



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

Financial sustainability of the NHS

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National Audit Office

Department of Health

Financial sustainability of the NHS

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

18 November 2016

This report examines whether the NHS is on track to achieve financial sustainability.

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Contents

Key facts 4

Summary 5

Part One

Financial performance in the NHS 14

Part Two

Managing financial sustainability 29

Part Three

Supporting local bodies to achieve financial sustainability 37

Appendix One

Our audit approach 44

Appendix Two

Our evidence base 46

Appendix Three

Technical notes 49

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Key facts

£1.85bn

net deficit of NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) overall in 2015-16

£2.45bn

net deficit of NHS trusts and NHS foundation trusts in 2015-16

66%

percentage of NHS trusts and NHS foundation trusts (156 out of 238) in deficit in 2015-16

32 out of 209 (15%) number of clinical commissioning groups reporting a cumulative deficit in 2015-16

£2.4 billion additional funding given to NHS trusts and NHS foundation trusts in financial difficulty as a cash injection, loan or other financial support in 2015-16

£1.8 billion funding for financial sustainability available for trusts in 2016-17 from the £2.14 billion Sustainability and Transformation Fund

£461 million net deficit reported by NHS trusts and NHS foundation trusts in the first three months of 2016-17

£14.9 billion savings that NHS trusts, NHS foundation trusts and clinical commissioners need to make by 2020-21 to help close the estimated £22 billion gap between patients' needs and resources

Summary

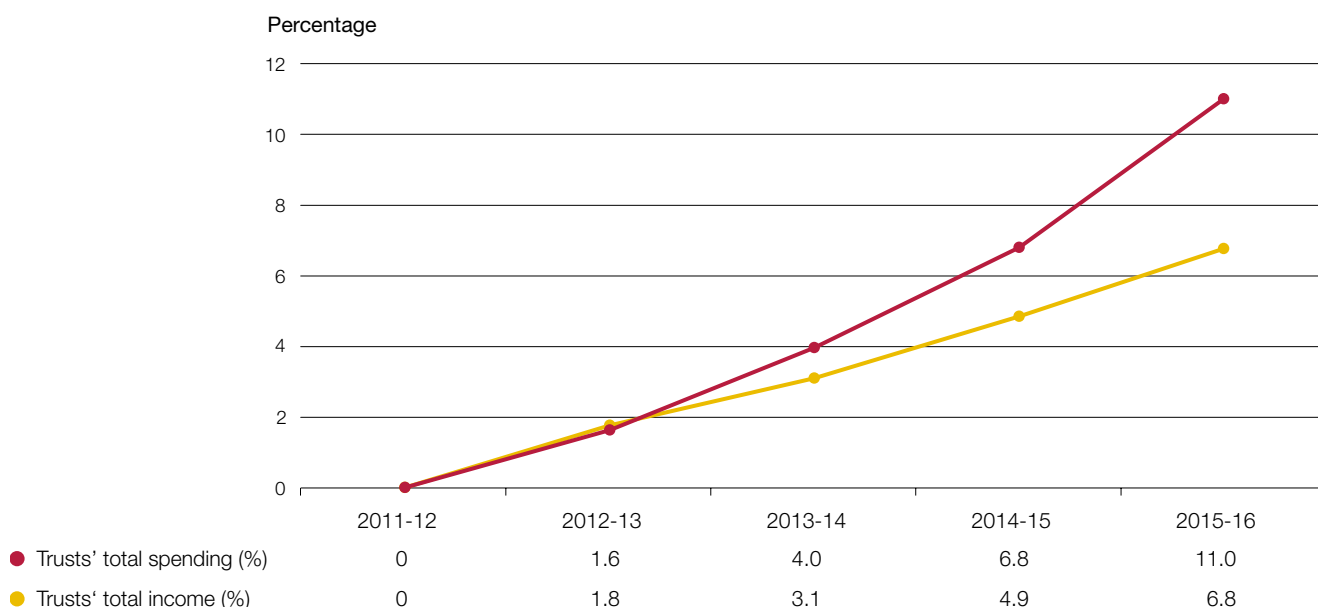
1 This is our fifth report on the financial sustainability of the NHS. The health service must be financially sustainable to provide high-quality services for patients both now and in the future. Health is an area of public spending that has been protected in recent years. However, finances have become increasingly tight.

2 NHS bodies achieve financial sustainability when they are able to successfully manage activity, quality and financial pressures within the income they receive. In recent years, the financial performance of NHS trusts and NHS foundation trusts has significantly declined. **Figure 1** shows that the growth in spending by trusts has outpaced growth in their income.

Figure 1

Cumulative increase in NHS trusts' and NHS foundation trusts' income and spending since 2011-12

Growth in trusts' income has not kept pace with growth in spending



Notes

- 1 NHS trusts' and NHS foundation trusts' spending and income figures are adjusted to remove the effects of impairments of assets, transfers of functions from or to other health bodies and charitable funds.
- 2 Figures are adjusted for inflation using the GDP deflator with the base year in 2015-16, as used by HM Treasury in setting departments' budgets.

Source: National Audit Office analysis of trusts' financial data

3 In December 2015 we concluded that this continued deterioration in financial performance was not sustainable and that financial problems were endemic. The Department of Health (the Department) has overall responsibility in central government for healthcare services. The Department is accountable to Parliament for ensuring that all spending by the Department, NHS England, NHS Improvement, other arm's-length bodies and by local NHS bodies is contained within the overall budget authorised by Parliament. It is responsible for ensuring that those organisations perform effectively and have governance and controls in place to ensure value for money. The Department has made NHS England and NHS Improvement responsible for ensuring that the NHS balances its budget in 2016-17.¹

4 The NHS *Five Year Forward View*, published in October 2014, set out proposed changes to healthcare services. The *Five Year Forward View* estimated that there would be a £30 billion gap between resources and patients' needs by 2020-21. It estimated that if the NHS had £8 billion more funding, the gap between resources and patients' needs would be £22 billion by 2020-21 if no action was taken. In November 2015 the government committed to increasing funding for the NHS by £8.4 billion by 2020. Included in this is £2.14 billion that the Department, NHS England and NHS Improvement set aside for the Sustainability and Transformation Fund in 2016-17, of which £1.8 billion will be used to help trusts sustain services and reduce deficits.

5 In this report on financial sustainability in the NHS:

- We give a summary of the financial position of NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts (Part One).
- We look at what the Department, NHS England and NHS Improvement have done to develop a plan for achieving financial sustainability, and how they are managing the risks in implementing their plans (Part Two).
- We examine the support the Department, NHS England and NHS Improvement have given to local bodies, including NHS trusts, NHS foundation trusts and clinical commissioning groups, to ensure the future sustainability of the NHS (Part Three).

6 We set out our audit approach in Appendix One and evidence base in Appendix Two. Technical notes explaining how we have used financial data are in Appendix Three. The report does not look in detail at primary care, social care, public health or similar services, although the transformation of primary care and public health and the need to sustain social care services are key elements of the *Five Year Forward View*.

¹ NHS Improvement includes Monitor, the regulator of NHS foundation trusts, and the NHS Trust Development Authority, which oversees NHS trusts.

Key findings

Trends in the financial performance of NHS bodies

7 In 2015-16, NHS commissioners, NHS trusts and NHS foundation trusts reported a combined deficit of £1.85 billion. This was made up of:

- NHS trusts and NHS foundation trusts reporting a combined deficit of £2.45 billion against their total income of £75.97 billion;
- clinical commissioning groups together achieving an overspend of £15 million, against the £72.24 billion available for locally commissioned services; and
- NHS England achieving an underspend of £614 million, spending £28.02 billion of the £28.64 billion available for its national functions and centrally commissioned services (paragraph 1.3).

8 The financial position of NHS bodies overall has continued to decline.

The £1.85 billion deficit in 2015-16 reported by commissioners, NHS trusts and NHS foundation trusts together, shows that the financial position has worsened since a £574 million deficit was reported in 2014-15 and a £234 million surplus in 2013-14 (paragraph 1.3).^{2,3}

9 The number of NHS bodies reporting a deficit rose significantly between 2014-15 and 2015-16.

In 2015-16 two-thirds of NHS trusts (65%) and NHS foundation trusts (66%) reported deficits, up from 44% of NHS trusts and 51% of NHS foundation trusts in 2014-15. The number of clinical commissioning groups reporting cumulative deficits was 32 in 2015-16, up from 19 in both 2013-14 and 2014-15 (paragraphs 1.5 and 1.9).

² The total deficit reported by NHS bodies in 2014-15 is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three). The restated figures for 2014-15 are used throughout this report.

³ The financial performance of NHS bodies in 2013-14 and 2014-15 is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because for consistency with NHS England's Annual Report and Accounts for 2015-16, we have restated the commissioner figures to use NHS England's non-ring-fenced budget. The non-ring-fenced budget excludes depreciation and impairment charges. Previously reported figures use NHS England's ring-fenced budget, which includes depreciation and impairment charges.

10 Trusts' overall deficit grew by 185% to £2.45 billion, up from £859 million in 2014-15.⁴ This continued trusts' sharp decline in financial performance from a £91 million deficit reported in 2013-14, and a £592 million surplus in 2012-13. At 30 June 2016, trusts reported a deficit of £461 million and forecast an end-of-year deficit of £644 million (paragraphs 1.10 to 1.11).

11 Trusts' performance against important indicators of financial health continued to decline in 2015-16. Trusts' overall margin of average earnings before interest, tax, depreciation and amortisation (EBITDA) fell for the fifth consecutive year. EBITDA is used as a measure of operating efficiency and underlying financial sustainability. At the end of 2015-16 the average EBITDA margin for NHS trusts fell sharply to 0.8% from 3.5% in 2014-15; for NHS foundation trusts, it had fallen from 3.6% to 2.2%. In 2015-16 trusts' balance of net current assets, showing how much capital trusts are generating and using, was negative for the first time. This suggests trusts are finding it difficult to finance their day-to-day operations. Trusts are increasingly struggling to pay suppliers on time with 77% paying their invoices within 30 days in 2015-16, compared with 81% in 2014-15 and 82% in 2013-14, against the Department's target that 95% of invoices are paid on time (paragraphs 1.12 to 1.15).

Reliance on financial support

12 NHS trusts and NHS foundation trusts under financial stress continue to rely on financial support from the Department and NHS England. The Department provides additional funding, mainly in the form of loans, so that trusts in difficulty have the cash they need to pay creditors and staff and to fund essential building works. NHS England provides income support to trusts to cover historically agreed transactions and private finance initiative payments. In 2015-16 the total amount of financial support funding provided by the Department and NHS England was £2.4 billion. This was an increase of 32% from £1.8 billion in 2014-15 (paragraph 1.17).

⁴ Trusts' 2014-15 deficit is different from that reported from our report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Achieving NHS targets and meeting quality requirements

13 There are indications that financial stress is having an impact on access to services and quality of care. Trusts' performance against important NHS access targets has worsened. For example, the target that a minimum of 95% of patients attending accident and emergency departments (A&E) must be discharged, admitted or transferred in under four hours was not met in 2015-16, with 91.9% spending fewer than four hours in A&E compared with 93.6% in 2014-15. We found an association between trusts' financial performance and trusts' overall Care Quality Commission rating (which does not include measures of actual financial performance). The trusts that achieved lower quality ratings also reported poorer average financial performance. We found that the five trusts rated 'outstanding' between December 2013 and August 2016 had a net deficit equal to 0.02% of their total income in 2015-16. The 14 trusts rated 'inadequate' had a net deficit equal to 10.4% of their total income in 2015-16 (paragraphs 1.18 to 1.20).

Impact of interventions to manage the 2015-16 financial position

14 The growth in trusts' spending on agency and contract staff has slowed, although their spending on these staff is still significant. Trusts spent 7.6% of their total staff costs on agency and contract staff in 2015-16, up from 7.1%, 5.6% and 4.8% in 2014-15, 2013-14 and 2012-13 respectively. The Department, Monitor and the NHS Trust Development Authority introduced controls on agency spending in October 2015. However, the amount trusts spent on agency and contract staff remained high. They spent £3.7 billion in 2015-16, compared with £3.3 billion in 2014-15. It may take years to resolve workforce issues that affect the successful recruitment and retention of permanent staff, and reduce the need for agency staff (paragraphs 1.22 to 1.25).

15 The Department has transferred funding for capital to funding for day-to-day spending; this has helped it to manage the NHS' financial position in 2015-16, but could risk trusts' ability to achieve sustainable service provision. In February 2016 the Department transferred £950 million of its £4.6 billion budget for capital projects, such as building works and IT, to revenue budgets to fund the day-to-day activities of NHS bodies. Of this, £331 million was exchanged for revenue support for 93 trusts, to fund healthcare services. The Department did not assess the long-term effects of transferring this funding to cover day-to-day spending. This means it does not know what risks trusts may face in future as a result of addressing immediate funding needs (paragraphs 1.27 to 1.29).

Managing financial sustainability

16 The Department, NHS England and NHS Improvement have a shared plan to close the estimated £22 billion gap between patients' needs and resources by 2020-21. Together, the Department, NHS England and NHS Improvement estimate that they can make £6.7 billion of efficiencies by capping public sector pay, renegotiating contracts, implementing income-generating activities and reducing running costs. They estimate that trusts and commissioners can make a further £14.9 billion by moderating the growth in demand for healthcare services and achieving 2% productivity and efficiency improvements (paragraphs 2.2 and 2.3).

17 Plans to close the estimated £22 billion gap have not been fully tested. The Department, NHS England and NHS Improvement used a financial model to estimate the gap between patients' needs and resources by 2020-21, and the savings their programmes need to achieve to close this gap. We found limited testing by the Department, NHS England and NHS Improvement of their estimates of how much they expect to generate from their savings programmes. This raises concerns about whether planned savings can be achieved. For example, plans assume that growth in trusts' acute activity (including specialised acute services) will be reduced from 2.9% to 1.3% through transformation and efficiency programmes such as Right Care, new care models and the Urgent and Emergency Care programme. However, NHS statistics show this will be challenging as hospital admissions, a key driver of activity, grew by 2.8% a year between 2013-14 and 2014-15 (paragraphs 2.4 to 2.7).

18 The NHS is implementing its plans to make the NHS financially sustainable from a worse than expected starting point. Plans to achieve financial sustainability were based on trusts ending 2015-16 with a combined deficit of £1.8 billion. The fact that trusts ended the year with an even larger deficit means that the level of deficit to be recovered is significantly greater than expected. This means that the trusts affected will need to catch-up by making more savings than planned to reach the intended starting position. For example, trusts with deficits greater than expected at the end of 2015-16 will need to make operational efficiencies above the 2% savings level applied to all providers of healthcare services in 2016-17 or subsequent years (paragraphs 1.8 and 2.8).

19 National bodies have not assessed the impact of all the wider cost pressures faced by local NHS organisations in plans for achieving financial sustainability.

The Department, NHS England and NHS Improvement expect trusts and commissioners to invest in transformation programmes. But they do not yet know what level of investment is required or whether local bodies will be able to make the changes at the scale and pace needed. Furthermore, the government has made a commitment that the health and social care system in England will be fully joined together by 2020. We have previously reported that local authority spending on adult social care fell by 10% in real terms between 2009-10 (£16.3 billion) and 2014-15 (£14.6 billion). The accounting officer for NHS England told the Committee of Public Accounts that “over the next two or three years, there is likely to be a widening gap between the availability of adult social care and the need for social care. That, will, inevitably show up as delayed discharges and extra pressure on hospitals.” However, in our review of the plans for financial sustainability, we did not see any estimate of the impact of pressures on social care spending on NHS bodies (paragraphs 2.6 to 2.13).

Supporting local NHS organisations to achieve financial sustainability

20 NHS England’s and NHS Improvement’s financial ‘reset’ announced in July 2016 outlined the steps they are taking to cut trusts’ deficits. NHS Improvement placed five trusts in ‘financial special measures’ and it continued to monitor trusts against the financial targets (control totals) that it introduced in January 2015. Trusts must meet these targets in order to access the £1.8 billion of sustainability funding from the Sustainability and Transformation Fund. In 2016-17 NHS England and NHS Improvement continued to implement their controls on trust spending that began in 2015-16, for example by limiting spending on agency staff (paragraph 3.2).

21 Despite efforts by NHS England and NHS Improvement to join up to support local NHS bodies, a lack of incentives and unrealistic targets remain. We heard from five of the 21 local bodies we spoke to that the pressure to meet the financial targets set by NHS Improvement for their individual organisation did not incentivise them to work with other bodies in their local area to develop sustainability and transformation plans as required by NHS England and NHS Improvement. Furthermore, in May 2016 the Committee of Public Accounts concluded that the 4% efficiency target for trusts set by NHS England and Monitor (now NHS Improvement) in 2015-16 was unrealistic and damaging to trusts’ finances. For the 2016-17 financial year, NHS England and NHS Improvement reduced the efficiency target to 2%. But, by July 2016, NHS Improvement said it expected that trusts will need to achieve an efficiency target greater than 2%, partly because of the higher than expected trust deficit at the end of 2015-16 (paragraphs 3.4 and 3.7 to 3.10).

Conclusion on value for money

22 The messages in our two previous reports on NHS financial sustainability have been consistent and clear in stating that the trend in NHS trusts' and NHS foundation trusts' declining financial performance was not sustainable. In 2015-16 trusts' financial performance worsened considerably. Efforts to get NHS finances on track, such as large savings and efficiency targets, have damaged trusts' financial positions and contributed to the current situation. With more than two-thirds of trusts in deficit in 2015-16, we repeat our view that financial problems are endemic and this is not sustainable.

23 Delivering financial stability in 2016-17 will be vital if the NHS is to make the changes needed to improve the quality and timeliness of healthcare services. The Department, NHS England and NHS Improvement must make sure their plans for restoring NHS finances to a stable position are achievable. They have put considerable effort and funding toward stabilising the system, but the starting position in 2016-17 was considerably weaker than assumed. The Department, NHS England and NHS Improvement have a way to go to demonstrate that they have balanced resources and achieved stability as a result of this effort. Therefore, value for money from these collective actions has not yet been demonstrated.

24 The National Audit Office (NAO) perceives differences in the position articulated by the Department – which views the funding for the NHS as having been adequate over the last few years, and in line with what NHS England set out it would need to deliver the NHS *Five Year Forward View* – and NHS England itself. Confronted as NHS England is by the pressures of rising demand for services, these signs of differences do not help build a confident feel about the future of the NHS.

Recommendations

- a The Department, NHS England and NHS Improvement should test the assumptions in both national plans as well as local sustainability and transformation plans.** The Department, NHS England and NHS Improvement have identified savings programmes for closing the estimated £22 billion gap between patients' needs and resources by 2020-21. They should test national plans as well as local sustainability and transformation plans and use this testing to identify the risks that need to be managed. They should be clear on who these risks are owned by.
- b NHS England and NHS Improvement should set realistic efficiency and savings targets for local bodies to achieve.** Setting overly optimistic efficiency and savings targets for local bodies could result in short term and ineffective interventions. NHS England and NHS Improvement should set informed efficiency and savings targets for providers and make sure the combined effect of these targets is achievable.

- c The Department should evaluate the impact and risks to future financial stability of the one-off measures used to manage the 2015-16 financial position, including the transfer of capital funding to resource.** The Department, NHS England and NHS Improvement took action to manage the financial position of the NHS in 2015-16 and address the growing deficit of trusts. While their measures are technically justifiable, they should not form the basis of a credible plan to secure the financial sustainability of the NHS in England. It is unclear what impact one-off measures will have on the future sustainability of the NHS or whether there is sufficient capital to renew existing assets and support the vision in the *Five Year Forward View*. The Department should assess its capital requirements and evaluate the impact and risks of transferring capital budgets to support routine spending.
- d The Department, NHS England and NHS Improvement should analyse the impact to the NHS of pressures on social care funding, and the cost of implementing seven-day services.** Local bodies are faced with wider cost pressures in addition to the need to achieve financial sustainability. However, not all of these have been taken into account in national plans for financial sustainability.
- e NHS England and NHS Improvement should assess whether current and planned incentives are helping local bodies to work together, plan for and achieve long-term financial sustainability.** The legislative and accountability framework for local NHS organisations is seen by some as a barrier to helping local bodies to work together. But NHS England and NHS Improvement could do more within the existing regulation and accountability framework to create the incentives for local bodies to collaborate. They should evaluate whether recent changes to the financial planning process for local bodies are working effectively and should have alternative plans if new approaches do not work as intended.

Part One

Financial performance in the NHS

1.1 In this part of the report we examine the financial position of NHS bodies (clinical commissioning groups, NHS trusts and NHS foundation trusts) and trends in the performance of clinical commissioning groups, NHS trusts and NHS foundation trusts. We also look at measures of financial sustainability for NHS trusts and NHS foundation trusts.

NHS funding and spending in 2015-16

1.2 In 2015-16, the Department of Health (the Department) gave £100.9 billion to NHS England to plan and pay for NHS services.⁵ The greatest share of the budget was spent by 209 clinical commissioning groups, which largely bought healthcare from 86 NHS trusts and 152 NHS foundation trusts. These provide hospital, community, ambulance, and mental health and disability services. **Figure 2** gives a summary of the financial performance of NHS commissioners, NHS trusts and NHS foundation trusts in 2015-16.

1.3 NHS bodies overall ended 2015-16 with a £1,848 million (£1.85 billion) deficit. This was significantly greater than the £574 million deficit recorded in 2014-15 and the £234 million surplus in 2013-14.^{6,7} In 2015-16 the deficit was made up of:

- NHS England reporting an underspend of £614 million, having spent £28,024 million of the £28,638 million available for national functions, centrally commissioned services and legacy claims;
- clinical commissioning groups reporting an overspend of £15 million against the £72,244 million available for locally commissioned services; and
- NHS trusts and NHS foundation trusts reporting a combined deficit of £2,447 million against their income of £75,966 million.

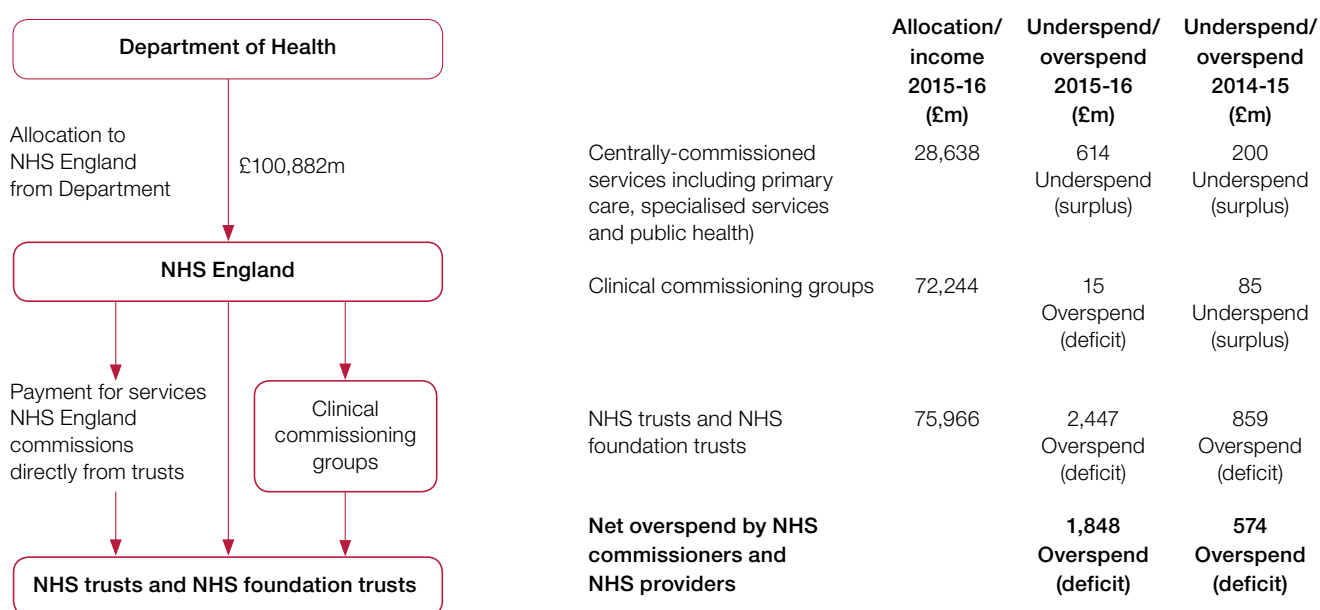
5 The £100.9 billion is NHS England's revenue budget for day-to-day spending. It is its non-ring-fenced budget, meaning it excludes depreciation and impairment charges.

6 Trusts' 2014-15 deficit is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three). The restated figures for 2014-15 are used throughout this report.

7 The financial performance of NHS bodies in 2013-14 and 2014-15 is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because for consistency with NHS England's Annual Report and Accounts for 2015-16, we have restated the commissioner figures to use NHS England's non-ring-fenced budget. The non-ring-fenced budget excludes depreciation and impairment charges. Previously reported figures use NHS England ring-fenced budget, which includes depreciation and impairment charges.

Figure 2

Summary of the financial performance of NHS commissioners, NHS trusts and NHS foundation trusts in 2015-16

**Notes**

- 1 NHS England's total revenue budget (including depreciation and impairment charges) was £101,708 million. The core measure for NHS England's financial performance is its non-ring-fenced revenue budget of £100,882 million, which excludes depreciation and impairment charges.
- 2 NHS trusts and NHS foundation trusts generate income as opposed to receiving 'allocations'. This is because they work on a more commercial basis than NHS England and clinical commissioning groups, which work within an annual resource limit.
- 3 NHS trusts and NHS foundation trusts receive income from clinical commissioning groups, NHS England and other trusts, including from services they provide to other trusts. The £75,966 million income shown here is the gross income from all these sources.
- 4 NHS England and clinical commissioning groups also buy healthcare services from other providers.
- 5 Several NHS trusts and NHS foundation trusts dissolved in 2015-16. Figures shown here include the results for these trusts up until the point of dissolution. All other data are for the whole 2015-16 financial year.
- 6 The 2014-15 balance is different from that reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).
- 7 The combined underspend of NHS England and clinical commissioning groups was £599 million.
- 8 Underspend or overspend on the legacy Continuing Healthcare claims programme have been included in the figures for centrally commissioned services.

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

Trends in the financial performance of healthcare commissioners

1.4 The financial performance of clinical commissioning groups is measured against the planned position at the end of the financial year agreed between each clinical commissioning group and NHS England. Any differences between the actual and planned position are reported as either underspends or overspends. NHS England asks clinical commissioning groups to balance their finances and not overspend by the end of the financial year. They must also report any underspending. In 2015-16 the £15 million overspend was made up of two components:

- a collective overspend of £28 million on locally commissioned services bought by clinical commissioning groups; and
- an underspend of £13 million on the Quality Premium programme.⁸

1.5 NHS England calculates clinical commissioning groups' financial position compared with their funding allocation each year. Any surplus or deficit is added to previous years' calculations to create a cumulative surplus or deficit for each group. In 2015-16:

- the number of clinical commissioning groups reporting a cumulative deficit increased to 32 clinical commissioning groups, up from 19 in 2014-15 and 19 in 2013-14; and
- the total net cumulative surplus fell to £328 million from £731 million in 2014-15, indicating that clinical commissioning groups needed to use their reserves as well as their allocated funding to commission healthcare services.

1.6 In 2015-16 NHS England underspent by £614 million against its central and direct commissioning budget. It achieved this by reducing the costs of restructuring; spending less than planned on programmes, which saved £340 million; achieving an underspend of £192 million on legacy Continuing Healthcare claims and making additional savings of £82 million from direct commissioning.⁹ Many of these savings were one-off in nature. NHS England's budget for 2016-17 onwards has been adjusted to reflect likely future performance. This means NHS England will continue to operate under financial constraint in 2016-17.

⁸ The Quality Premium programme rewards clinical commissioning groups for improving the quality of services they commission and for associated improvements in health outcomes.

⁹ The NHS Continuing Healthcare programme provides free care outside of hospital that is arranged and funded by the NHS. Clinical commissioning groups now provide funding, but NHS England is responsible for accounting for claims made before the healthcare system was reorganised following the Health and Social Care Act 2012.

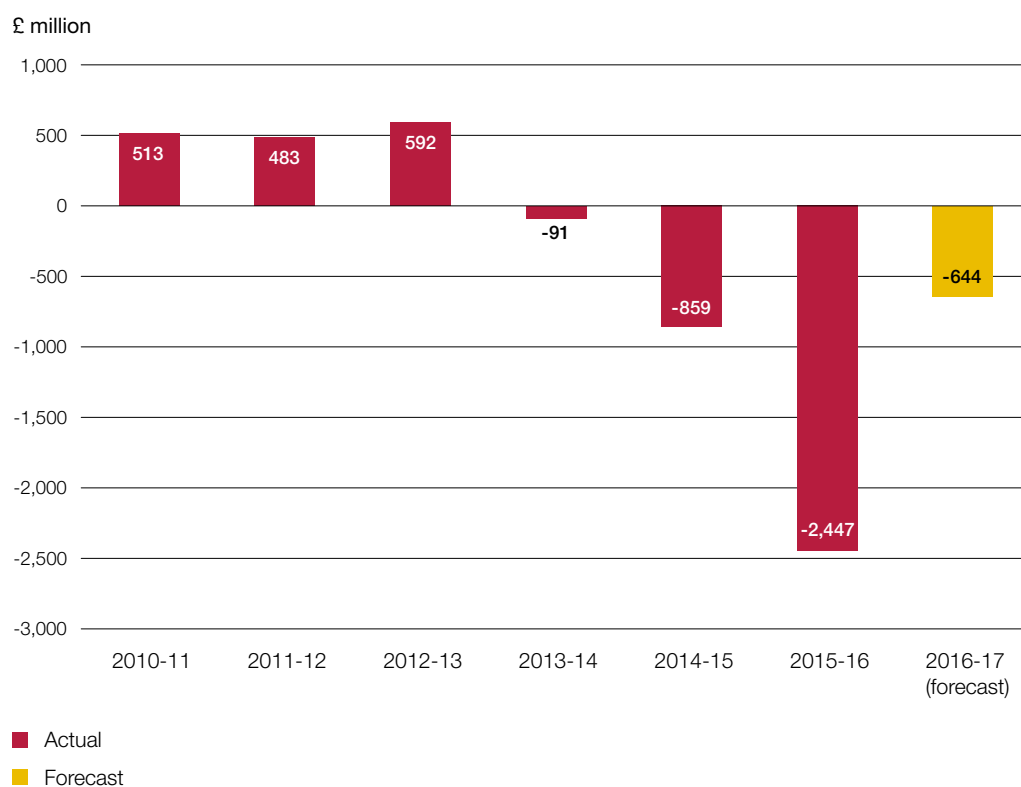
Trends in the financial performance of NHS trusts and NHS foundation trusts

1.7 **Figure 3** shows that, between 2013-14 and 2015-16, the financial performance of NHS trusts and NHS foundation trusts deteriorated considerably. Trusts have forecast that their financial performance will improve by the end of 2016-17. They expect a net deficit of £644 million by 31 March 2017. This improvement is expected to come largely from trusts accessing £1.8 billion of sustainability funding during 2016-17 (see paragraph 3.2).

Figure 3

Surplus/deficit of NHS trusts and NHS foundation trusts, 2010-11 to 2015-16, and forecast for 2016-17

There was a significant decline in the financial position of NHS trusts and NHS foundation trusts in 2015-16 with trusts forecasting an improved position by the end of 2016-17



Notes

- 1 The 2016-17 forecast figure is taken from NHS Improvement, *Quarter 1 sector performance report*, May 2016.
- 2 The 2014-15 balance is different from that reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of trusts' financial data, and 2016-17 forecast data from NHS Improvement

1.8 Trusts' financial deficit at the end of 2015-16 was greater than the deficit forecast in their financial plans submitted in May 2015. In September 2015 the NHS Trust Development Authority gave each NHS trust a target to improve its forecast overall deficit. NHS foundation trusts were asked to show improved forecast outturn positions. Despite efforts to improve trusts' finances, the net deficit at 31 March 2016 (£2,447 million) was significantly greater than both the end-of-year deficit forecast in April 2015 (£2,075 million) and the final planned deficit of £1,800 million estimated after NHS trusts had been given their stretch targets.¹⁰

1.9 In 2015-16 there were 238 trusts, made up of 86 NHS trusts and 152 NHS foundation trusts. **Figure 4** shows that a growing number of trusts have reported a deficit since 2012-13, when just 25 trusts overall reported a deficit. At the end of 2015-16 this had risen to 156 trusts. In 2015-16:

- 65% of NHS trusts (56 of 86) reported a deficit up from 44% in 2014-15 (40 of 90), 23% in 2013-14 (23 of 98), and 5% in 2012-13 (5 of 100); and
- 66% of NHS foundation trusts (100 of 152) reported deficits, up from 51% (76 of 150) in 2014-15, 28% in 2013-14 (41 of 147) and 14% in 2012-13 (20 of 145).

1.10 In 2015-16 the overall deficit of NHS trusts and NHS foundation trusts (£2,447 million) was 2.8 times the size of the deficit in 2014-15 (£859 million).¹¹

- NHS trusts' overall deficit increased to £1,337 million in 2015-16 from £514 million in 2014-15.
- NHS foundation trusts overall deficit increased to £1,110 million in 2015-16 from £345 million in 2014-15.
- For all trusts that had a deficit, their combined deficit was £2,800 million in 2015-16 up from £1,268 million in 2014-15.

1.11 At 30 June 2016, trusts reported a deficit for the first quarter of 2016-17 of £461 million. If the size of the deficit is maintained, it would mark a significant improvement in the financial performance of trusts from the £2,447 million deficit reported in 2015-16. However, it will be challenging for trusts to go from a £461 million quarter one deficit to meet their forecast end-of-year deficit of £644 million. The quarter one deficit of £461 million includes £450 million of sustainability funding. Without this funding the deficit would be £911 million, compared with a deficit of £930 million for the first quarter of 2015-16.

10 HC Committee of Public Accounts, *Sustainability and financial performance of acute hospital trusts*, Thirtieth Report of Session 2015-16, HC 709, March 2016, available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/709/709.pdf

11 Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Figure 4
Surpluses and deficits of NHS trusts and NHS foundation trusts, 2012-13 to 2015-16

	2012-13		2013-14		2014-15		2015-16	
	Number of trusts in surplus	Number of trusts in deficit	Number of trusts in surplus	Number of trusts in deficit	Number of trusts in surplus	Number of trusts in deficit	Number of trusts in surplus	Number of trusts in deficit
NHS trusts	95	5	75	23	50	40	30	56
NHS foundation trusts	125	20	106	41	74	76	52	100
Total	220	25	181	64	124	116	82	156
	Surplus (£m)	Deficit (£m)	Surplus (£m)	Deficit (£m)	Surplus (£m)	Deficit (£m)	Surplus (£m)	Deficit (£m)
NHS trusts	238	-139	217	-424	120	-634	97	-1,434
NHS foundation trusts	651	-158	432	-316	289	-634	256	-1,366
Gross total	889	-297	649	-740	409	-1,268	353	-2,800
Net total	592		-91		-859		-2,447	

Notes

- 1 The number of trusts are those were in existence on 31 March for each year. Trusts that stopped providing services during the year through mergers or break-ups are not counted.
- 2 Surpluses and deficits of trusts ceasing to provide services in each year are added to the successor trusts' surpluses and deficits.
- 3 Figures exclude NHS Direct.
- 4 The 2014-15 figures for NHS foundation trusts are different from those reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of trusts' financial data

Indicators of trusts' financial sustainability

1.12 The EBITDA margin (earnings before interest, tax, depreciation and amortisation, expressed as a percentage of income) is a measure of operating efficiency and underlying financial sustainability. The average EBITDA margin for both NHS trusts and NHS foundation trusts has fallen over the past five years, reflecting the widening gap between income and expenditure (**Figure 5**). In 2015-16 the margin was 0.8% for NHS trusts and 2.2% for NHS foundation trusts, down from 5.7% and 6.6% respectively in 2010-11.

1.13 The balance of net current assets held by trusts indicates how much capital trusts are generating or using through day-to-day activities. If net current assets are negative, it may indicate that a trust is having difficulty financing its day-to-day operations.

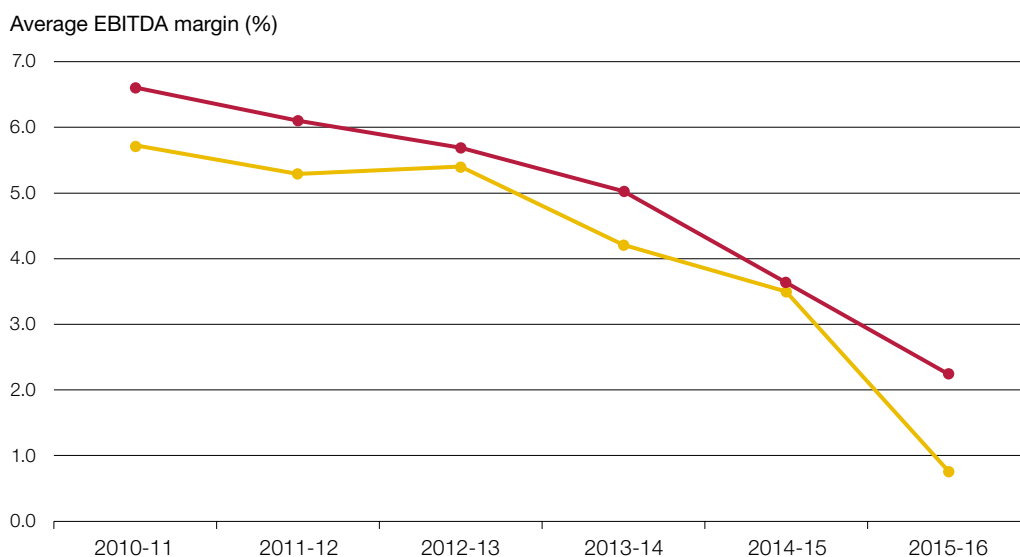
Figure 6 shows that in 2015-16:

- trusts reported a negative total net current assets balance of £25 million for the first time, down from £1,328 million in 2014-15;
- net current assets held by NHS trusts fell considerably (198%) to a negative balance of £593 million, from a negative balance of £199 million in 2014-15; and
- net current assets held by NHS foundation trusts fell by 63% to £568 million, down from £1,527 million in 2014-15.

Figure 5

Average EBITDA margins for NHS trusts and NHS foundation trusts, 2010-11 to 2015-16

The average EBITDA margin has fallen over the past six years



● NHS trusts	5.7	5.3	5.4	4.2	3.5	0.8
● NHS foundation trusts	6.6	6.1	5.7	5.0	3.6	2.2

Note

1 The 2014-15 figures for NHS foundation trusts are different from those reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Figure 6
Cash and other current assets and liabilities at the end of the financial year, 2012-13 to 2015-16

	2012-13		2013-14		2014-15		2015-16	
	NHS trusts (£m)	Total (£m)	NHS trusts (£m)	Total (£m)	NHS trusts (£m)	Total (£m)	NHS trusts (£m)	Total (£m)
Cash and cash equivalents	1,308	5,791	1,269	5,482	1,005	4,976	790	4,134
Other current assets	1,714	4,102	2,290	5,429	2,312	5,892	2,239	6,038
Current liabilities	-3,174	-8,261	-3,656	-9,247	-3,516	-9,540	-3,622	-10,197
Net current assets	-152	1,632	-97	1,664	-199	1,328	-593	-25

Notes

- 1 Current assets and current liabilities include balances between trusts (figures are gross, not netted off for transactions between trusts).
- 2 Data exclude trusts' charitable funds.
- 3 Data are taken from trusts' statements of financial position on 31 March in each year; balances of trusts that dissolved in-year are included in the balances of the successor trusts for that year. Balances of trusts that became NHS foundation trusts during the financial year are included in the NHS foundation trust figures for that year.

Source: National Audit Office analysis of NHS trusts and NHS foundation trusts accounts data, 2012-13 to 2015-16

1.14 Figure 6 shows that cash balances for trusts continued to fall in 2015-16. Trusts may have fewer reserves that they can easily draw on in times of need, so there is a higher risk that trusts in difficulty will still need financial support from the Department. In 2015-16, the amount of cash held by:

- all trusts had fallen by 29% since 2012-13, to £4,134 million down from £5,791 million;
- NHS trusts had fallen by 40% since 2012-13, to £790 million down from £1,308 million; and
- NHS foundation trusts had fallen by 25% since 2012-13, to £3,344 million from £4,483 million.

1.15 Trusts are increasingly not paying their bills on time. The Department's Better Payment Practice Code (BPPC) states that trusts should pay 95% of all undisputed invoices "within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed".¹² Trusts paid 77% of invoices on time in 2015-16 compared with 81% in 2014-15 and 82% in 2013-14.¹³

1.16 A significant number of trusts face severe financial pressures. In 2015-16, there were 57 trusts with deficits that made up more than 5% of their income. Appendix Four, published alongside this report, shows which trusts these were.

Trusts' reliance on financial support

1.17 Trusts in financial difficulty received £2.4 billion of extra financial support from the Department and NHS England in 2015-16 compared with £1.8 billion in 2014-15: an increase of 32%. Historically, the Department gave trusts in financial difficulty cash in the form of public dividend capital (PDC). This gave them money to pay creditors and staff and to fund essential building works and continue delivering services. To encourage financial recovery, in March 2015, the Department introduced interest-bearing loans and fee-bearing PDC for trusts in difficulty. In 2015-16:

- the Department gave £1,996 million of revenue-based support to trusts in difficulty to help them meet their day-to-day operating expenses, up from £960 million in 2014-15;¹⁴
- the Department gave trusts in difficulty £255 million of capital support for essential building works (this was less than the £308 million provided in 2014-15, reflecting system-wide constraints on capital spending); and
- NHS England gave £154 million of financial support (compared with £554 million from the Department and NHS England in 2014-15) as income to trusts in difficulty. Income support affects the reported surplus or deficit and is provided to support trusts that have undergone mergers and to trusts with private finance initiative (PFI) schemes.

¹² Department of Health, *Group manual for accounts 2015-16*, May 2016.

¹³ NHS foundation trusts are not required to disclose their performance against BPPC, therefore we only have complete data for 88 (out of 152) NHS foundation trusts. Monitor, *NHS foundation trust annual reporting manual 2015/16*, November 2015.

¹⁴ Our figures exclude £2.4 million that was paid to Mid Staffordshire NHS Foundation Trust. Our analysis throughout the report does not include any balances relating to the trust in 2015-16, as it ceased to provide services on 1 November 2014 and exists as a shell company (see Appendix Three).

Trusts' achieving NHS access targets and meeting quality requirements

1.18 There are indications that trusts are struggling to manage activity within their budgets and meet NHS access targets. Performance against key access targets declined consistently from 2012-13 to 2015-16, and into the first quarter of 2016-17 (**Figure 7**). **Figure 8** overleaf shows that the downward trend in performance against key targets is mirrored by a worsening trend in financial performance.

Providing quality services

1.19 Poor financial performance can affect the quality of a trust's clinical services and may reflect poor leadership. The Care Quality Commission (CQC) aims to "monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led". It produces ratings against these five inspection areas as well as an overall rating.¹⁵

Figure 7

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

Performance against key access targets has declined over the past four years and into the first quarter of 2016-17

Target	Target (%)	2012-13 (%)	2013-14 (%)	2014-15 (%)	2015-16 (%)	Q1 2016-17 (%)
Incomplete referral to treatment pathways: Patients waiting for treatment at the end of each month, waiting within 18 weeks	92	94.1	93.5	93.0	91.2	91.0
A&E: Patients should be admitted, transferred, or discharged within four hours of arrival in A&E	95	95.9	95.7	93.6	91.9	90.3
Ambulance: Red 1 calls (highest priority) should result in an emergency response arriving within eight minutes	75	74.0	75.6	71.9	72.5	70.4

Notes

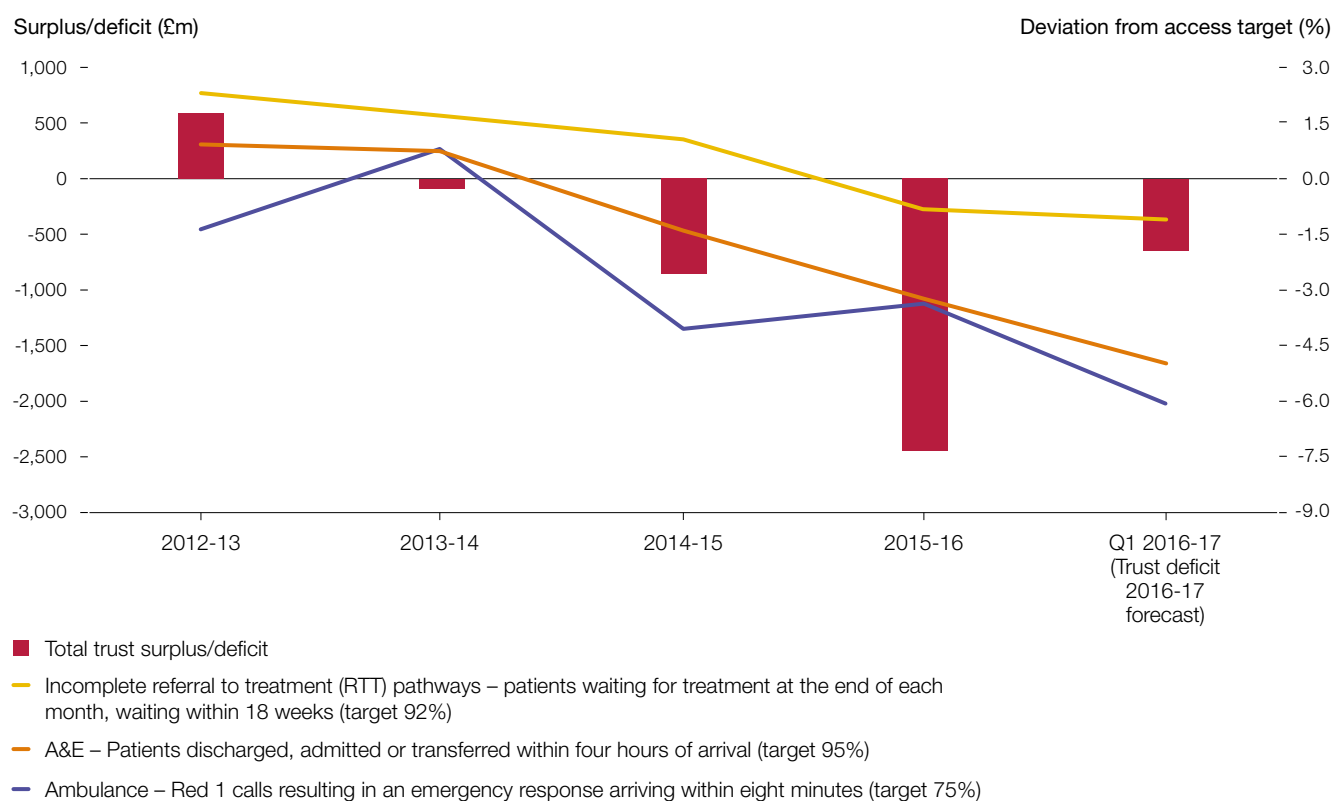
- 1 For 2014-15, 2015-16 and 2016-17, the ambulance data only include eight of the 11 ambulance trusts. The remaining three trusts are participating in a trial and do not report against this target.
- 2 The incomplete referral to treatment data set represents incomplete activity at a point in time. The figures reported are for performance at the end of March each year.
- 3 Our data set for incomplete referral to treatment covers NHS providers only and so may not match NHS England's publicly reported figures, which also include independent providers.

Source: NHS England's performance against access targets data set

Figure 8

Financial position of trusts against trusts' deviation from key access targets

Trusts' financial performance and their performance against key access indicators have both declined over the previous four years



		2012-13	2013-14	2014-15	2015-16	2016-17 (forecast)
Surplus/deficit (£m)		592	-91	-859	-2,447	-644
Incomplete referral to treatment pathways: Patients waiting for treatment at the end of each month, waiting within 18 weeks (%)	Deviation from target	2.3	1.7	1.0	-0.8	-1.1
Target 92%						
A&E: Patients admitted, transferred, or discharged within four hours of arrival (%)	Deviation from target	0.9	0.7	-1.4	-3.3	-5.0
Target 95%						
Ambulance: Red 1 calls resulting in an emergency response arriving within eight minutes (%)	Deviation from target	-1.4	0.8	-4.1	-3.4	-6.1
Target 75%						

Note

1 The 2014-15 balance is different from that reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of NHS trusts and NHS foundation trusts accounts data, 2012-13 to 2015-16, and NHS England's performance against access targets data set

1.20 We found an association between trusts' latest CQC overall quality ratings (which do not include measures of actual financial performance) and trusts' financial performance in 2015-16. The group of trusts that were rated as 'outstanding' or 'good' reported a better average financial position than the trusts with a 'requires improvement' rating, where financial performance was measured as the surplus or deficit expressed as a percentage of income. The group of trusts that were rated as 'requires improvement' also reported a better average financial performance than trusts rated as 'inadequate'. We found that the five trusts rated 'outstanding' overall had a net deficit equal to 0.02% of their total income, compared with net deficits equal to 1.6% of their total income for the 67 trusts rated 'good'; 3.9% of their total income for the 124 trusts rated 'requires improvement'; and 10.4% of their total income for the 14 trusts rated 'inadequate' overall. Assessing the relationship between financial and clinical performance is challenging because of the range of influences and the difficulty of attributing cause and effect. But these findings, together with the downward trend in trusts' compliance with key access targets, may suggest that financial stress is having an impact on the quality of care.

Impact of interventions to manage NHS spending in 2015-16

1.21 In 2014-15 the Department came close to exceeding its £91.9 billion voted revenue expenditure budget authorised by Parliament, underspending by just £1.3 million or 0.001%.^{16,17} In 2015-16 the Department underspent by £210 million or 0.22% against its £95.6 billion voted revenue expenditure budget authorised by Parliament. It achieved this by taking action with NHS England and NHS Improvement to manage the financial position of the NHS in 2015-16 and address the growing deficit of trusts.

Reducing trusts' spending on agency staff and consultancy contracts

1.22 In June 2015 the Department announced spending controls on agency and contract staff, which came into effect in October 2015. In 2015-16 the overall rate of growth in spending on agency and contract staff by trusts slowed, suggesting that controls to reduce spending have started to have an impact. On average, in 2015-16 trusts spent 7.6% of their total staff costs on agency and contract staff compared with 7.1% in 2014-15, 5.6% in 2013-14 and 4.8% in 2012-13 (**Figure 9** overleaf). However, trusts' spending on agency and contract staff is still at historically high levels, at £3.7 billion in 2015-16, compared with £2.1 billion in 2012-13 (an increase of 76.2%).

¹⁶ Parliament authorises two types of spending. Voted expenditure is approved by Parliament each year through a formal vote. Non-voted expenditure can be approved through statute without the need for an additional vote. The numbers presented here refer to the annual voted expenditure. The total revenue expenditure limit, made up of voted and non-voted expenditure, was £110.6 billion in 2014-15 and £114.5 billion in 2015-16.

¹⁷ The numbers reported here do not match those reported in our previous report *Sustainability and financial performance of acute hospital trusts*. We have previously reported the annual voted and non-voted expenditure.

1.23 We found a statistically significant association between trusts' spending on agency and contract staff as a percentage of total payroll costs and their surplus or deficit expressed as a share of income. Trusts that spent a smaller percentage of their total staff costs on agency and contract staff also performed better financially and had smaller deficits.

1.24 Limits on spending on agency and contract staff were introduced to control costs but have also highlighted that trusts have poor-quality data on agency staffing. Poor data prevent trusts from effectively and efficiently planning and allocating staffing resources. This means they are more likely to require agency staff to fill staffing gaps. NHS Improvement reviews weekly submissions from trusts to monitor their performance against the agency spending controls. This work has highlighted poor-quality data, including incomplete or missing information, misclassification of information and returns that were submitted without being authorised by trust executives. NHS Improvement has worked with trusts to improve their workforce data, including by visiting trusts and telephoning each week to check the data submissions. It also requires sign-off from executive members of the trust to encourage trusts' boards to discuss workforce planning problems.

1.25 We and the Committee of Public Accounts have reported that agency caps do not address the underlying problem of increasing demand for agency staff and inaccurate staff planning.^{18,19} The Committee reported that factors preventing trusts from successfully recruiting and retaining permanent staff (therefore increasing demand for agency staff) are likely to take years to resolve. These include the lack of affordable homes for NHS staff and cuts to nursing and midwifery bursaries.

1.26 In June 2015 the Department set a £50,000 limit on the amount NHS trusts and NHS foundation trusts in receipt of financial support or in breach of their licence could spend on professional services consultancy contracts without needing sign-off from NHS Improvement. Trusts' total spending on consultancy contracts fell by 34% (from £385 million) in 2014-15, to £255 million in 2015-16. Trusts' spending on consultancy contracts as a proportion of their total non-staff operating expenditure decreased from 0.5% in 2014-15 to 0.3% in 2015-16.

¹⁸ Comptroller and Auditor General, *Department of Health, Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016, available at: www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/

¹⁹ HC Committee of Public Accounts, *Managing the supply of NHS clinical staff in England*, Fortieth Report of Session 2015-16, HC 731, April 2016, available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/731/731.pdf

Transferring funding from capital to revenue budgets

1.27 The Department's capital budget in 2015-16 was £4.6 billion. In February 2016, £950 million of this budget, intended for capital projects such as building works, was transferred to revenue budgets to fund day-to-day services. Trusts contributed £500 million of the £950 million. The remaining £450 million came from centrally managed programmes, including a £100 million super dividend from the Medicines and Healthcare products Regulatory Agency.

1.28 This was the second year that the Department has used money originally intended for capital projects to cover a shortfall in the revenue budget. In 2014-15, the Department transferred £640 million to help mitigate the trusts' deficit. In the coming years, the Department plans to continue transferring capital funding into day-to-day spending under 2015 Spending Review agreements.

1.29 Of the £500 million contribution from trusts, £331 million was exchanged by 93 trusts for revenue support to fund healthcare services. The revenue support reduced the deficit (or increased the surplus) reported by those trusts. But there is a risk that trusts have sacrificed long-term investment to meet the immediate needs of service provision. For example, some trusts may have delayed projects to fund day-to-day running costs.

Administrative adjustments

1.30 In 2015-16 the Department received £417 million in National Insurance contributions, more than originally anticipated. The Department did not notify HM Treasury of these extra receipts it received from HM Revenue & Customs and said this was because of an administrative error. Therefore neither HM Treasury nor Parliament has had the opportunity to consider whether to reduce the Department's budget by an equal and opposite amount. Without these extra receipts, the Department would have exceeded the budget authorised by Parliament by £207 million rather than underspending by £210 million.

Part Two

Managing financial sustainability

2.1 In this part of the report, we look at what the Department of Health (the Department), NHS England and NHS Improvement have done to develop a plan to make the NHS financially sustainable, and how they are managing the risks to this plan.

Planning to achieve financial sustainability

2.2 In our December 2015 report, we said we would expect the Department and its arm's-length bodies to develop a plan that shows clearly how they will close the gap between resources and patients' needs at all levels of the NHS.²⁰ In May 2016 NHS England published broad estimates of the £22 billion expected gap between patients' needs and resources by 2020-21 if no action is taken. The Department, NHS England and NHS Improvement have agreed on their responsibilities for improving efficiency to close this gap. They recognise that savings across the NHS cannot be made only through asking NHS healthcare providers to meet efficiency targets linked to receiving tariff income. They have set out programmes to help the NHS make savings (**Figure 10** overleaf).

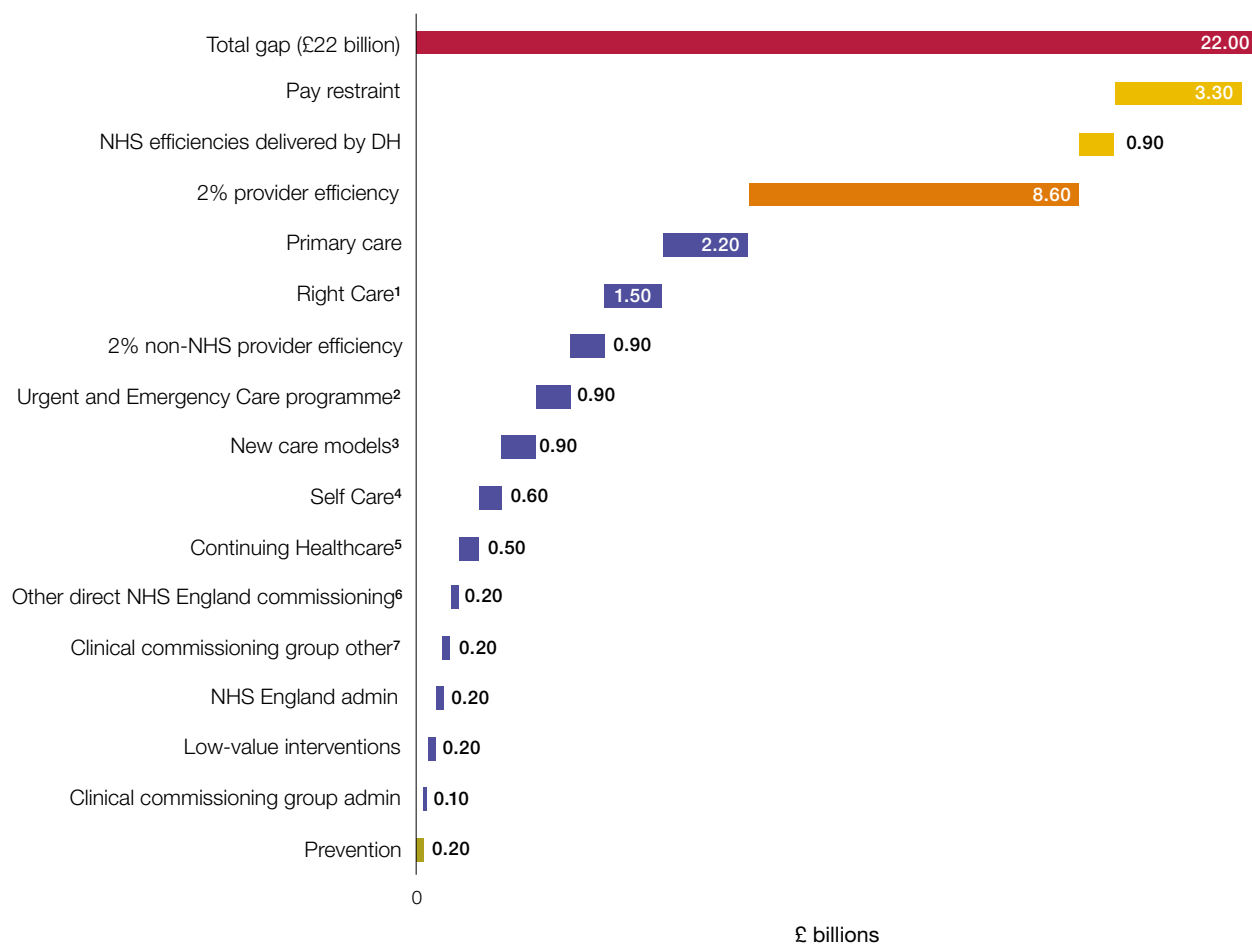
2.3 The Department, NHS England and NHS Improvement plan for £6.7 billion of efficiencies to be delivered nationally by capping public sector pay, renegotiating the community pharmacy contract, implementing income-generating activities, reducing central budgets and admin costs, making efficiencies from non-NHS healthcare provider contracts and freezing the running costs of clinical commissioning groups. They estimate that local NHS bodies can make further savings of £14.9 billion by reducing the growth in demand for healthcare services through NHS England's initiatives such as Right Care, new care models and the Urgent and Emergency Care programme, and by NHS trusts and NHS foundation trusts achieving 2% productivity improvements each year, which will deliver £8.6 billion of the 14.9 billion.

²⁰ Comptroller and Auditor General, *Department of Health, Sustainability and financial performance of acute hospital trusts*, Session 2015-16, HC 611, National Audit Office, December 2015, available at: www.nao.org.uk/report/sustainability-and-financial-performance-of-acute-hospital-trusts/.

Figure 10

The Department's, NHS England's and NHS Improvement's proposed savings programmes

The Department, NHS England and NHS Improvement have introduced savings programmes to close the estimated £22 billion gap between resources and patients' needs by 2020-21



■ Savings target ■ Department ■ NHS improvement ■ NHS England ■ Public Health England

Notes

- 1 'Right Care' relates to NHS England's support to clinical commissioning groups to reduce wasteful and ineffective spending.
- 2 The 'Urgent and Emergency Care programme' relates to savings that are anticipated from implementing the recommendations of the Urgent and Emergency Care Review.
- 3 'New models of care' refers to savings expected from supporting clinical commissioning groups and providers to implement the new ways to organise care outlined in the *Five Year Forward View*.
- 4 The 'Self Care' programme aims to release savings by assisting people to manage their own healthcare.
- 5 'Continuing Healthcare' is healthcare funded by the NHS for ongoing healthcare needs provided outside of hospital. It is estimated that the Continuing Healthcare programmes can deliver 2% of efficiency savings each year until 2020-21.
- 6 'Other direct NHS England commissioning' includes savings from military and offender healthcare.
- 7 'Clinical commissioning group other' includes savings from NHS 111 and commissioning of enhanced GP services.
- 8 The savings programmes identified by the Department, NHS England and NHS Improvement add up to £21.6 billion.
- 9 Numbers shown in the above figure do not add up to £21.6 billion due to rounding.

Source: Department, NHS England and NHS Improvement's shared financial model

Quality of long-term plans to achieve financial sustainability

Making forecasts

2.4 The plan to make the NHS financially sustainable is based on a number of assumptions about the future. These include the demands on NHS finances, demand for NHS services, workforce productivity and pay. The assumptions were used to forecast that:

- the gap between patients' needs and resources by 2020-21 will be £22 billion if no action is taken; and
- the savings programmes introduced by the Department, NHS England and NHS Improvement (Figure 10) will close the £22 billion gap.

2.5 **Figure 11** overleaf shows four of the assumptions that underpin plans to achieve financial sustainability; the intended impact of national bodies' savings programme; and the challenge in achieving these savings.

2.6 There has been limited testing of the assumptions supporting the calculation of the £22 billion gap between patients' needs and resources by 2020-21, meaning the real gap might be larger or smaller. We also saw limited testing of the assumptions that underpinned the estimated effect of savings programmes in closing the gap. Many of the savings programmes are innovative and untested. However, we would expect a degree of testing to understand the level of certainty about how effective the savings programmes are likely to be. The Department, NHS England and NHS Improvement intend to use sustainability and transformation plans, submitted by local bodies in October 2016, to test the realism of assumptions used in national planning.

2.7 The Department, NHS England and NHS Improvement believe that aiming to make £22 billion of efficiency savings is a call to action rather than a precise estimate of the gap between patients' needs and resources by 2020-21. They believe their estimate, and the overall impact, of the savings programmes on NHS finances is reasonable and achievable.

Figure 11

Examples of the underpinning assumptions of plans to achieve financial sustainability

Assumptions if no action is taken	Assumptions in plans for achieving financial sustainability	Challenge to making savings in plans for financial sustainability
Activity, which is the quantity of healthcare provided, in acute hospitals will grow on average by 2.9% per year and will be 19% higher in 2020-21 compared with 2014-15.	NHS England estimates that if the Department's, NHS England's and NHS Improvement's savings programmes are successful the rate at which activity at acute trusts grows will be reduced to an average of 1.3% per year, which includes specialised acute services. This means that overall acute activity would be 6.6% higher in 2020-21 compared with 2015-16.	Hospital admissions grew by 2.8% between 2013-14 and 2014-15. The Nuffield Trust has estimated that activity growth of 1.5% per year would just keep up with population and ageing. ¹ This implies that there would be little room for increased activity driven by changes to healthcare technology, increasing expectations and improving access to care.
Pay of non-agency staff will be 17.3% higher in 2020-21 compared with 2014-15.	The growth rate of pay for permanent staff is held down by the 1% public sector pay restraint. As pay is made up of elements other than the basic pay settlement, pay is assumed to grow by 1.9% per year.	The NHS <i>Five Year Forward View</i> stated that NHS pay will need to stay broadly in line with private sector pay in order to recruit and retain frontline staff. The Office of Budget Responsibility estimated that average earnings will grow by 3.3% per year on average between 2014-15 and 2020-21. If pay restraint is successful, NHS pay growth will diverge from the average pay growth of the rest of the economy.
Workforce productivity, which is the quantity of healthcare that each member of staff is able to provide in a given period of time, is assumed to not improve between 2014-15 and 2020-21.	Workforce productivity is assumed on average to improve by 2% per year. As the starting point in 2016-17 was worse than expected, the Department is now aiming to deliver improvements in workforce productivity of around 3% in 2016-17.	Workforce productivity improved on average by 1.4% per year between 2011-12 and 2014-15. It declined by 0.5% in the first three quarters of 2015-16. This was because growth in staff numbers exceeded growth in activity.
The total cost of agency staff for all trusts is assumed to grow on average by 6.5% per year from 2014-15 to 2020-21. This means that the total cost of agency staff is 46.1% higher in 2020-21 compared with 2014-15.	The total cost of agency staff is assumed to fall on average by 4% per year, and will be 26.3% smaller in 2020-21 than in 2014-15. Most of this decline will occur in 2016-17 when it is assumed that agency spend will fall to £2.5 billion compared with £3.7 billion in 2015-16.	The overall rate of growth in agency spending slowed in 2015-16, but was still at historically high levels. The National Audit Office and the Committee of Public Accounts have both reported that agency caps do not address the underlying workforce issues, which are likely to take years to resolve (see paragraph 1.25).

Note

1 Nuffield Trust, *Feeling the crunch: NHS finances to 2020*, August 2016, available at: www.nuffieldtrust.org.uk/publications/feeling-crunch-nhs-finances-2020.

Source: Department, NHS England and NHS Improvement's estimates

Setting the baseline

2.8 NHS England's and NHS Improvement's plans to achieve financial sustainability were based on trusts' starting the financial year in 2016-17 with a combined deficit of £1.8 billion. The fact that trusts ended 2015-16 with a greater deficit (see paragraph 1.8) means that trusts overall will need to make more savings than planned to reach the intended starting position. For example, trusts with deficits greater than expected at the end of 2015-16 will need to make operational efficiencies above the 2% savings level applied to all providers of healthcare services in 2016-17.

Including all cost drivers in plans

2.9 Local bodies face other cost pressures in addition to becoming financially sustainable. It is not clear to us that the Department, NHS England and NHS Improvement are managing these wider cost pressures adequately.

- The £340 million transformation funding from the £2.14 billion Sustainability and Transformation Fund for 2016-17 will not fund all health transformation programmes. The Department, NHS England and NHS Improvement expect trusts and commissioners to fund and invest in savings programmes, such as implementing new models of care. However, they have not estimated the level of investment required by local bodies. Local bodies were required to set out the investment they needed in sustainability and transformation plans, submitted in October 2016, but it is not yet clear whether their requirements are within the available funding envelope. There is a risk that if plans for achieving financial sustainability do not deliver the expected savings in 2016-17, there will be less money available for delivering the changes and transformation set out in the *Five Year Forward View* in future years. NHS England had planned for a greater proportion of the Sustainability and Transformation Fund to be used on transformation after 2016-17, but it clarified in September 2016 that £1.8 billion would again be used for sustainability in 2017-18 and 2018-19.
- In February 2016 the Mental Health Taskforce reported that mental health services needed £1 billion a year to improve services. The NHS implementation plan for mental health shows that improvements in mental health are expected from 2016-17. However, as most funding for mental health is not ring-fenced, there is a risk that not all the additional funding intended for mental health will be spent by clinical commissioning groups to improve mental health services.
- In our review of the plan to achieve financial sustainability shared by the Department, NHS England and NHS Improvement, we did not see how the cost of implementing seven-day NHS services had been taken account of in plans for the NHS to achieve long-term financial sustainability.

- In our report on *Managing the supply of NHS clinical staff in England*, we found that around three-quarters of the increase in spending on temporary nurses from 2012-13 to 2014-15 was due to greater use of such staff, often to cover vacancies.²¹ The shortage of nurses is expected to continue for the next three years.²²
- The Committee of Public Accounts raised concerns that funding cuts and wage pressures will make it harder for local authorities to fulfil their Care Act obligations at a time when demand for social care is rising. We have previously reported that local authority spending on adult social care fell by 10% in real terms between 2009-10 (£16.3 billion) and 2014-15 (£14.6 billion).²³ The accounting officer for NHS England told the Committee of Public Accounts that “over the next two or three years, there is likely to be a widening gap between the availability of adult social care and the need for social care. That, will, inevitably show up as delayed discharges and extra pressure on hospitals.”²⁴ We did not see in our review of the shared plan to achieve financial sustainability any estimate of the impact of pressures on social care spending on the NHS budget. The accounting officer for NHS England acknowledged that the effect of social care pressures “is not costed into the NHS funding envelope for the next five years”.²⁵
- Spending on specialised healthcare services has increased at a faster rate (6.3% a year) than the NHS as a whole (3.5% a year). It accounts for around 14% of the total NHS budget.²⁶ In July 2016 the Committee of Public Accounts concluded that, despite the large increase in the budget for specialised services, NHS England has not kept its spending within the budget it set itself. This has created a risk to the financial sustainability of the NHS. The Committee warned that if NHS England is unable to keep its spending on these services under control, this will affect its ability to resource other health services and the wider health transformation set out in the *Five Year Forward View*.²⁷

21 Comptroller and Auditor General, *Department of Health, Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016, available at: www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/

22 HC Committee of Public Accounts, *Managing the supply of NHS clinical staff in England*, Fortieth Report of Session 2015-16, HC 731, April 2016, available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/731/731.pdf

23 Comptroller and Auditor General, *Department of Health, Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016, available at: www.nao.org.uk/report/discharging-older-patients-from-hospital/

24 Hansard HC, 13 July 2016, HC 76, available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/discharging-older-people-from-acute-hospitals/oral/34184.html>

25 See footnote 24

26 Comptroller and Auditor General, *Department of Health, The commissioning of specialised services in the NHS*, Session 2015-16, HC 950, April 2016, available at: www.nao.org.uk/report/the-commissioning-of-specialised-services-in-the-nhs/

27 HC Committee of Public Accounts, *NHS specialised services*, Tenth Report of Session 2016-17, HC 387, July 2016, available at: www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/387/387.pdf

Strategic oversight and programme management

2.10 The Department, NHS England and NHS Improvement have arrangements in place to oversee plans for financial sustainability.

- In June 2015 the Department established the Finance and Efficiency Board to monitor financial information and oversee the Department's efficiency initiatives. It is made up of the directors of finance or strategy from the Department, NHS England, NHS Improvement, the Care Quality Commission and Health Education England. Meetings of the Finance and Efficiency Board were suspended between November 2015 and May 2016 while the government made decisions about future health funding as part of the Comprehensive Spending Review. Since its re-instatement in May 2016, the Finance and Efficiency Board has met three times.
- The Department has also established Programme Challenge Groups, which have met since April 2016 to examine the Department's efficiency initiatives. The Programme Challenge Groups report to the Finance and Efficiency Board on the progress of initiatives. The lead of the programme being considered is invited and the meetings are chaired by the Department's director-general of finance. Membership includes the chief operating officer and NHS Improvement's director of productivity and efficiency. Other Departmental directors and representatives of HM Treasury's health team are invited to attend when the Department considers it appropriate.
- In June 2015 NHS England established the Financial Sustainability Programme Oversight group, which oversees NHS England's efficiency initiatives. It is chaired by NHS England's chief financial officer and its membership includes programme leads from each of the efficiency programmes for which NHS England is responsible, including Right Care, the Urgent and Emergency Care programme and new care models.
- HM Treasury is taking an active role in governing how local NHS bodies spend their funding. For example, the conditions for trusts to access the £1.8 billion of sustainability funding in the 2016-17 Sustainability and Transformation Fund were jointly developed by HM Treasury, the Department, NHS England and NHS Improvement, which meet on a quarterly basis to decide whether to release funds to trusts. HM Treasury also meets the Department, NHS England and NHS Improvement to discuss clinical commissioning groups' use of the 1% of their funding that they have been asked to hold uncommitted. Given the financial position of the NHS, we consider it appropriate that HM Treasury has increased its strategic oversight of how NHS funding is spent through dialogue with the Department, NHS England and NHS Improvement.

2.11 NHS England and NHS Improvement have established programme management arrangements for the savings programmes they are responsible for.

- NHS England has established programme boards and appointed senior responsible owners for each of its savings programmes. These individual programme boards report to the Financial Sustainability Programme Oversight group. The senior responsible owners attend monthly meetings where they report against: the critical milestones for their programmes, such as whether support packages have been established; and progress metrics, for example, reductions in emergency admissions.
- NHS Improvement has established a new directorate of operational productivity to manage work originally led by Lord Carter of Coles to improve the operational productivity of acute trusts. Officials at the Department previously managed this work.

2.12 Good programme management is vital in monitoring progress towards making savings and achieving financial sustainability. It enables individual programme plans and the overall plan to be revised and goals to be updated:

- The Finance and Efficiency Board is monitoring performance in closing the £22 billion gap by tracking the overall financial position of the NHS against what would be expected if all savings programmes were succeeding. The Programme Challenge Groups assess individual programmes and consider if they have clear milestones and quantified success measures.
- The Finance and Efficiency Board and the Financial Sustainability Programme Oversight group are monitoring milestones related to the implementation of individual programmes. However, many programmes designed to close the expected gap between patients' needs and resources are at an early stage of implementation, for example the Self Care programme. In some cases performance measures, which would show whether the programme is succeeding, are not yet being tracked.
- The Financial Sustainability Programme Oversight group does not plan to measure the savings achieved from individual programmes, because it says it will be hard to attribute success to any one programme due to their independencies. For example, many programmes aim to reduce emergency attendances and admissions and it will be difficult to determine the proportion of activity reduction attributed to each of them. The savings programmes are also interdependent – for example, programmes that aim to reduce activity in acute settings, such as Right Care, Self Care and the Urgent and Emergency Care programme, depend on more investment in general practice services.

2.13 Many of the programmes that focus on reducing activity assume that most of the savings will occur in later years, as anticipated in the *Five Year Forward View*. For example, more than 60% of the savings associated with Right Care and the new care models are expected to be realised between 2018-19 and 2020-21. If savings programmes do not produce expected savings, it is not yet clear what the contingency plans are for bringing in line the cost of patients' needs and the resources available to meet these needs.

Part Three

Supporting local bodies to achieve financial sustainability

3.1 This part considers the support the Department of Health (the Department), NHS England and NHS Improvement have given to local NHS organisations to support local bodies to achieve financial sustainability.

Managing trusts' financial deficit

3.2 To address the severe financial deficit reported by trusts in 2015-16, NHS England and NHS Improvement are taking steps to improve the financial position of trusts in 2016-17, through the financial 'reset' announced in July 2016.²⁸

- In 2016-17 trusts must meet NHS Improvement's financial targets (control totals). They have been asked to take action to meet these targets and provide safe services. The Department, NHS England, NHS Improvement and HM Treasury will not give trusts funding from the Sustainability and Transformation Fund if they do not meet control totals.
- NHS England set aside £2.14 billion for a 2016-17 Sustainability and Transformation Fund, of which £1.8 billion will be used to help trusts sustain services and reduce deficits. NHS Improvement had expected trusts' deficit in 2015-16 to be £1.8 billion. This meant that the additional funding for sustainability would have cleared the deficit. However, the trusts' end-of-year reported deficit was £2.45 billion, which left a £650 million shortfall between the sustainability funding and trusts' deficit position.
- NHS England and NHS Improvement introduced a new intervention regime of 'financial special measures'. This will be applied to both trusts and clinical commissioning groups that are not meeting their financial commitments. In July 2016 five trusts were placed into financial special measures.
- NHS England has asked clinical commissioning groups to hold back 1% of their budget to insulate local areas from financial risks.
- The Department, NHS England and NHS Improvement have continued to implement the controls on agency and consultancy spending that were first applied in 2015-16 (see paragraphs 1.22 to 1.26).

²⁸ NHS England and NHS Improvement, *Strengthening financial performance and accountability in 2016-17*, July 2016, available at: www.england.nhs.uk/publications/performance/

Joined-up national working

3.3 It is important that the Department, NHS England and NHS Improvement work together to coordinate their activities if they are to support local NHS bodies to achieve financial sustainability. If they do not, there is a risk that local NHS organisations will receive mixed messages or be faced with competing priorities. The Department, NHS England and NHS Improvement are working closely in some areas:

- The Department, NHS England and NHS Improvement each have a role in overseeing plans to achieve financial sustainability. They have agreed responsibilities for closing the £22 billion gap between patients' needs and resources by 2020-21 (see paragraphs 2.2 to 2.4).
- In December 2015, NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England and the National Institute for Health Care Excellence published shared planning guidance that asked NHS organisations to produce two separate but interconnected plans:
 - a five-year local health and care system 'sustainability and transformation plan' that will cover the period from October 2016 to March 2021; and
 - a plan by organisation for 2016-17.
- From April 2016, Monitor (the regulator of NHS foundation trusts) and the NHS Trust Development Authority (which oversees NHS trusts) became a jointly led organisation, NHS Improvement. From October 2016, NHS Improvement has been overseeing all trusts using a single oversight framework, which assesses trusts against their contribution to local sustainability and transformation plans.
- In September 2016, to help NHS bodies to plan services with greater certainty, NHS England and NHS Improvement published guidance on a two-year NHS operational planning process for clinical commissioning groups, NHS trusts and NHS foundation trusts. This guidance was also intended to support the implementation of local areas' sustainability and transformation plans. NHS England and NHS Improvement also published the NHS National Tariff Payment System consultation in October 2016, which sets out its proposed prices and rules for healthcare providers. This is an improvement on previous years; for example, the 2016-17 NHS National Tariff Payment System consultation was published in February 2016 and concluded in March 2016, just one month before the start of the year to which it applied.

3.4 In July and August 2016 we spoke to senior leaders from 21 local NHS bodies and local authorities, including: chief executives of trusts; clinical commissioning group accountable officers; local government directors of adult social care services and project managers of sustainability and transformation plans; to help us understand how the Department, NHS England and NHS Improvement were supporting local bodies to achieve financial sustainability (see Appendix Two). Five of the 21 local bodies we spoke to told us that NHS England and NHS Improvement were working more closely than in the past. They said that the messages they were receiving from these national bodies were more consistent. However, we heard from three local bodies that conflicting messages from NHS England and NHS Improvement remained an issue.

Supporting joined-up working locally

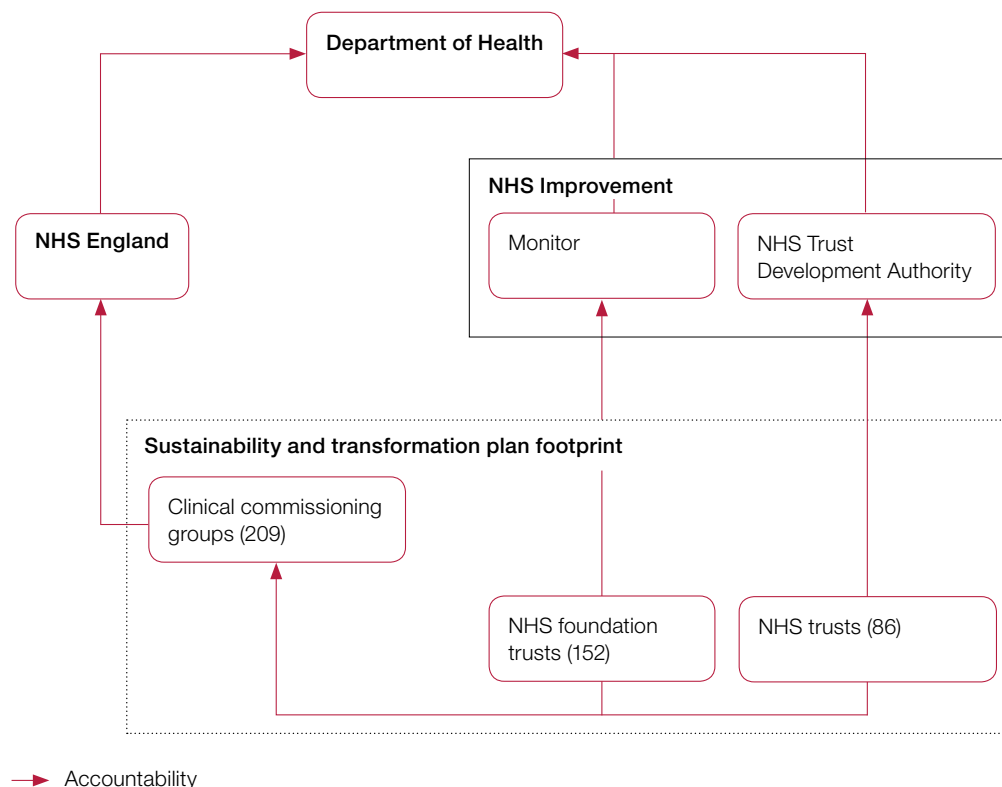
3.5 To develop sustainability and transformation plans, NHS England and NHS Improvement asked local health and care leaders, organisations and communities to come together in January 2016 to form 44 planning ‘footprints’. Sustainability and transformation plan footprints are not statutory bodies. They do not replace existing local bodies or change local accountabilities. The legislative and accountability framework for local NHS bodies is set out in **Figure 12** overleaf.

3.6 NHS England and NHS Improvement want sustainability and transformation plans to be a ‘route map’ for how local NHS bodies and its partners make a reality of the *Five Year Forward View*.²⁹ NHS England and NHS Improvement expected footprints to be locally defined, and based on natural communities and existing working relationships. However, in some cases NHS England played a role in defining the geographical boundaries of the footprint.

²⁹ NHS England and NHS Improvement, *NHS shared planning guidance*, September 2016, available at: www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Figure 12

Accountability framework for local NHS bodies

**Note**

- 1 The figure is simplified to show accountability arrangements for sustainability and transformation footprints. It does not include primary care and NHS England's role in commissioning specialised services.

Source: National Audit Office

Setting realistic expectations

3.7 For the 2016-17 financial year, NHS England and NHS Improvement reduced the efficiency requirement in the national tariff payment that trusts receive for providing care. The efficiency requirement was reduced from 4% in 2015-16 to 2% in 2016-17. In its February 2016 review, Monitor (now part of NHS Improvement) found that, on average, trusts improved their efficiency by 1.4% per year between 2008-09 and 2013-14. It assessed that a 2% efficiency target was a more reasonable requirement. However, by July 2016, NHS Improvement said that healthcare providers will need to achieve an efficiency requirement significantly greater than 2%. This is partly because of the higher than expected trust deficit, commissioner losses during the contracting period and rising trust activity. NHS Improvement told us that if trusts

do not achieve efficiency savings greater than 2%, then their financial position will not improve over time. Overall, NHS Improvement said it was now planning for providers to achieve efficiencies of around 4% for 2016-17. This is concerning given the Committee of Public Account's conclusion in its March 2016 report that the previous 4% target set by NHS England and Monitor (now part of NHS Improvement) to make efficiencies was unrealistic and had caused long-term damage to trusts' finances. It is understandable that NHS England and NHS Improvement aim to recover last year's under achievement of targeted efficiencies from trusts but this makes significant assumptions about what can be delivered which is likely to vary from trust to trust.

3.8 Footprints have developed their five-year sustainability and transformation plans without full awareness of national plans and the assumptions that underpin the *Five Year Forward View*. NHS England made public its broad estimates of the expected gap between patients' needs and resources by 2020-21 and how it plans to close this gap (see paragraph 2.4). However, the finer details of its estimates, such as how much demand for health services needs to be constrained, were not communicated to local NHS bodies. A lack of transparency creates uncertainty. For example, some of the clinical commissioning groups we spoke to told us that they did not know why NHS England had asked them to hold back 1% as a reserve fund. They were unclear about what would happen to this funding at the end of the financial year.

3.9 Twelve of the 21 local bodies we spoke to told us that the original timetable for completing the sustainability and transformation plan was extremely ambitious. It did not allow enough time to build relationships across local areas and to determine the changes needed for local areas to achieve financial stability.

- NHS England and NHS Improvement had intended for local areas, including NHS and local authority organisations, to submit their five-year sustainability and transformation plans in June 2016. Local areas were first told about this new requirement in planning guidance published in December 2015.
- In May 2016, NHS England identified that local areas were at different stages of developing their sustainability and transformation plans.
- At this point NHS England decided to delay the requirement for local areas to submit their full plans by the end of June 2016. It asked local areas to set out their broad aims for the local area over the next five years by the end of June 2016 and to submit their finance plans in September 2016.
- By the end of October 2016 all footprints had submitted their sustainability and transformation plans to NHS England and NHS Improvement and were ready to start implementing these plans.

3.10 We heard from five local bodies that NHS England and NHS Improvement had not set clear expectations about the required content of sustainability and transformation plans, while three said expectations were clear. Six said that expectations had changed over time, with new requirements added at short notice. For example, one organisation said that delays in providing the template meant they had to reproduce material, which they told us was an inefficient use of time and resources.

Providing appropriate resources and guidance

3.11 The local bodies we spoke to were supportive of the aim of local areas coming together to develop sustainability and transformation plans. However, several raised concerns about how plans will be implemented going forward.

- Five told us they were uncertain about the capacity in their organisations to meet the immediate requirement to improve their financial positions and at the same time implement changes that will support longer-term transformation of healthcare services.
- Five of the local bodies we spoke to raised concerns about achieving transformation at the scale and pace that is expected by NHS England and NHS Improvement.
- Six were concerned about whether there will be sufficient funding for ‘double running’ and to invest in capital and transformation.

3.12 Footprints did not receive additional funding to cover the expense of developing sustainability and transformation plans and we heard that this impacted on the capacity of local leaders to develop plans alongside other priorities. Some local bodies told us that they had employed a contractor to support them in developing plans. Furthermore, we heard that NHS Improvement had given some footprints extra support to help them develop their financial plans.

3.13 NHS England and NHS Improvement provided system leaders with guidance to support the development of sustainability and transformation plans, as well as information and data about their local areas. Three of the local bodies we spoke to told us this information was helpful. However, we heard from a further nine organisations that this information was shared late in the planning process and three said it contained old or obsolete data.

Creating incentives to support collaboration

3.14 Five of the NHS organisations we spoke to felt that NHS England and NHS Improvement could do more to create the right incentives to collaborate. For example, we heard from five of the local bodies that they are under immense pressure to meet their financial targets (quarterly control totals) in order to receive sustainability and transformation funding. They said that because these were set at an organisation level, rather than for the footprint as a whole, it forced local bodies to think about their own individual organisations' short-term financial position, and did not encourage a focus on longer-term planning or collaboration with other local bodies. In September 2016, NHS England and NHS Improvement announced that from April 2017, each sustainability and transformation footprint will have a financial control total which is the summation of individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and system control total. However, it is unclear whether this goes far enough to address the concerns expressed by local bodies, or how individual bodies will be held to account for system control totals.

3.15 The legislative and accountability framework for local NHS organisations was seen as a barrier to collaboration by seven of the local bodies we spoke to. NHS Improvement has statutory responsibilities for overseeing the performance of the individual organisations that it regulates. Local NHS organisations are accountable for their individual organisational plans and financial performance. We were told that these vertical lines of accountability acted as a barrier to local bodies coming together under sustainability and transformation plan footprints and integrating on a horizontal basis. We are also unclear how greater collaboration will fit alongside existing regulation on choice and competition and impact on ongoing tendering activities.

Appendix One

Our audit approach

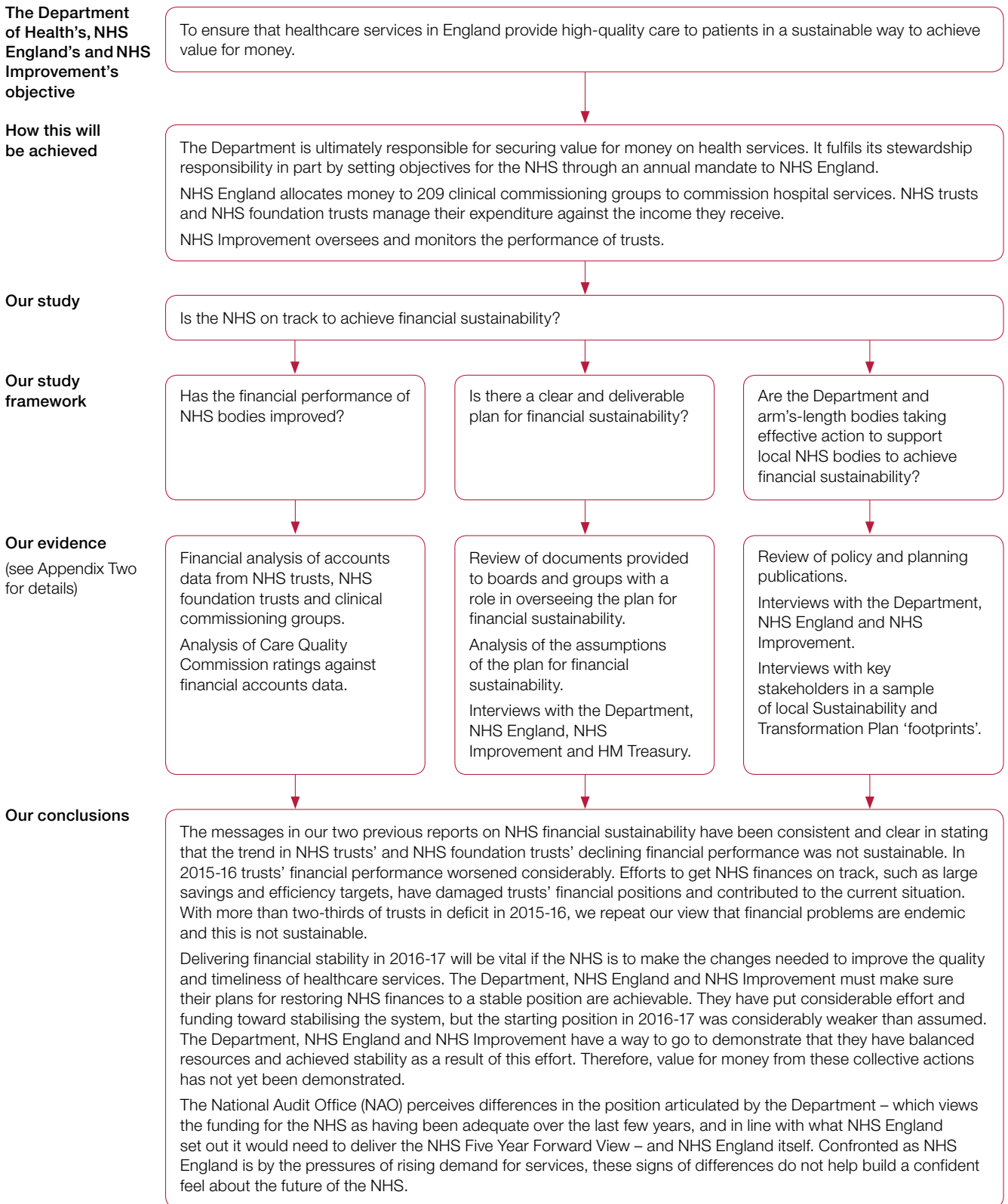
1 This study examines the progress the Department of Health (the Department), NHS England and NHS Improvement have made towards achieving financial balance. We reviewed:

- the headline financial performance of the NHS overall;
- trends in the financial performance of clinical commissioning groups between 2013-14 and 2015-16 and trends in the financial performance of NHS trusts and NHS foundation trusts between 2012-13 and 2015-16, including financial indicators such as earnings before interest, tax, depreciation and amortisation (EBITDA), cash and other assets and average time taken to settle undisputed invoices;
- the financial support provided to NHS trusts and NHS foundation trusts in financial difficulty in 2014-15 and 2015-16;
- the correlation between financial performance and Care Quality Commission ratings;
- the impact on financial performance of controls on agency staff and consultancy contracts;
- the movement of funding from capital to revenue at a Departmental and local level;
- the actions, initiatives and governance arrangements that the Department, NHS England and NHS Improvement have implemented to improve the financial position of NHS bodies including their assumptions; and
- the support being provided to local NHS bodies to achieve financial sustainability, including the actions taken to establish the new sustainability and transformation plans.

2 In reviewing these issues, we applied an analytical framework with evaluative criteria, to consider what arrangements would be optimal for moving the NHS towards financial sustainability. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied constraints. We used output-based criteria (for example, the trend in performance against key financial indicators) and adapted a National Audit Office framework on structured cost reduction to consider whether arrangements being put in place to restore financial sustainability met good practice.

3 Our audit approach is summarised in **Figure 13**. Our evidence base is described in Appendix Two.

Figure 13
Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on whether the NHS is on track to achieve financial sustainability after analysing evidence we collected between May and September 2016. Our audit approach is outlined in Appendix One.

2 We analysed existing financial data from NHS accounts and data provided by the Department of Health (the Department) and NHS Improvement:

- an analysis of the overall financial position of the NHS in 2015-16;
- a time series analysis of clinical commissioning groups' finances against their planned and actual year-end positions;
- a time series analysis of the financial position of NHS trusts and NHS foundation trusts against surplus/deficit, income, EBITDA, current assets and current liabilities; and
- additional financial support compared with 2014-15.

3 We compared existing financial data on NHS trusts and NHS foundation trusts to Care Quality Commission ratings.

- We compared the average financial performance across trusts with different overall Care Quality Commission ratings. We took the Care Quality Commission ratings as at August 2016 and used 2015-16 NHS trust and NHS foundation trust accounts data.

4 We analysed data relating to the controls the Department and NHS Improvement implemented in 2015-16:

- a time series analysis of spending by trusts on agency and contract staff;
- a correlation analysis of trust spending on agency and contract staff compared with financial performance;
- a time series analysis of the percentage of agency and contract staff compared with full-time equivalent staff; and
- a time series analysis of consultancy expenditure as a percentage of total non-staff operating expenditure.

5 We conducted a review of the 2016-17 planning process.

We reviewed planning guidance and associated documents in order to:

- understand the actions taken by the Department, NHS England and NHS Improvement to manage financial sustainability in 2016-17; and
- assess the level of support being provided to local bodies including under the sustainability and transformation plan arrangements.

6 We examined the plan developed by the Department, NHS England and NHS Improvement to close the gap between patients' needs and resources.

To evaluate the plan we adapted an existing National Audit Office framework on structured cost reduction.³⁰ We used this framework to understand:

- whether the Department, NHS England and NHS Improvement have developed a plan which clearly shows how the gap between patients' needs and resources will be closed;
- whether the plan considers dependencies; and
- if there are clear governance, risk and project management arrangements in place to ensure delivery.

We examined governance documents from boards identified by the Department, NHS England and NHS Improvement as overseeing the plan. This included examining terms of references, minutes from meetings and documents stating risks, metrics and milestones being tracked for:

- The Department's Finance and Efficiency Board and finance, efficiency and delivery meetings and Programme Challenge Group; and
- NHS England's Finance Sustainability Programme Oversight Group and Five Year Forward View Board.

We examined parts of the shared financial model produced by the Department, NHS England and NHS Improvement as part of the 2015 Spending Review to identify:

- the assumptions that underpin the estimated size of the gap between patients' needs and resources and estimates of the savings from initiatives intended to close this gap;
- what scenario testing and sensitivity analysis had been carried out; and
- what investment is required to achieve the estimated savings.

³⁰ A short guide to the National Audit Office's structured cost reduction framework is available at: www.nao.org.uk/wp-content/uploads/2010/06/short_guide_to_structured_cost_reduction.pdf

7 We interviewed key stakeholders including the Department, NHS England, NHS Improvement and HM Treasury.

The work was designed to understand:

- whether the Department, NHS England and NHS Improvement have developed plans which show how the gap between patients' needs and resources can be closed;
- what actions and initiatives are included in these plans; and
- whether the assumptions that underpin these plans and dependences and risks are well understood.

We also interviewed other stakeholders including The King's Fund and NHS Providers.

8 We conducted interviews at a sample of six sustainability and transformation plan footprints in July and August 2016.

This work was designed to understand:

- how local bodies worked together to produce sustainability and transformation plans;
- what support NHS England and NHS Improvement provided to help local bodies develop the sustainability and transformation plans; and
- what is the expected impact in the footprints of initiatives and actions implemented by the Department, NHS England and NHS Improvement to close the gap between patients' needs and resources.

In our review we did not try to examine the content of footprints' sustainability and transformation plans, nor did we attempt to draw wider conclusions about all sustainability and transformation plan footprints.

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

- a diverse range of relative financial performance selecting two footprints with relatively high financial performance across all constituent NHS bodies, two footprints with relatively low financial performance across all constituent NHS bodies and two footprints where trusts with relatively high financial performance were grouped with trusts with relatively low financial performance;
- a broad geographic spread across England;
- a range of rural and non-rural footprints;
- footprints with and without vanguards (sites receiving support from NHS England for early implementation of new care models); and
- a range of leadership including where the sustainability and transformation plan leader was from a trust, clinical commissioning group or local authority.

Overall, we met with 21 individuals including 11 trust chief executives, eight clinical commissioning group accountable officers as well others involved with developing the sustainability and transformation plans.

Appendix Three

Technical notes

- 1 In preparing and analysing the data used throughout the report, we have made a number of assumptions and adjustments.
- 2 Information on NHS trusts and NHS foundation trusts may differ to that reported by NHS Improvement due to the way we have treated trusts which changed their status in-year.

Presentation of figures

- 3 Except where otherwise noted, figures are presented in nominal terms and have not been adjusted for inflation.
- 4 Where possible, income and expenditure figures are presented on a basis consistent with the underlying trusts' published accounts.
- 5 Income figures for both NHS trusts and NHS foundation trusts include:
 - income from patient care activities; and
 - other operating income (including income from training activities, rental income and income from other miscellaneous sources).
- 6 Expenditure figures for both NHS trusts and NHS foundation trusts include:
 - staff costs, except those capitalised as part of the costs of non-current assets;
 - operating costs, including purchase of healthcare services from other organisations, expenditure on medical supplies including drugs and other consumables, and transport costs;
 - premises costs, including depreciation and amortisation and support services;
 - net interest and other finance costs;
 - public dividend capital dividends payable;
 - other gains and losses, including share of profit or loss of associates and joint arrangements, gains and losses on disposals of assets, and other movements in fair values of assets;
 - corporation tax expenses; and
 - premiums payable for clinical negligence liabilities.

NHS trusts' and NHS foundation trusts' income and expenditure figures have also been adjusted for the effects of organisational changes, to report underlying performance by excluding the effects of one-off transactions.

Adjusting for restated balances

7 In our report *Sustainability and financial performance of acute hospital trusts*, we reported Doncaster and Bassetlaw Hospitals NHS Foundation Trust as having a surplus of £1.6 million in 2014-15. During 2015-16 it emerged that its financial position had been misreported by the trust – the corrected year-end position for 2014-15 is a deficit of £14.8 million. This increased the net deficit reported in 2014-15 for trusts to £859 million from £843 million and increased the net deficit for all NHS bodies by £16.4 million. The restated figures for 2014-15 are used throughout this report.

Adjusting for the effects of organisational changes during 2015-16

8 This report refers to 152 NHS foundation trusts in existence on 31 March 2016. This excludes Mid Staffordshire NHS Foundation Trust, which ceased to provide services on 1 November 2014. Mid Staffordshire NHS Foundation Trust recorded a deficit of £1.1 million in 2015-16. The costs relate to the payment of historic liabilities and the overhead costs of the shell company. Our analysis throughout the report does not include any balances relating to Mid Staffordshire NHS Foundation Trust in 2015-16.

9 Two NHS trusts became NHS foundation trusts in 2015-16:

- Bradford District Care NHS Trust on 1 May 2015; and
- Oxford University Hospitals NHS Foundation Trust on 1 October 2015.

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

11 Several mergers between trusts occurred in 2015-16:

- Torbay and Southern Devon Health and Care NHS Trust was taken over by South Devon Healthcare NHS Foundation Trust on 1 October 2015, at which point the trust was renamed Torbay and South Devon NHS Foundation Trust; and
- West Middlesex University Hospital NHS Trust was taken over by Chelsea and Westminster Hospital NHS Foundation Trust on 1 September 2015.

12 For all these mergers of trusts, we have totalled the demising trusts' income, expenditure and surplus/deficit arising between 1 April 2015 and the date of merger and added it to the income, expenditure and surplus/deficit of the post-transaction trust. This has the effect of treating the merger as if it had occurred on 1 April 2015.

13 Three clinical commissioning groups also merged in 2015-16. NHS Gateshead clinical commissioning group, NHS Newcastle North and East clinical commissioning group and NHS Newcastle West clinical commissioning group merged on 1 April 2015 to form NHS Newcastle Gateshead clinical commissioning group. This reduced the number of clinical commissioning groups from 211 to 209.

Adjustments to NHS trusts' figures

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

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

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

Adjustments to NHS foundation trusts' figures

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

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

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

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