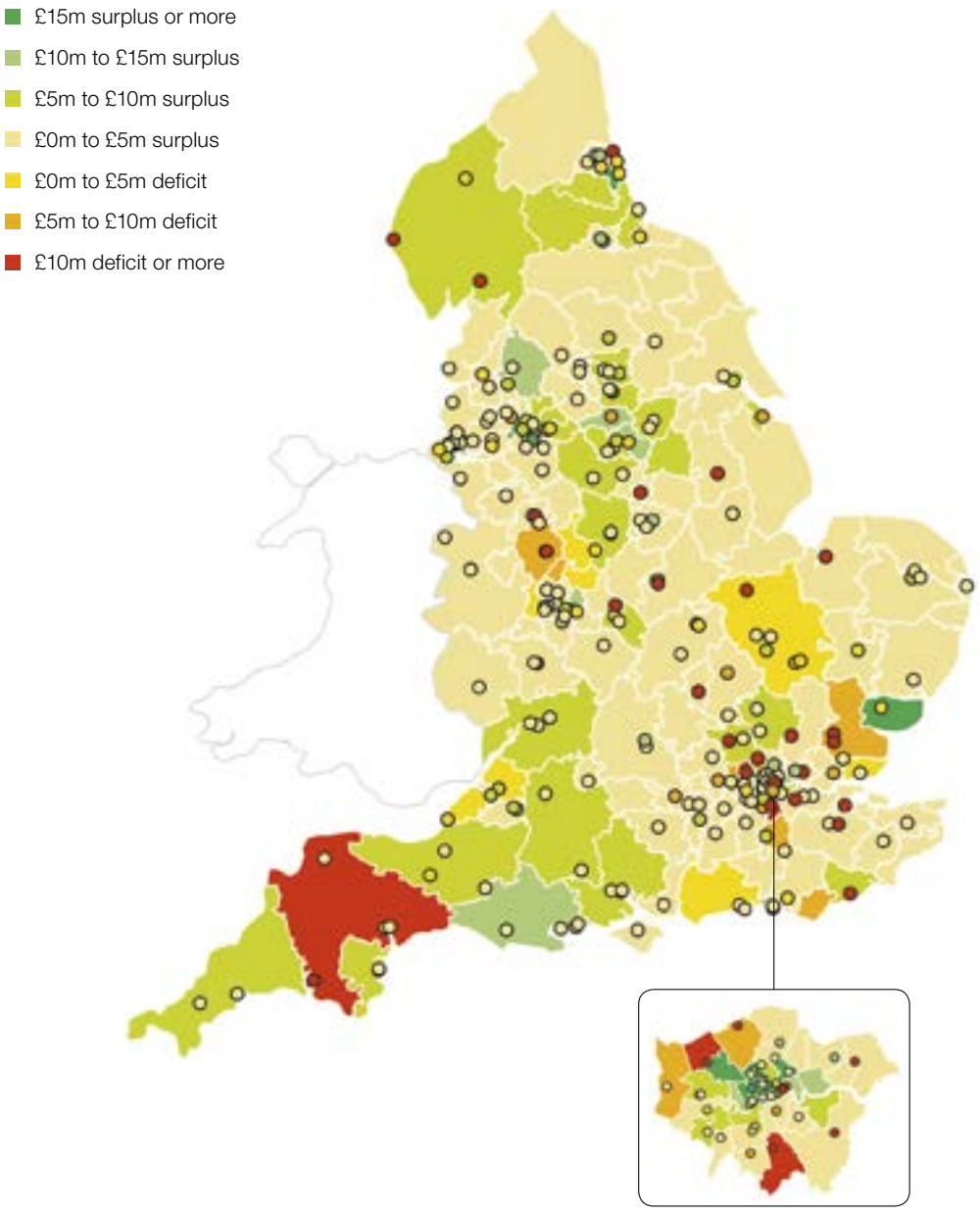
9 Comptroller and Auditor General, *Funding healthcare: making allocations to local areas*, Session 2014-15, HC 625, National Audit Office, September 2014.

10 Of the 20 clinical commissioning groups, 19 had a deficit and 1 had a surplus of 0.01%.

Figure 15

Trust and commissioner financial positions at the end of 2013-14

The surplus or deficit of a clinical commissioning group does not explain the size of a trust's surplus or deficit, but there are contrasts between different parts of the country



Notes

1 These data include South London Healthcare NHS Trust, which dissolved on 1 October 2013. All other data are as at 31 March 2014.

2 Clinical commissioning groups are shown as shaded areas. NHS trusts and foundation trusts are shown as dots.

Source: National Audit Office analysis of NHS England, NHS Trust Development Authority and Monitor data

Providers' costs

2.12 Cost structures of different NHS trusts and foundation trusts, such as the balance between fixed and variable costs, vary substantially. They can depend, for example, on whether trusts manage property and maintenance services using their own employees or have negotiated contracts with external suppliers. Trusts do not collect and record cost data consistently enough or in enough detail for systematic analysis.[11] This challenges the ability of system regulators to diagnose organisations with underlying structural problems or to identify good practice models.

2.13 An organisation's financial performance is affected by a combination of cost pressures and influences in the local health economy. Weston Area Health NHS Trust is an example of a small acute provider that illustrates how financial performance can be affected by factors including local contracting arrangements, the proportion of non-elective work and reliance on agency staff (**Figure 16**).

Figure 16

Case study: Weston Area Health NHS Trust and NHS North Somerset Clinical Commissioning Group

Background

Weston Area Health NHS Trust is the smallest acute trust in England, providing acute services to the Weston-Super-Mare area.

Financial situation

The trust's deficit in 2013-14 was £4.7 million before impairments, compared with a surplus of £2.3 million in 2012-13 and £3.6 million in 2011-12. It has a planned deficit of approximately £5 million for 2014-15.

Challenges to sustainability

North Somerset is historically an underfunded area. Our study *Funding healthcare: Making allocations to local areas*, published in August 2014, showed that North Somerset is 6.2% below its target allocation.

Around 70% of the trust's activity is non-elective. In 2013-14 it moved from a block contract with North Somerset Clinical Commissioning Group to a variable contract on a local tariff for this work. The trust estimates its non-elective work is significantly underfunded, while demand for A&E services is rising.

Because it is small, the trust sees limited opportunities either to achieve economies of scale or to make efficiency savings.

Staff turnover and sickness absence levels are similar to national averages, but the trust has had difficulty recruiting additional staff locally and has been reliant on relatively expensive agency staff.

Source: National Audit Office analysis of trust data and interviews with Weston Area Health NHS Trust and North Somerset Clinical Commissioning Group

11 Monitor's analysis of regional differences in trusts' costs found that there was limited availability of consistent detailed data on employment costs. Monitor reported that this made it almost impossible to distinguish between avoidable and unavoidable components of expenditure. Monitor, *A guide to the market forces factor*, December 2013.

Estate costs including private finance initiative commitments

2.14 The physical estates structure of an organisation can influence its financial performance and level of efficiency. For example, University Hospitals Morecambe Bay NHS Foundation Trust identified an unsustainable structural deficit largely due to the cost of running multiple hospitals in a large rural area.[12] More widely, investment in capital assets continues, as evidenced by a 20% increase in spending between 2012-13 and 2013-14. The ratio of investment in long-term assets to depreciation expense also rose from 1.3:1 to 1.6:1. Therefore, despite an overall deficit in the trust sector, providers are reinvesting in their assets rather than extending their use to minimise costs. As an example, West Hertfordshire Hospitals NHS Trust told us it planned to invest heavily in estates, equipment and IT to support services to patients.

2.15 While renewing assets is important, 4 out of 6 trusts (67%) with a deficit greater than £25 million had a PFI scheme. We previously reported that over-optimistic forecasts in the business case for a PFI scheme at one of these, Peterborough and Stamford NHS Foundation Trust, contributed to a £45.8 million deficit in 2011-12.[13] In 2013-14, the trust had a deficit of £36.8 million. Long-term PFI commitments can create a lack of flexibility that makes it harder for trusts to achieve new efficiencies.

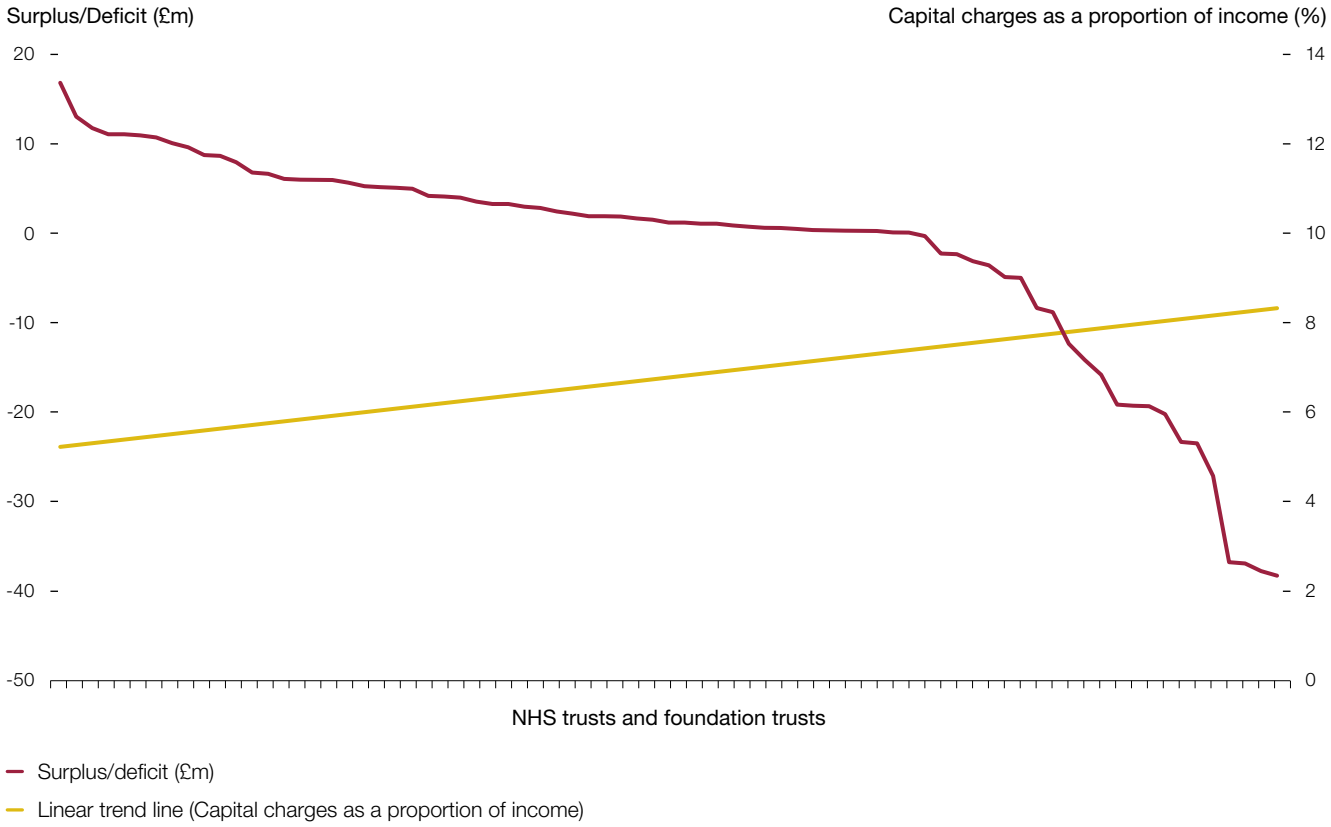
2.16 As other trusts with PFI commitments delivered surpluses in 2013-14, we tested the financial performance of trusts with PFI assets in relation to their capital charge (interest, depreciation and dividends payable). **Figure 17** overleaf shows that organisations with the highest capital charges, as a proportion of their income, were the most likely to report weak financial results in 2013-14. In contrast, we found no statistically significant relationship between capital charges and financial results for trusts which do not have PFI assets.

2.17 Northumbria Healthcare NHS Foundation Trust, a large acute trust, is an example of how a trust can refinance its PFI scheme to help improve future sustainability. The trust arranged a loan with Northumberland County Council to buy out its PFI scheme. While the buyout caused the trust to post an exceptional deficit in 2013-14, it expects to save £3.5 million in borrowing costs for the remaining 19 years of the loan. The trust plans to deliver a £21.5 million surplus in 2014-15. The changes to PFI funding arrangements depend on the local authority's financial position, so may not be possible or appropriate for other trusts.

12 University Hospitals of Morecambe Bay NHS Foundation Trust, *Operational Plan 2014-16*.
13 Comptroller and Auditor General, *Peterborough and Stamford Hospitals NHS Foundation Trust*, Session 2012-13, HC 658, National Audit Office, November 2012.

Figure 17

The impact of capital charges for trusts with PFI assets on a trust's financial position



Source: National Audit Office analysis of Department of Health data

Staffing

2.18 On average, in 2013-14, trusts spent 65% of all revenue on staff costs (64% in 2012-13). Comparing 2012-13 with 2013-14, trusts with the largest increases in the proportion of income they spent on staff costs were most likely to have a worsening financial position (a lower surplus or bigger deficit). Trusts that reduced staff costs as a proportion of income were more likely to have an improved financial position. There were, nonetheless, 30 trusts that improved their financial position despite increased staff costs.

2.19 We found 9.7% of staff costs were for non-permanent staff (an increase from 8.1% in 2012-13). Four of our case study trusts had increased their spending on temporary or locum staff to tackle shortages or maintain standards. Total spending on temporary staff by NHS trusts and foundation trusts increased by 23% between 2012-13 and 2013-14.

Achieving clinical targets

2.20 We tested whether there is a correlation between providers' financial positions and their performance against national clinical indicators. The indicators we looked at included: 18-week referral to treatment waiting times; proportion of patients admitted, transferred or discharged from emergency departments within 4 hours; rates of hospital-acquired infections such as MRSA and *c.difficile*; mortality rates using the standardised hospital mortality indicator; and patient experience (measured by asking patients: "Overall, did you feel you were treated with dignity and respect while you were in hospital?").

2.21 Assessing the relationship between financial and clinical performance is challenging because of the range of influences and the difficulty of attributing cause and effect. In our exploratory analysis we found statistically significant but weak correlations between a trust's surplus or deficit and some clinical indicators (such as patient experience and the proportion of patients admitted, transferred or discharged from A&E departments within 4 hours), but little evidence of statistically significant relationships with the other clinical performance variables we tested. There is very little evidence of a causal link between financial and clinical performance. Trusts with similar clinical performance could have very different financial performance (as measured either in terms of surplus or deficit, or by using EBITDA margin as an indicator of sustainability).

Collaboration within the local health economy

2.22 Other factors can influence the financial performance of an organisation. Evidence from our case studies showed that the strength of leadership and relationship between the commissioner and provider were key to an organisation's ability to tackle financial issues. Relationships between providers and commissioners are particularly important when difficulties relate to underlying issues in the local health economy. North East London NHS Foundation Trust and NHS Havering Clinical Commissioning Group offer a good-practice example of how providers and commissioners can work together to address issues in a challenged health economy (**Figure 18** overleaf).

2.23 Some NHS trusts have recognised that they are not financially viable in their current form. One reason is that some smaller trusts do not have sufficient patients to gain economies of scale and generate levels of activity that allow medical staff to continue to develop their skills. In our 2011 report we concluded that 20 trusts could not achieve foundation trust status in their current form.[14] Of these, 16 have become, or are becoming, part of an existing foundation trust.

2.24 Figure 19 overleaf shows how Hampshire Hospitals NHS Foundation Trust sought strategic reconfiguration to address financial problems in both Winchester and Eastleigh Healthcare NHS Trust and Basingstoke and North Hampshire NHS Foundation Trust. However, reconfiguration may not help a trust achieve financial sustainability unless improvements to operational efficiency follow, and focus is maintained on achieving productivity savings.

14 Comptroller and Auditor General, *Achievement of Foundation Trust status by NHS hospital trusts*, Session 2010–2012, HC 1516, National Audit Office, October 2011.

Figure 18

North East London NHS Foundation Trust and NHS Havering Clinical Commissioning Group

Background

North East London NHS Foundation Trust is a mental health trust providing mental health and community services for people living in the London boroughs of Waltham Forest, Redbridge, Barking & Dagenham and Havering.

Financial situation

The trust has been in surplus year-on-year: £8.8 million surplus in 2011-12; £6.4 million surplus in 2012-13; and £2.9 million surplus in 2013-14 (after restructuring costs and exceptional profit from asset sales).

Challenges to sustainability

The trust lies in 1 of 11 challenged health economies, with other local non-foundation trusts struggling to achieve their cost improvement targets. It has a strong financial performance and is part of a solution to longstanding problems in the local health economy. There is a £700 million funding gap across local providers and commissioners over the next 5 years. This places the trust at risk and it is planning a £2 million deficit for 2014-15, after allowing for restructuring costs of £4 million.

However, the challenges in the local health economy are also an opportunity for local partners to work together to tackle them. The trust told us it is taking a more strategic approach by increasing its activity and reducing costs by providing more care in the community. Havering Clinical Commissioning Group told us it is working with 2 local clinical commissioning groups to coordinate strategic change and reconfigure services across the local health economy. For example, they are reviewing supply across the health economy with a view to matching this to demand.

Source: National Audit Office analysis of trust data and interviews with North East London NHS Foundation Trust, Havering Clinical Commissioning Group and Monitor

Figure 19

Hampshire Hospitals NHS Foundation Trust and NHS North Hampshire Clinical Commissioning Group

Background

Hampshire Hospitals NHS Foundation Trust is a medium-sized acute hospital trust providing services to around 600,000 people across Hampshire and West Berkshire. It was formed in January 2012 after Basingstoke and North Hampshire NHS Foundation Trust acquired Winchester and Eastleigh Healthcare NHS Trust.

Financial situation

The trust had a surplus of £1.5 million in 2010-11, £1.2 million in 2011-12 and £3.1 million in 2012-13. The trust's financial position worsened in 2013-14, when it had a £0.3 million surplus. The trust expects its financial position to worsen further in 2014-15, as non-recurrent financial support for the acquisition ended in March 2014.

Challenges to sustainability

The trust took a strategic decision to acquire Winchester and Eastleigh Healthcare NHS Trust to serve a larger population and achieve critical mass for both trusts to be sustainable. The trust anticipated that the proposed new critical treatment hospital would provide sufficient critical mass to retain clinical, staffing and financial sustainability.

However, the efficiencies from the acquisition have not yet been fully realised. The trust is running 2 separate hospitals and its plans for a new critical treatment hospital are yet to materialise, due to unanticipated delays in the commencement of the public consultation led by the clinical commissioning group.

Source: National Audit Office analysis of trust data and interviews with Hampshire Hospitals NHS Foundation Trust and NHS North Hampshire Clinical Commissioning Group

Part Three

Managing future financial risks

3.1 In this part of the report we consider the support given to NHS trusts and foundation trusts in financial difficulty, commissioners' and providers' forecasts for 2014-15 and their planning assumptions for 2015-16. We also look at what NHS England, the NHS Trust Development Authority (NHS TDA), Monitor and the Department of Health (the Department) have done to manage risk proactively and strategically.

Additional financial support

3.2 In 2013-14 NHS trusts and foundation trusts received £1.8 billion in funding from the Department and NHS England as well as income from contracts with their commissioners (**Figure 20** overleaf). Some of this money provided capital to fund investment or strategic change, but some trusts also needed revenue support to maintain services. The largest amounts of funding were:

- £432.5 million of strategic change public dividend capital (PDC), used to fund strategic investments that trusts could not make using a loan; and
- £511.4 million cash support in the form of revenue-based PDC.

3.3 NHS England continues to give non-recurrent funding to trusts via clinical commissioning groups, similar to the support strategic health authorities provided via primary care trusts. For example, NHS England gave £385 million of winter resilience funding to trusts in 2013-14.

3.4 We previously reported that, in addition to centrally provided financial support, there may have been other non-recurrent funding agreed locally between primary care trusts and healthcare providers.[15] We found that some commissioners also needed financial support totalling £157 million in 2012-13. Some of this extra support was managed by redistributing funds within primary care trust clusters. The existence or nature of any local agreements between clinical commissioning groups and provider trusts is not centrally collated, and is not included in Figure 20.

15 Comptroller and Auditor General, *2012-13 update on indicators of financial sustainability in the NHS*, Session 2013-14, HC 590, July 2013, pages 18–21.

Figure 20

Financial support provided to NHS trusts and foundation trusts in 2013-14

Type of support	Oversight	Purpose	Total amount (£m)	Number of trusts receiving support
Support for trusts including those in financial difficulty				
Revenue-based public dividend capital funding[1]	Department of Health	Short-term support for trusts in financial difficulty	511.4	31
Capital support		Support for essential capital works for trusts unable to fund works from internal funding sources	95.3	17
Deficit support	NHS England	Non-recurrent funding for NHS trusts in 2013-14, deployed with NHS TDA advice	60.0	13
Private finance initiative (PFI) support		Agreed support to trusts with PFI schemes	132.4	14
Additional non-recurrent support				
Strategic change public dividend capital	Department of Health	Funding for strategic investments	432.5	182
Merger and acquisition support	NHS England	Funding for historically agreed merger and acquisition transactions	25.2	2
Other historic support arrangements		Other previously agreed funding	88.7	47
South London Healthcare NHS Trust special administration		NHS England's share of costs of the Special Administration for South London Healthcare NHS Trust, which was dissolved on 1 October 2013	45.5	3
Other centrally provided funding				
Winter resilience funding[2]	NHS England via clinical commissioning groups	Support for urgent and emergency performance during periods of high demand	385.0	146
Total			**£1,776.0**	

Notes

1 Revenue-based PDC capital funding is provided to trusts as cash rather than income, and does not affect the reported surplus or deficit.

2 NHS England made an additional £15 million winter resilience funding available to providers of NHS 111 services.

Source: National Audit Office Analysis of Department of Health and NHS England data

3.5 NHS England will make similar support available to trusts in 2014-15, including specific funds to support key initiatives. It is, for example, providing £250 million targeted to help reduce the number of people waiting a long time for treatment. Additional planned funding includes £400 million to support system resilience including pressures experienced during winter. Of this, NHS England will hold £50 million centrally to support NHS 111, ambulance services and specialised commissioning, and distribute the remaining £350 million to clinical commissioning groups. NHS England has agreed to fund a series of projects in 11 challenged health economies to help groups of commissioners and providers work together to develop integrated 5-year plans that effectively address the particular local challenges they face.

Revenue-based public dividend capital

3.6 **Figure 21** overleaf shows that in 2013-14 the Department issued £511 million of revenue-based PDC to trusts. This is an increase of £248 million compared with 2012-13. PDC is the equivalent of share capital for NHS bodies. It is a cash injection that directly strengthens an organisation's net asset base, shown in its statement of financial position. It does not affect the surplus or deficit position of an organisation. Some of the PDC issued (revenue-based PDC) is to support operational cash requirements. Since 2006-07, the Department has issued £1.8 billion to 46 organisations, of which just under £160 million has been repaid.

3.7 Some of the increase in direct support from the Department may be because it is replacing direct or indirect support previously provided by primary care trusts or strategic health authorities. Funding from the Department is reported in trust accounts, so is more transparent than local arrangements. However, the amount of support now needed is also likely to reflect the increase in the number of trusts in deficit.

Trusts receiving revenue-based PDC

3.8 **Figure 22** on page 45 shows that the Department issued revenue-based PDC to 31 trusts in 2013-14, compared with 14 in 2012-13. Twenty-one of these were NHS trusts and 10 foundation trusts. Sixteen of the 31 trusts that received revenue-based PDC support in 2013-14 had not received it before.

3.9 A small number of trusts have now received substantial PDC support. Between 2006-07 and 2013-14, South London Healthcare NHS Trust and its predecessors received £423 million.[16] On 1 October 2013, the trust was dissolved and its services taken over by King's College Hospital NHS Foundation Trust, Oxleas NHS Foundation Trust and Lewisham and Greenwich NHS Trust.

16 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.

Figure 21

Total revenue-based PDC issued to, and repaid by, trusts, 2006-07 to 2013-14

Source: National Audit Office analysis of Department of Health data

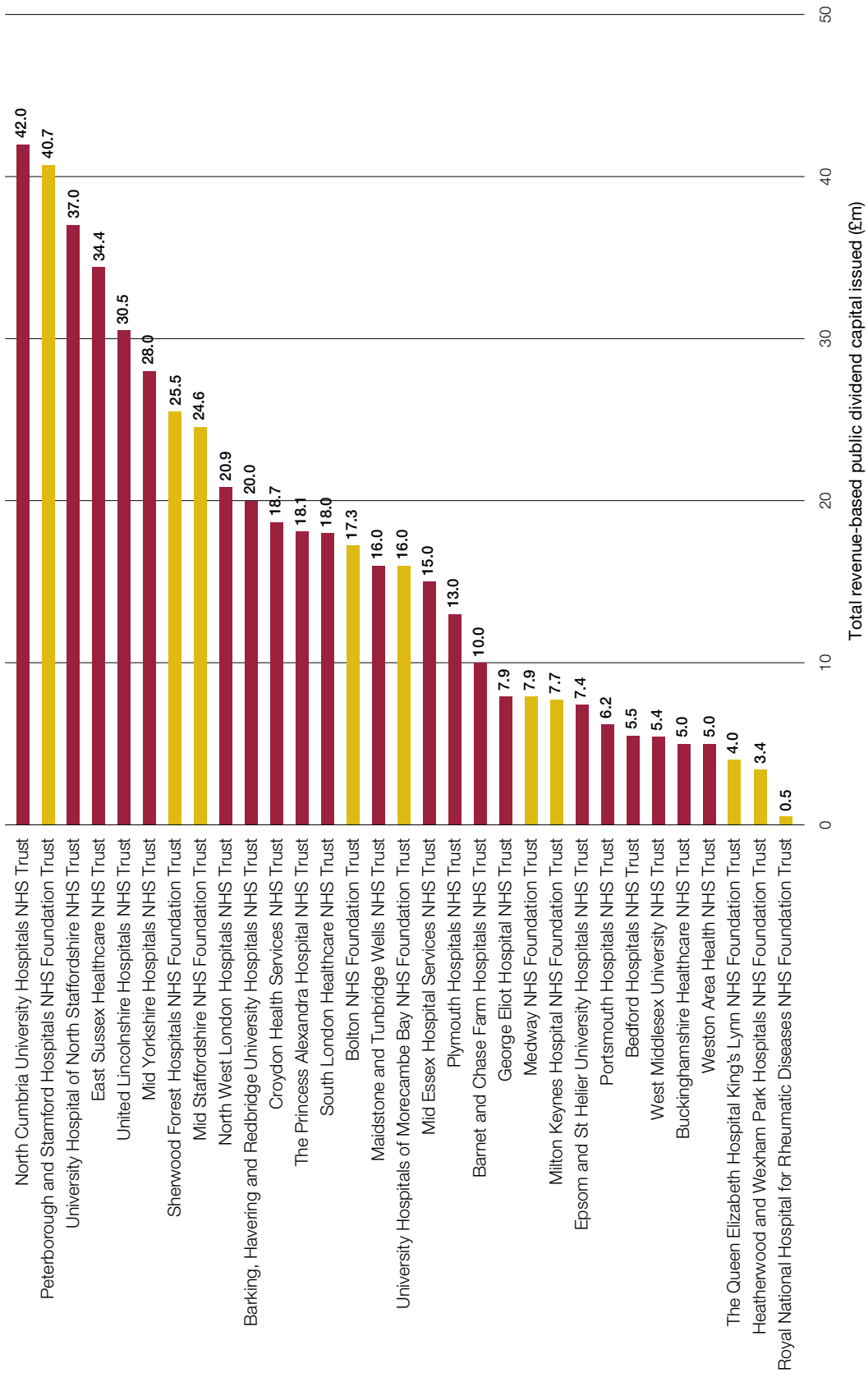
Local and national planning

3.10 In November 2013, and in response to the financial pressures faced by the NHS, Monitor published the results of research into the quality of strategic planning in foundation trusts.[17] It found that planning needed to improve significantly to achieve clinical and financial sustainability. In particular, too many trusts assumed that initial deterioration in their finances would be followed by recovery without clear evidence of how they would achieve this, and why it would differ from past performance that had failed to deliver such improvements.

3.11 In the 2013-14 planning rounds Monitor and NHS TDA requested a detailed analysis for year 1, and a more strategic view for years 2 and 3. The NHS England planning round covered only the next financial year. For 2014-15, the oversight bodies agreed a more aligned planning process across the NHS and published a set of common assumptions. The strategic planning horizon was increased to 5 years, with detailed operational plans covering 2014-15 and 2015-16. The aim was to achieve greater consistency across commissioners and providers, including local authorities.

17 Monitor, *Meeting the needs of patients: Improving strategic planning in NHS foundation trusts*, November 2013.

Figure 22
Revenue-based public dividend capital issued to hospital trusts, 2013-14



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

3.12 **Figure 23** summarises the key dates set out at the start of the 2014-15 planning process. Business rules call for planned surpluses from NHS trusts and commissioners, the latter specifically to identify a minimum 0.5% contingency and 1% surplus in 2014-15. Foundation trusts do not have to deliver a surplus, but must show they have enough funds to maintain services.

3.13 There is no common template for operational and strategic plans across the NHS. However, Monitor, NHS TDA and NHS England evaluate plans against similar criteria. For example, they look at the degree of alignment within the wider health economy, the strength of initiatives to address local challenges and responses to new requirements arising from reviews of the health sector.

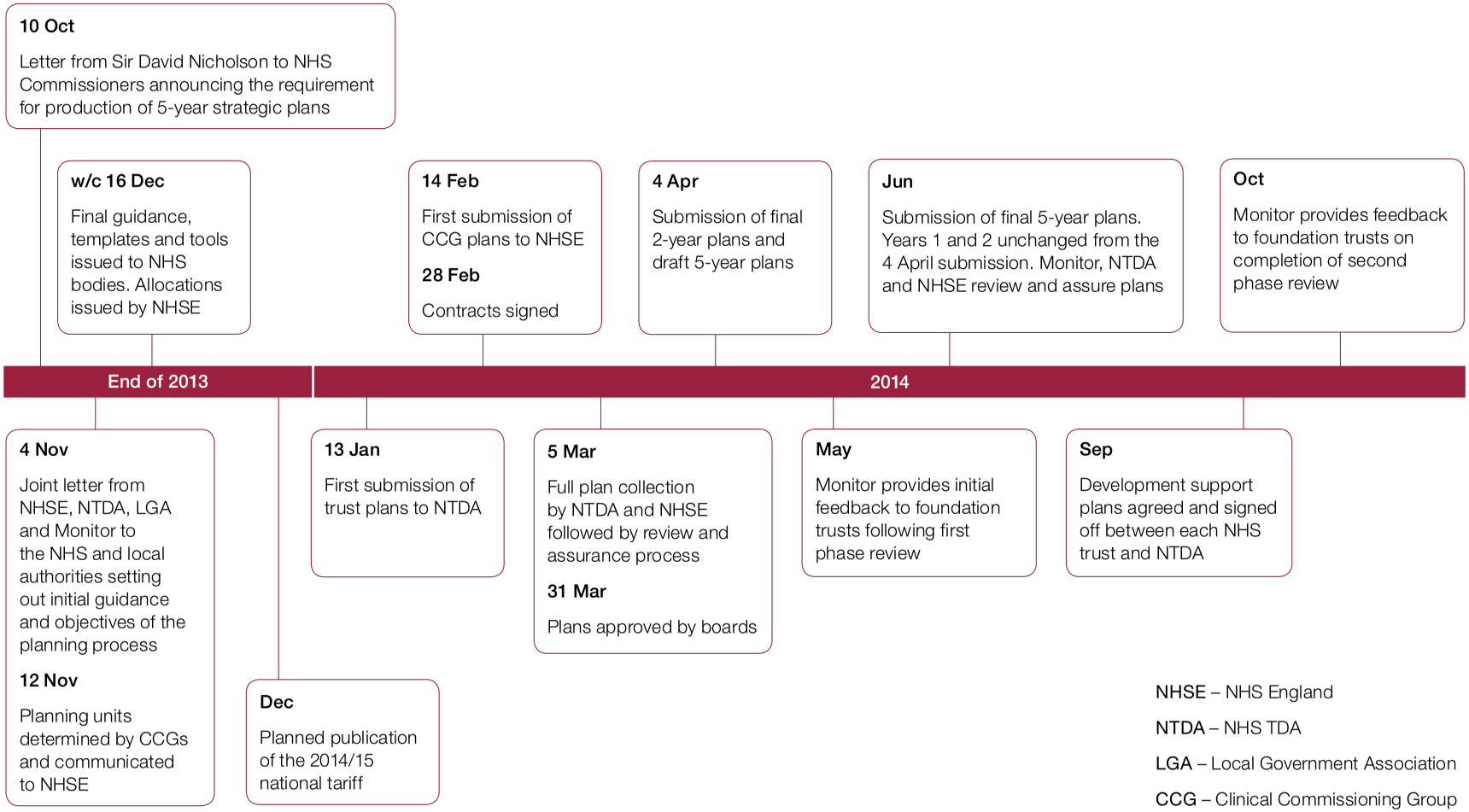
Reviewing operational and strategic plans

3.14 Monitor used the 2-year plans to assess risks to trusts' short-term resilience on a 4-point scale. At May 2014, Monitor rated 27 (18%) foundation trusts as red, 60 (41%) as amber and 57 (39%) as green, with 3 plans not yet rated. All the trusts rated red were subject to enhanced scrutiny. Monitor began regulatory investigations into Barnsley Hospital NHS Foundation Trust and West Suffolk NHS Foundation Trust during this stage of the planning process. It focused on reviewing plans in the middle 2 quartiles of the risk scale because it considered these involved greatest uncertainty. In place of planned 'deep-dives' into the most uncertain plans, Monitor analysed risk factors to assess how robust plans were overall.

3.15 NHS TDA risk-assessed each plan to inform its judgement about the level of assurance and oversight required. It assessed 62% of trusts' 2-year plans as low or medium risk, but expected this figure to increase as review and feedback continued. Trusts with the highest risk scores (including those in special measures) were signed off by the NHS TDA Executive after planning meetings with the trust board. NHS trusts were expected to prepare development support plans in discussion with NHS TDA and submit them by 30 September 2014. NHS TDA also considered trust plans at regional level, to identify common themes and challenges, and to seek consistency. Conclusions from these reviews were fed back to the trusts via local teams.

Figure 23

Key steps in the planning process, 2013-14



Source: National Audit Office

The quality of draft plans

3.16 Some of the 2-year plans submitted in April 2014 were over-optimistic, particularly for 2015-16. While NHS TDA reported an improvement in the quality of the plans from previous years, many had capital and cash issues that needed further work. Several factors contributed to the poor quality of initial plans:

- The timetable was challenging, given the change in approach from the previous year and the greater collaboration required with stakeholders across the healthcare system. The original April deadline for submission fell before the results of the 2013-14 financial year were known.
- There were delays in signing contracts between commissioners and providers. Thirty-four of the 63 clinical commissioning groups who responded to a survey by the Healthcare Financial Management Association reported that none of their contracts had been signed by the deadline of 28 February.[18] By May 2014, 29% of the contracts between clinical commissioning groups and providers were still not agreed. The highest proportion of these were among clinical commissioning groups in the south.
- Other changes, such as the impact of the Better Care Fund, and safe staffing guidance issued by the Care Quality Commission (CQC), had to be considered in detail for the first time. The Better Care Fund is a £3.8 billion programme aimed at integrating health and social care. However, the original plans, particularly those of NHS trusts and foundation trusts, did not fully reflect its intended impact, particularly for secondary care services.
- Both NHS England and Monitor expected plans to evidence that an organisation's strategy was the driving force behind its operational plan. However, the approach taken in 2014-15 meant that NHS bodies had to submit operational plans before they had completed strategic plans.

3.17 Monitor, NHS TDA and NHS England had expected plans to be locked after the April 2014 deadline for submission of 2-year plans, with few amendments allowed during production of the 5-year strategic plans. However, uncertainty about contract values, particularly for specialised commissioning, and over-optimism in some areas, resulted in further amendments to operational plans between the April and June submission dates. More than 50% of foundation trust operational plans changed between April and June, with most amendments made to 2015-16 projections. Nearly 75% of NHS trust plans for 2014-15 were also refreshed, most to resolve technical accounting issues. Changes to the forecasts were considered material in 8 cases.

3.18 NHS England expects 2015-16 operational plans to be refreshed between December 2014 and March 2015. These plans will also need to take account of revised Better Care Fund plans, which were submitted on 19 September and are currently being reviewed. Until Better Care Fund submissions are better understood later in 2014, 2015-16 plans will not be stable.

18 Healthcare Financial Management Association, *NHS financial temperature check*, June 2014.

3.19 Review of 5-year plans across the sector informed NHS England's 5-year forward view, published in October 2014. This sets out the key challenges facing the NHS and seeks to enable transformational change at a local level. Despite considerable effort by NHS trusts, foundation trusts and clinical commissioning groups to prepare and submit 5-year plans, oversight bodies do not regard planning estimates beyond 2015-16 to be robust. NHS England, for example, plans to review long-term plans after the general election and agreement of the next comprehensive spending review.

Forecast income and spending

3.20 As at August 2014 income forecasts from NHS trusts and foundation trusts exceeded clinical commissioning groups' and NHS England's planned commissioning expenditure by £404 million for 2014-15. The value of the data was limited because some organisations did not complete returns. The largest variances between individual commissioners and providers were due to mistakes in matching income in providers' plans to the right NHS England area team. These differences did not affect the resources available to the trust. However, these errors and gaps in the data make it more difficult for oversight bodies to test whether planned expenditure by commissioners is consistent with planned income for providers, to assess risk and to monitor performance.

3.21 Forecasts for years beyond 2014-15 are not finalised. However, based on the August 2014 plans, for 2015-16 the indicative gap between commissioners' and providers' plans was £2.2 billion, rising to a potential £8.7 billion by 2018-19.

NHS England's plans

3.22 In July 2014, NHS England was forecasting an overall surplus of £467 million for 2014-15. This included a drawdown of £400 million brought-forward surpluses that NHS England allocated to specialised commissioning budgets in 2014-15. Allocation of this drawdown was prompted by initial estimates showing a deficit of £800 million in specialised commissioning. In revised plans submitted at the end of May 2014, 9 of the 10 area teams submitted balanced plans, of which 4 were dependent on achieving additional efficiency savings, of £23.5 million, or transfers from clinical commissioning groups' budgets, of £62 million. The London area team initially forecast a deficit of £65 million, subsequently revised to a balanced budget in July 2014. This was achieved by removing a £40 million National Institute of Clinical Excellence drugs reserve, and reductions of £10 million in the budget for non-recurrent payments and £15 million in the risk budget held against achievement of savings targets.

Clinical commissioning groups' plans

3.23 NHS England required clinical commissioning groups to submit plans developed with relevant area teams, providers and local authorities showing how they would achieve specified outcomes. NHS England encouraged clinical commissioning groups to engage in wider strategic planning across larger 'units of planning'. These could include several clinical commissioning groups, the relevant local authority, the NHS England area team and health and wellbeing board with the aim of addressing challenges over a wider geographical area. The Committee of Public Accounts has previously questioned how devolved commissioning decisions could take a sufficiently strategic and joined-up approach to meet patients' needs.[19] In some areas, clinical commissioning groups are starting to do this. For example, in North London, Havering Clinical Commissioning Group is developing a 5-year strategic plan across the local health economy, and Walsall Healthcare NHS Trust has reported that it is working with Walsall Clinical Commissioning Group and other providers in the Black Country to develop a consistent provision of service. NHS England expects health and wellbeing boards to be the principal local forum for agreeing strategic changes to health and care services.[20]

3.24 Commissioning plans for 2014-15 submitted in April were not balanced, prompting resubmission in May. NHS England completed its review of these plans in July, which showed the 1% required revenue surplus and a non-recurrent spend of 1.9% of total expenditure (against the 2.5% required by the guidance). Eighteen of the 211 clinical commissioning groups are forecasting a deficit, and a further 30 plan to return a surplus of less than 1%.

3.25 Some clinical commissioning groups have concluded they would be more effective as part of a larger group, or that they are unsustainable in their current form. NHS Gateshead, NHS Newcastle North and East and NHS Newcastle West clinical commissioning groups have recently been authorised to merge into one statutory body from 1 April 2015. NHS Ashford and NHS Canterbury and Coastal clinical commissioning groups are also in the early stages of discussing a merger. This is to help establish community networks and secure greater future financial sustainability.

3.26 Financial sustainability presents challenges for the whole health economy that cannot be resolved by bodies acting in isolation. The example of West Hertfordshire NHS Trust and NHS Herts Valleys Clinical Commissioning Group, in **Figure 24**, shows how financial and service sustainability depend on achieving clinical quality targets, capacity to invest, the extent of reliance on agency staff, cash support and the relationship between payment by results tariffs and the provider's actual costs.

19 Committee of Public Accounts, *Department of Health: Securing the future financial sustainability of the NHS*, Sixteenth Report of Session 2012-13, HC 389, October 2012.

20 The Health and Social Care Act 2012 required a health and wellbeing board to be established for every upper-tier local authority with effect from April 2013. The membership must include at least one elected local government representative, a representative from each clinical commissioning group in the local authority area, the local authority directors of adult social services, children's services and public health, and a representative from the local Healthwatch organisation. NHS England is expected to have a representative on health and wellbeing boards when formulating plans and considering services that NHS England commissions.

Figure 24

West Hertfordshire Hospitals NHS Trust and NHS Herts Valleys Clinical Commissioning Group

Background

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a population of around 500,000 living in West Hertfordshire and the surrounding area. The trust has 3 main hospital sites as well as outpatient services. Herts Valleys Clinical Commissioning Group commissions around 90% of the trust's activities.

Financial situation

The trust achieved surpluses of £3.7 million and £1.9 million in 2011-12 and 2012-13, respectively. However, by 31 March 2014 the trust was in deficit of around £13.4 million. It predicts that this will increase by the end of 2014-15 because of the ongoing challenges that it faces.

Challenges to sustainability

Recent failures to meet clinical targets have led the trust to prioritise investment in patient safety and quality. It recognises that in the short and medium term this will contribute to a growing deficit.

West Hertfordshire plans to invest heavily in estates, equipment and IT infrastructure to support services for patients and its capacity to make improvements in future.

In 2013-14 the trust invested in staff numbers, mainly in nursing to improve services for patients. It also continues to rely on agency staff.

The growth in emergency admissions means that activity above the 2008-09 baseline is paid at a rate of 30% of total treatment costs. The trust estimates that this 'payment by results' mechanism contributes around £10.5 million per year towards its current challenges.

The trust is an active partner in the area-wide strategic review being launched by Herts Valleys Clinical Commissioning Group. It recognises that it needs a whole-system solution to reverse its current prediction of year-on-year deficits.

Source: National Audit Office analysis of trust data and interviews with West Hertfordshire Hospitals NHS Trust, NHS Herts Valleys Clinical Commissioning Group and NHS Trust Development Authority

Appendix One

Our audit approach

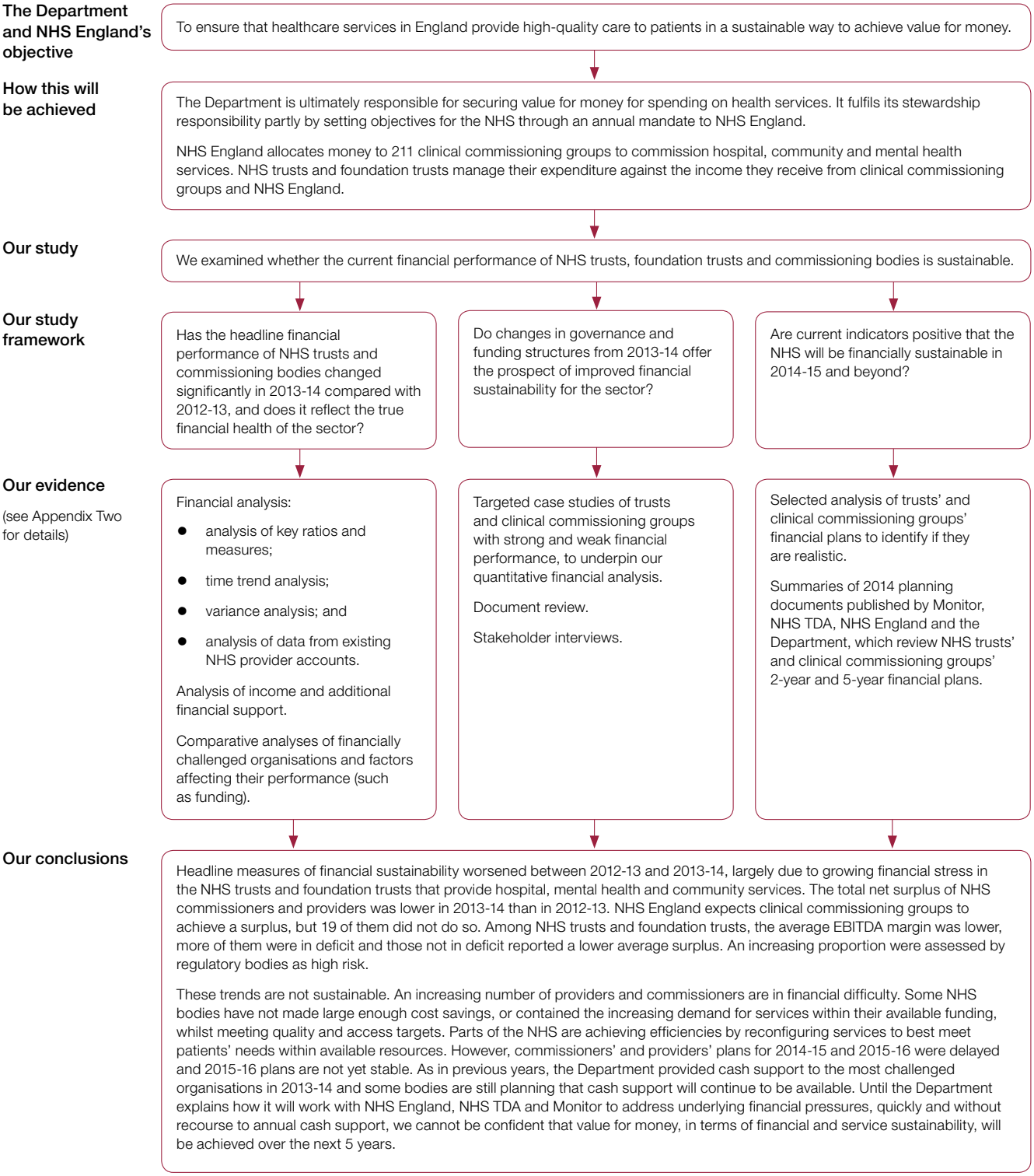
1 This report examines whether the current financial performance of NHS trusts, foundation trusts and commissioning bodies is sustainable. We reviewed:

- the headline financial performance of NHS trusts and commissioning bodies in 2013-14 compared with 2012-13;
- the extent to which this headline performance reflects the true financial health of the sector;
- how changes in governance and funding structures from 2013-14 offer the prospect of improved financial sustainability for the sector; and
- the extent to which current indicators are positive that the NHS will be financially sustainable in 2014-15 and beyond.

2 In reviewing these issues, we applied an analytical framework with evaluative criteria, to consider what arrangements would be optimal for financial sustainability. We used mainly output-based criteria (for example, performance against key financial indicators is stable or improving, or NHS bodies are receiving the same or less cash support than in previous years). By 'optimal', we mean the most desirable possible, while acknowledging expressed or implied constraints.

3 Our audit approach is summarised in **Figure 25**. Our evidence base is described in Appendix Two.

Figure 25
Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on the financial sustainability of the current financial performance of NHS trusts and commissioning bodies after analysing evidence that we collected between June and August 2014. Our audit approach is outlined in Appendix One.

2 We analysed existing financial data from provider and commissioner accounts.

- A time series analysis of provider performance against key indicators, including surpluses and deficits, EBITDA and cash and current liabilities. Appendix Three outlines the technical notes for this data.
- Analysis of the in-year performance of commissioners including clinical commissioning groups and NHS England for 2013-14 against their planned performance.
- A time series analysis of the overall financial position of the NHS.
- Analysis of additional financial support such as revenue-based public dividend capital for 2013-14 compared with the previous year.

3 We analysed data on NHS foundation trusts, such as financial and governance risk ratings and the number of trusts in breach of their licence conditions.

4 **We conducted 8 case studies of trusts and commissioners with varying financial performance**.

- We selected pairs of a trust and the clinical commissioning group providing the largest funding to include instances where at the end of 2013-14 both were in deficit, both in surplus, or one was in surplus and the other in deficit. We also used secondary selection criteria, which included:
    - a range of different types of organisation, such as a specialist acute provider versus a mental health provider;
    - a range of different-sized trusts, such as small acute hospitals versus large teaching hospitals;
    - trusts with and without significant financial commitments such as private finance initiative commitments or a recent merger or acquisition;
    - geographical information across a spread of locations, urban and rural areas; and
    - **Figure 26** overleaf provides a list of the case study trusts and clinical commissioning groups.
- The case studies were designed to collect evidence on a range of issues including:
    - the key factors influencing the financial position of an organisation or local area;
    - how providers and commissioners are addressing financial sustainability of an organisation or local area;
    - whether the roles and responsibilities of national bodies for sustaining services are clear; and
    - the future risks to financial sustainability.
- The case studies included:
    - interviews with senior people at the trust and clinical commissioning group, such as the chief executive, finance director and operations director;
    - interviews with Monitor or NHS TDA staff responsible for overseeing the trusts in question; and
    - reviewing documents about the trust, such as accounts data and minutes from meetings with the trust and clinical commissioning group during which financial and clinical quality matters are discussed.

Figure 26
Case study sites

Trust	Type of trust	CCG
Hampshire Hospitals NHS Foundation Trust	Medium acute, formed after Basingstoke and North Hampshire NHS Foundation Trust acquired Winchester and Eastleigh Healthcare NHS Trust in January 2012	North Hampshire CCG
North East London NHS Foundation Trust	Mental health	Havering CCG
Northumbria Healthcare NHS Foundation Trust	Large acute	Northumberland CCG
Nottingham University Hospitals NHS Trust	Teaching acute	Nottingham City CCG
Sheffield Children's Hospital NHS Foundation Trust	Specialist acute	Sheffield CCG
Walsall Healthcare NHS Trust	An integrated hospital and community healthcare trust with a private finance initiative scheme	Walsall CCG
Weston Area Health NHS Trust	Small acute that received additional revenue support	North Somerset CCG
West Hertfordshire Hospitals NHS Trust	Large acute with a challenging financial position	Herts Valleys CCG

Note

1 We identified clinical commissioning groups for case studies on the basis of which gives a provider most of its funding.

Source: National Audit Office

5 We interviewed key stakeholders including the Department, NHS England, Monitor and the NHS Trust Development Authority. This work was designed to obtain views on:

- whether the risks and challenges of the new structures are being managed and addressed;
- whether the roles and responsibilities for sustaining services and managing the performance of providers are clear; and
- the 3–5-year plans and future NHS financial sustainability.

We also reviewed material from other stakeholders including the Foundation Trust Network, Care Quality Commission, Kings Fund and Nuffield Trust on their views about current and future NHS financial sustainability.

6 **We reviewed existing documents**. This was designed to evaluate the process for producing 1–2-year and 3–5-year plans. We also reviewed a small selection of provider and commissioner plans to understand how they work in practice. We were unable to systematically review plans across the NHS because of delays in the planning process.

7 **We analysed existing data**. We performed simple scatterplots and regression analyses to investigate the relationship between trusts' financial positions and their performance against national clinical targets, such as waiting times or infection rates. We also investigated wider factors that might explain the variation in trusts' financial performance. These factors included:

- financial positions of nearby commissioners;
- PFI commitments;
- funding allocations;
- spending on, and number of, non-permanent staff;
- cash positions; and
- ratio of estate-related costs to turnover.

Appendix Three

Technical notes

1 There are some caveats that need to be recognised when reading the data:

- Two trusts became foundation trusts in 2012-13: one on 1 May 2013 and one on 1 July 2013. We have included these trusts, when appropriate, in the totals for foundation trusts. This has the effect of treating them as though they had been a foundation trust all year.
- All figures are quoted in absolute terms as reported, and are not adjusted for inflation.
- As in our report last year, net surplus and deficit figures for NHS trusts are reported:
    - before net impairments;
    - before the impact of absorption accounting for bodies that merged with or were acquired by other organisations;
    - before additional revenue charges associated with bringing private finance initiative (PFI) assets on to the balance sheet, due to the introduction of IFRS accounting in 2009-10 (IFRIC 12); and
    - before the impact of changes in accounting for donated assets and government grant reserves.

2 Surplus and deficit figures for foundation trusts are reported on the same basis as Monitor reports them in its annual review of NHS foundation trust consolidated accounts. This means that their net surplus or deficit is reported:

- before net impairments;
- before the impact of absorption accounting for bodies that merged with or were acquired by other organisations;
- after the impact of incurring additional revenue charges associated with bringing PFI assets onto the balance sheet due to the introduction of IFRS accounting in 2009-10;
- before the consolidation of charities; and
- after the impact of changes in accounting for donated assets and government grant reserves.

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