



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health & Social Care

NHS financial management and sustainability

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Department of Health & Social Care

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Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 3 February 2020

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

Gareth Davies
Comptroller and Auditor General
National Audit Office

28 January 2020

This is our eighth report on the financial sustainability of the NHS. To be sustainable, the NHS needs to manage patient demand (including how long patients wait) and the quality and safety of services and remain within the resources given to it.

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007698 02/20 NAO

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Key facts

£827m

combined deficit of NHS trusts and NHS foundation trusts (trusts) in 2018-19 (not including a favourable £256 million technical adjustment from the collapse of Carillion)

£4.3bn

amount transferred from the capital to revenue budget between 2014-15 and 2018-19 (including £0.5 billion in 2018-19)

£10.9bn

outstanding debt in March 2019 issued by the Department of Health & Social Care to trusts in financial difficulty

£1,066 million underspend by NHS England on the budget for its national functions and centrally commissioned services in 2018-19, compared with an underspend of £1,183 million in 2017-18

£150 million combined deficit of clinical commissioning groups (CCGs) in 2018-19

£89 million net surplus of NHS bodies (NHS England, CCGs and trusts) in 2018-19

£844 million combined deficit of the 10 trusts with the largest deficits in 2018-19

31% percentage of trusts' savings that were one-off savings in 2018-19, up from 26% in 2017-18

64% percentage of sustainability and transformation partnerships and integrated care systems in deficit in 2018-19, when all the finances of their constituent trusts and CCGs were added together

38% percentage of sustainability support funding allocated to trusts that helped reduce or eliminate their deficits in 2018-19

Summary

1 This is our eighth report on the financial sustainability of the NHS. To be sustainable, the NHS needs to manage patient demand (including how long patients wait) and the quality and safety of services and remain within the resources given to it.

2 The Department of Health & Social Care (the Department) has overall responsibility for healthcare services. It is accountable to Parliament for ensuring that its spending, as well as spending by NHS England, NHS Improvement, other arm's-length bodies and local NHS bodies, is contained within the overall budget authorised by Parliament. The Department is responsible for ensuring that those organisations perform effectively and have governance and controls in place to ensure that they provide value for money. It made NHS England and NHS Improvement responsible for ensuring that the NHS balances its budget. From April 2019, NHS England and NHS Improvement (NHSE&I) came together to act as a single organisation.

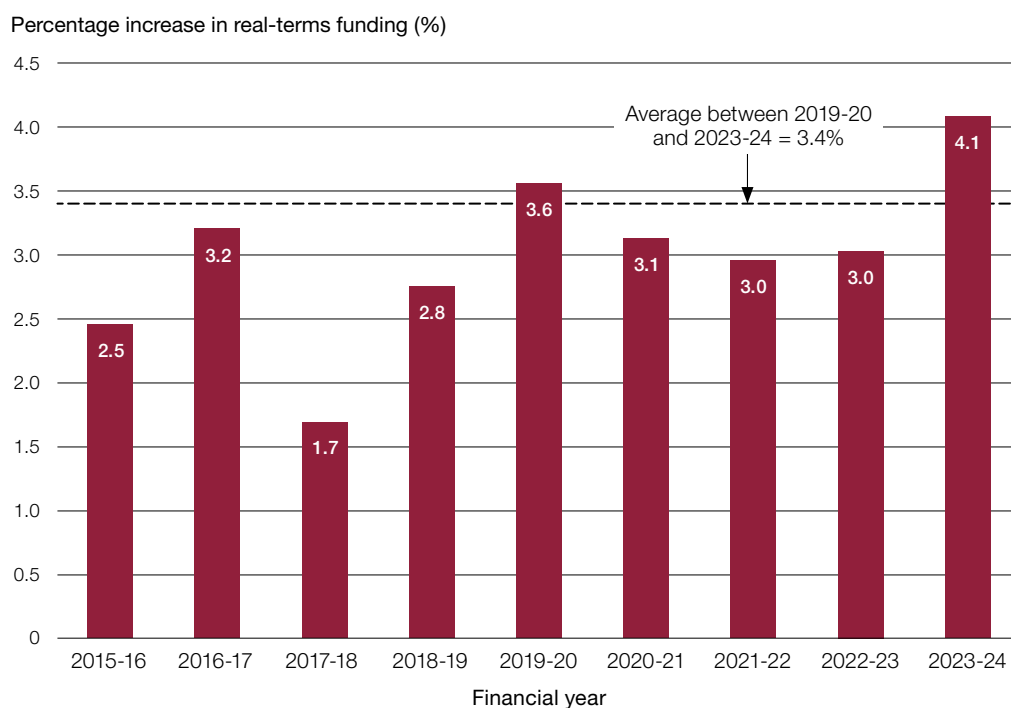
3 In June 2018, the Prime Minister announced a long-term funding settlement for the NHS, which will see NHS England's budget grow by an average 3.4% a year in real terms over the next five years (**Figure 1** overleaf). This amounts to a £33.9 billion increase in cash terms by 2023-24. In January 2019, the NHS published *The NHS Long Term Plan*. This set out how it aims to achieve the range of priorities and five financial tests set by the government in return for the long-term funding settlement. Local partnerships of clinical commissioning groups (CCGs), NHS trusts and foundation trusts (trusts), and local authorities are due to publish plans setting out how they aim to deliver *The NHS Long Term Plan*. These partnerships are known as sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) in areas where partnership work is most advanced.

4 Our last report on the financial sustainability of the NHS, published in January 2019, noted that we would only be able to judge if the funding package will be enough to achieve the NHS's ambitions when we know the level of settlement for other key areas of health spending, such as capital and prevention. It concluded that the growth in waiting lists, the slippage in waiting times and the existence of substantial deficits in some parts of the system, offset by surpluses elsewhere, do not add up to a picture that we could describe as sustainable.

Figure 1

Growth in NHS England's revenue funding in real terms, 2015-16 to 2023-24

Between 2019-20 and 2023-24, NHS England's budget will increase by 3.4% a year on average in real terms, an extra £33.9 billion a year in cash terms by 2023-24

**Notes**

- 1 The 2018-19 baseline was £114.6 billion.
- 2 Real-terms increases at the time of the long-term funding settlement, calculated using gross domestic product (GDP) deflators October 2018.
- 3 The numbers in the bars are rounded to one decimal place.

Source: National Audit Office analysis of Department of Health & Social Care data

5 In this report we:

- summarise the financial and operational performance of the NHS as a whole in England in 2018-19 (Part One);
- examine the financial performance of local NHS organisations (Part Two); and
- examine NHS service transformation and sustainability (Part Three).

6 We set out our audit approach in Appendix One and evidence base in Appendix Two. Appendix Three provides further details about our regression analysis and Appendix Four technical notes explaining how we have used financial data.

Key findings

Overall financial and operational performance of the NHS

7 In 2018-19, NHS commissioners and trusts reported a combined surplus of £89 million, with financial balance only being achieved with significant underspends by NHS England. Trusts reported a combined deficit of £827 million (not including a £256 million favourable exceptional technical adjustment resulting from the collapse of Carillion), 1.0% of their total income of £86,946 million. CCGs together reported an overspend of £150 million, 0.2% of the £84,384 million available for locally commissioned services. As in previous years, overspends by trusts and CCGs were offset by an NHS England underspend. It achieved an underspend of £1,066 million, 3.6% of the £29,237 million available for its national functions and centrally commissioned services. This underspend was £117 million lower than in 2017-18 (paragraphs 1.3 and 1.4).

8 Although the NHS delivered increased activity in 2018-19, patient waiting times continued to slip. For example, while 717,000 more patients were treated in accident and emergency departments within four hours, performance against the target that 95% of patients should be seen within four hours fell to 88.1% (from 88.3% in 2017-18). The NHS only met six out of 16 access standards for acute services in 2018-19. NHS England is undertaking a clinically led review to consider the current performance standards and is due to report by the end of March 2020. The number of patients on waiting lists for non-urgent treatment also continued to rise, from 3.85 million in 2017-18 to 4.23 million in 2018-19 (paragraphs 1.7 and 1.8).

Financial performance of local NHS organisations

9 In 2018-19, CCGs failed to achieve financial balance again. As a result of changes to CCG funding in 2018-19, NHS England expected all CCGs to achieve financial balance with no overspends. Changes included additional funding allocations for all CCGs and a new £400 million Commissioner Sustainability Fund to support CCGs that would otherwise not be able to live within their means. In 2018-19, CCGs reported a £150 million deficit, compared with a £213 million deficit in 2017-18. This included £384 million in payments from the fund (paragraphs 2.2 to 2.4).

10 Trusts were unable to contain their combined deficit to NHSE&I's ambition in 2018-19. NHSE&I increased the additional support funding available to trusts in 2018-19 to £2.45 billion, from £1.8 billion in 2017-18. As a result, trusts planned to contain their combined deficit to £394 million. In 2018-19, trusts reported a combined deficit of £827 million compared with a combined deficit of £991 million in 2017-18. Of the trusts that accepted financial targets (control totals) in 2018-19, 75% (149) reported positions at or better than their plan at the end of the year, compared with 71% in 2017-18. NHSE&I has committed to returning the trust sector to balance in 2020-21 (paragraphs 2.5 and 2.11, and Figure 5).

11 Trusts are becoming increasingly dependent on short-term measures to meet financial targets.

Financial sustainability relies on local bodies making year-on-year savings, rather than one-off savings. Over recent years, trusts have become increasingly reliant on one-off savings to deliver efficiency targets. In 2018-19, 31% of their savings were one-off, up from 26% in 2017-18. Relying on one-off savings means that trusts must find new savings each year in addition to savings already planned (paragraph 2.26, and Figure 12).

12 Variation in the financial performance of trusts grew in 2018-19.

NHSE&I aims for no NHS organisation to be reporting a deficit by 2023-24. Between 2017-18 and 2018-19, the percentage of trusts in deficit increased from 43% to 46%. The gap in financial performance between the best- and worst-performing trusts (with the largest surplus and the largest deficit) also increased from £218 million to £282 million over this period. The allocation of support funding (the Provider Sustainability Fund and its predecessor the Sustainability and Transformation Fund) increased the levels of variation in trust performance, because payments were conditional on the delivery of control totals, to provide incentives to deliver the best position nationally. In 2018-19, only 38% of these payments helped trusts reduce or eliminate their deficits, compared with 46% in 2017-18. Recognising that this support funding had not focused on those trusts most in need, NHSE&I reduced it from £2.45 billion in 2018-19 to £1.25 billion in 2019-20, to make more money (£1 billion) available for urgent and emergency care. It also set up a £1 billion Financial Recovery Fund, which will be directed to support those trusts in deficit in 2019-20, with more being directed to those in financial distress in future years. This should help to reduce the variation in trust financial performance and enable NHSE&I to move away from nationally mandated control totals (paragraphs 2.6, 2.12 to 2.14 and Figures 6 and 7).

13 Financially distressed trusts are increasingly relying on short-term loans from the Department with little or no prospect of paying them back.

Some trusts continue to rely on borrowing from the Department just to meet their running costs. Extra financial support to trusts in difficulty has continued to increase year-on-year. Most of this support (£3.3 billion out of £3.6 billion issued in 2018-19) is interim revenue support, rather than 'normal course of business' loans. By 31 March 2019, outstanding debt issued by the Department to these trusts was £10.9 billion, up from £8.0 billion on 31 March 2018. Where trusts have been unable to repay loans in line with their initial agreements, they have been able to agree new repayment plans, but the profile of loans and interest repayments indicates that there is no realistic prospect of this debt being repaid. Although the Financial Recovery Fund will go some way towards reducing the level of loans, loans will continue. This is not an acceptable or sustainable approach to the financial management of major public bodies and the Department is reviewing options to address this issue (paragraphs 2.16 to 2.20).

14 The underlying reasons for deficits in the most financially challenged trusts are complex and not always fully understood. The financial performance of the 10 worst-performing trusts has continued to deteriorate over several years. In 2018-19, they had a combined deficit of £844 million (up from £758 million in 2017-18), representing 31% of the combined deficit of all trusts reporting a deficit. NHSE&I aims to provide central funding to cover trusts' deficits for the next few years by transferring the remaining Provider Sustainability Fund and Commissioner Sustainability Fund into the Financial Recovery Fund from 2020-21. It recognises that a better understanding is needed of how much of these deficits can be tackled by the trusts or the local health systems themselves through improving operations, compared with issues outside of their control that may require adjustments to funding flows. NHSE&I plans to deploy an accelerated turnaround process in the 30 worst financially performing trusts (paragraphs 2.6 to 2.9).

15 Trusts continue to struggle to make the capital investments needed to maintain the estate and support transformation, storing up problems for the future. Since 2014-15, the Department has transferred £4.3 billion from capital to revenue spending, foregoing longer-term investment in buildings and other long-term assets to support day-to-day spending on current services. Transfers peaked at £1.2 billion in 2016-17 and have since decreased to £0.5 billion in 2018-19. In March 2019, the Department was unable to give a definitive measure of the impact on patients' services of repeatedly making these transfers. Local NHS bodies told us that the current capital regime does not address the challenges local health economies face and expressed a need for a long-term capital strategy and settlement. The Department acknowledges that: there is a significant unmet need for capital in the NHS; the current approach to allocating capital funding is outdated; the approvals process is bureaucratic; and the capital regime has become disconnected from revenue and cash systems. In September 2019, it published a *Health Infrastructure Plan*, that aims to deliver a five-year programme of investment in health infrastructure. This plan is contingent on a multi-year capital settlement, which is yet to be announced (paragraphs 2.22 to 2.25).

Service transformation and sustainability

16 The NHS has not fully achieved the vision set out in the *Five Year Forward View*. The *Five Year Forward View*, published in October 2014, set out the NHS's vision to support a sustainable NHS. The strategy had several key themes:

- **Developing and rolling out new care models to provide integrated services**

Evaluation of the programme found that while there were signs that some new care models had a positive impact on reducing demand for urgent care, the programme had not provided the evidence needed at a system level on what worked and what did not work. When the programme ended in 2018 place-based new care models covered 9% of the population. The programme also supported the development of primary care homes, which led to the development of primary care networks which were rolled out across the country in 2019. NHSE&I told us that new care models will continue to be rolled out by integrated care systems.

- **Reducing demand for services through a greater focus on public health and prevention**

This aspiration was not matched by dedicated funding. For example, the public health grant to local authorities decreased by £0.5 billion, in real terms, between 2015-16 and 2018-19. Ongoing pressures in social care provision also presented challenges for NHS services.

- **Strengthening care out of hospitals**

This theme had out-of-hospital (primary and community) care becoming more integrated and a larger part of what the NHS does. But, between 2015-16 and 2018-19, total spending on primary medical and community health services as a proportion of the NHS expenditure decreased from 20.0% to 19.4%.

However, stakeholders told us that the *Five Year Forward View* had helped to build consensus across the health system for collaborative working and the need for more focus on prevention and integration (paragraphs 3.2 to 3.9, and Figure 14).

17 The NHS Long Term Plan has built on lessons learnt from the *Five Year Forward View* but the NHS may struggle to deliver all its commitments with the additional money available. For example: it is more realistic in the efficiencies required of trusts (1.1% tariff efficiency requirement compared with 2% in 2017-18 and 2018-19, although individual trusts may have to deliver higher levels of efficiencies in practice); it has committed investment in priority areas such as primary care and mental health; and it is in the process of developing a people plan to support the delivery of the long-term plan. However, the plan contains more than 500 general ambitions and more than 100 commitments. Local partnerships are free to define their pace of delivery for many commitments with only about half of the commitments needing to be delivered in line with nationally defined timetables. Local bodies told us that it will be challenging to deliver all the commitments over the life of the plan (paragraphs 3.16 and 3.17).

18 Local partnerships continue to develop system working but still face significant challenges to become sustainable and deliver *The NHS Long Term Plan*. The sustainability and transformation partnerships and integrated care systems that we visited continue to make progress towards joint working. They are developing their five-year implementation plans to support the delivery of *The NHS Long Term Plan*. However, they continue to face a range of challenges, many of which have been highlighted in our previous reports, and some of which may affect partnerships' ability to deliver *The NHS Long Term Plan*. For example, in 2018-19, 64% of partnerships had deficits when all their constituent trusts' and CCGs' finances were added together, down from 73% in 2017-18. Partnerships also remain 'coalitions of the willing' as they are constrained by the existing legislative framework and rely primarily on the goodwill of participating organisations. NHSE&I recommended amendments to legislation in September 2019 to help promote collaboration and service integration (paragraphs 3.11 and 3.12, and Figure 15).

19 There continues to be a risk that the NHS will be unable to use the extra funding from the long-term settlement optimally because of staffing shortages. Difficulties in recruiting NHS staff present a real risk that some of the extra £33.9 billion funding will not be used optimally (more expensive agency staff will need to be used to deliver additional services), even if commissioners have the resources to commission additional activity, healthcare providers may not have the staff to deliver it. The NHS continues to carry about 40,000 nursing vacancies and 9,000 vacancies for medical staff. Local NHS bodies told us that staffing shortages are one of the biggest risks to delivering the long-term plan. The NHS people plan, which is due for publication in spring 2020, aims to address this risk and an *Interim NHS People Plan* was published in July 2019, with a focus on the actions needed for 2019-20 (paragraphs 1.9, 3.16 and 3.17).

20 A lack of clarity persists on key areas of health and care spending that are likely to affect the NHS's ability to deliver *The NHS Long Term Plan*. Local NHS bodies remain concerned that without a long-term funding settlement for social care, it will be very difficult to make the NHS sustainable. The government has committed to ensuring that adult social care funding is such that it does not impose any additional pressure on the NHS between 2019-20 and 2023-24. Other areas of health spending where there is a lack of long-term clarity are prevention initiatives run by Public Health England and local authorities, and funding for doctors' and nurses' training. Spending in these areas could affect the NHS's ability to deliver the priorities of the long-term plan. The 2019 Spending Review originally intended to set day-to-day budgets for three years and capital budgets for four years. However, it only provided budgets for one year (paragraph 3.17).

21 NHSE&I continues to adopt a more joined-up approach to oversight but is still in a period of transition. The *NHS Oversight Framework 2019-20* set out a new approach where NHSE&I's regional teams review performance and identify support needs across local partnerships with a single voice and a greater emphasis on system performance, working with and through system leaders. It also suggests greater autonomy for systems with evidenced capability for collective working and a track record of successful delivery of NHS priorities. Local areas we visited reported that NHSE&I's approach continued to feel more joined-up, but its regional teams were still in a state of transition. Local bodies told us that it is not clear where responsibilities will sit between the national and regional NHSE&I teams, and also between regional teams and local partnerships (paragraphs 3.18 to 3.20).

Conclusion on value for money

22 The NHS is treating more patients but has not yet achieved the fundamental transformation in services and finance regime needed to meet rising demand. The short-term fixes that the Department, NHS England and NHS Improvement put in place to manage resources in a constrained financial environment are not sustainable. The extra money brought in to stabilise the finances of NHS bodies has continued to drive volatility and variability among trusts, while patient waiting times continue to deteriorate and the number of people waiting for treatment continues to increase. Loans provided to financially distressed trusts by the Department are effectively being treated as income by these organisations and they have built up a level of unsustainable debts which they have no ability to ever repay. The system has tolerated this for several years but using loans in this way is not an acceptable approach to the financial management of major public bodies.

23 Years of short-term funding decisions for the health sector means that resources have moved away from areas of investment in the future, such as the workforce, public health and capital. This will need to be rebalanced to ensure that the ambitions set out in *The NHS Long Term Plan* are realised. To bring about lasting stability, the NHS needs a financial restructuring programme not just a recovery programme. If integrated care systems are to be successful, funding mechanisms and incentives need to support collaborative behaviours. The delivery of long-term financial sustainability is at risk unless every organisation is on a realistic path to breaking even. Until the Department and NHSE&I have implemented more sustainable solutions and dispensed with short-term financial fixes, we cannot conclude that they have delivered value for money through their collective actions.

Recommendations

- 24** These recommendations aim to ensure that the additional funding supporting *The NHS Long Term Plan* is spent optimally to maximise its impact, and that financial rigour and transparency is improved over this funding settlement period.
- a** The Department and NHSE&I should redesign the financial architecture to promote the behaviours that will be needed to achieve *The NHS Long Term Plan*. It should draw on the lessons from previous schemes which have not worked, such as the use of punitively high interest-bearing loans to deter trusts from overspending.
 - b** As part of these wider financial reforms to establish a more stable funding system, the Department should put in place an alternative support system to provide assistance to the most financially distressed organisations, stop issuing loans where there is no realistic prospect of those loans being repaid, and restructure the balance sheets of these trusts to address the accumulated debt that will not be repaid.
 - c** The Department and NHSE&I should develop a better understanding of how much of the deficits in trusts in severe financial difficulties are down to structural issues that cannot be addressed by local health systems and develop a plan to address these structural issues and include this in any changes to payment systems.
 - d** The Department and NHSE&I should develop a coherent long-term capital strategy, based on a long-term capital settlement, to support the development of *The NHS Long Term Plan*. This should include establishing a transparent, simplified, needs-based mechanism for prioritising, accessing and spending capital that better addresses high- and significant-risk backlog maintenance and supports place-based reform.
 - e** NHSE&I should put in place a regulatory and oversight system that aligns with the responsibilities placed upon individual NHS bodies and their role within non-statutory sustainability and transformation partnerships and integrated care systems. This should clearly set out how roles and responsibilities sit between the national NHSE&I team, regional NHSE&I teams and local partnerships.

Part One

Financial and operational performance of the NHS as a whole in England

1.1 This part examines the overall financial and operational performance of the NHS and its bodies – clinical commissioning groups (CCGs), NHS trusts and NHS foundation trusts (trusts) – in 2018-19.

NHS funding and spending in 2018-19

1.2 Most of the funding allocated to the Department of Health & Social Care (the Department) is given to NHS England to plan and pay for NHS services. In 2018-19, this amounted to £113.6 billion.¹ Most of NHS England's budget was spent by 195 CCGs, which purchased healthcare services from 227 NHS trusts.² These trusts deliver acute, community, ambulance, specialist, mental health and disability services. **Figure 2** summarises the overall financial performance of CCGs and trusts in 2018-19.

1.3 Overall, the commissioner and trust sectors ended 2018-19 with a surplus of £89 million.³ This was better than 2017-18, when they recorded a £21 million deficit. The surplus in 2018-19 was made up of:

- NHS England reporting an underspend of £1,066 million, 3.6% of the £29,237 million available for national functions, centrally commissioned services and legacy claims;
- CCGs reporting an overspend of £150 million, 0.2% of the £84,384 million available for locally commissioned services; and
- trusts reporting a combined deficit of £827 million (not including a £256 million favourable exceptional technical adjustment resulting from the collapse of Carillion), 1.0% of their income of £86,946 million.

1 The £113.6 billion excludes the depreciation ringfence – see table 36 in the Department's Annual Report and Accounts.

2 Number of organisations at 31 March 2019.

3 The trusts' deficit position does not include £1 million in adjustments needed to report against the Department's budget for day-to-day resources and administration costs, including adjustments relating to income and depreciation of donated assets, private finance initiative spending and provisions.

Figure 2

Summary of the financial performance of clinical commissioning groups (CCGs) and NHS trusts and NHS foundation trusts (trusts) in England, 2018-19

The commissioner and trust sectors ended 2018-19 with a surplus of £89 million

	Planned expenditure/ income 2018-19 (£m)	Underspend/ overspend 2018-19 (£m)	Underspend/ overspend 2017-18 (£m)
NHS England national spending on centrally commissioned services, including primary care, specialised services and public health	29,237	1,066 underspend (surplus)	1,183 underspend (surplus)
CCGs	84,384	150 overspend (deficit)	213 overspend (deficit)
Trusts	86,934	827 overspend (deficit)	991 overspend (deficit)
Net underspend/overspend by NHS commissioners and trusts		89 underspend (surplus)	21 overspend (deficit)

Notes

- 1 NHS England's total revenue budget (including depreciation and impairment charges) was £113,787 million. The core measure for NHS England's financial performance is its non-ringfenced revenue budget of £113,621 million, which excludes depreciation and impairment charges.
- 2 The combined deficit of trusts does not include £256 million of exceptional technical adjustments. After Carillion's liquidation, two private finance initiative hospitals were brought onto providers' books as part-donated assets. These were Sandwell and West Birmingham Hospital NHS Trust (£149 million) and Royal Liverpool and Broadgreen NHS Trust (£107 million).
- 3 Trusts generate income as opposed to receiving 'allocations'. This is because they work on a more commercial basis than NHS England and CCGs, which work within an annual resource limit.
- 4 Trusts receive income from CCGs, NHS England and other trusts, including from services provided to other trusts. The gross income from all these sources was £86,946 million.
- 5 NHS England and CCGs also buy healthcare services from other providers.
- 6 These figures exclude any central accounting adjustments that the Department of Health & Social Care (the Department) makes when reporting its total revenue position to Parliament.

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

1.4 In 2018-19, NHS England underspent by £1,066 million against its central and direct commissioning budget (excluding CCGs), a five-fold increase since 2014-15, but less than the £1,183 million underspend in 2017-18. It achieved this by spending less than planned on:

- programmes, administration and other central budgets (£756 million), for example by holding back funding for transformation, not filling staff vacancies and income from GP rates rebates and counter-fraud receipts; and
- direct commissioning (£310 million), including for specialised services, where, for example, controls have been put in place regarding the Cancer Drugs Fund.

The underspend was used to offset the deficits in local NHS bodies.

NHS mandate

1.5 The mandate to NHS England sets the government's objectives for NHS England, and therefore the direction for the NHS. In July 2019, the Secretary of State for Health and Social Care reported that NHS England had made good progress in achieving its mandate deliverables for 2018-19, with 33 out of 62 deliverables having been delivered and a further 22 having not been delivered but plans and action to address performance were in place to bring performance back in the next quarter. However, the report highlighted concerns in a number of areas including patient access standards to NHS services.

Achieving NHS performance standards and quality requirements

1.6 A recent study has shown that NHS productivity has been growing at more than double the rate of the productivity of the economy as a whole.⁴ Between 2004-05 and 2016-17, NHS productivity, a measure of output against input, grew by 16.5% compared with 6.7% for the economy. NHS Improvement estimates that the provider sector's implied productivity was 2.3% for 2018-19 year end, up from 1.2% the previous year end.⁵

1.7 In 2018-19, the NHS continued to deliver increasing activity, but performance against key access standards for acute services declined further (**Figure 3**). The NHS only met six out of 16 key access standards for acute services in 2018-19. For example, while some 717,000 more patients were treated in accident and emergency (A&E) departments within four hours in 2018-19, more than 165,000 waited more than four hours. Only 88.1% of A&E patients were seen within four hours, against a target of 95% and a rate of 88.3% in 2017-18. NHS planning guidance for 2018-19, published by NHS England and NHS Improvement, set an ambition that the majority of providers would meet the A&E standard by March 2019. However, only 40 out of 161 trusts met the standard in March 2019 and many of these do not have major A&E departments.

⁴ A Castelli et al, *Productivity of the English National Health Service: 2016/17 update*, Centre for Health Economics, University of York, April 2019.

⁵ The implied productivity is calculated by reviewing the changes to provider costs, adjusted for estimated unavoidable inflationary pressures, and then comparing these to the change in provider outputs.

Figure 3

NHS performance against key waiting times standards in England, between 2015-16 and 2018-19

Performance against key waiting times standards declined further in 2018-19

Activity	Increase in activity between 2017-18 and 2018-19 (%)	Target	2015-16 (%)	2016-17 (%)	2017-18 (%)	2018-19 (%)	Standard last met
Accident and emergency (A&E)	4.2	95% of patients should be admitted, transferred, or discharged within four hours of arrival in A&E	91.9	89.1	88.3	88.1	2013-14
GP urgent referral to a first treatment for cancer patients	11.0	85% of patients should start definitive treatment within 62 days of receipt of referral at hospital	82.4	82.0	82.3	79.1	2013-14
Referral to treatment for routine non-urgent conditions	4.4 ¹	92% of patients should start their treatment within 18 weeks of being referred	91.5	90.3	87.2	86.7	March 2015 ³
Diagnostic tests	8.8 ²	Less than 1% of patients should wait six weeks or longer for a diagnostic test from referral	1.8	1.4	1.9	2.7	2012-13

Notes

- 1 Based on the total number of people treated regardless of the number of weeks waited before their treatment.
- 2 Based on the number of people waiting for diagnostic tests at the end of each month. As more people are waiting longer, the increase in activity may be lower than our estimate.
- 3 This is the last time that the standard that 92% of patients should start their treatment within 18 weeks of being referred was met at the end of a financial year (March). When all months are considered, the standard was last met in February 2016.
- 4 The performance against waiting times standards reported here is the average performance across a financial year except for routine non-urgent referrals, which is based on the performance at the end March each year. However, the Department of Health & Social Care and the NHS monitor performance on a weekly or monthly basis and may not report annual averages.

Source: National Audit Office analysis of NHS England data

1.8 The clinical priority of emergency care and cancer services means that practically the Department and NHS England have focused more on those than elective care. NHS England is undertaking a clinically led review to consider the current performance standards and is due to report by the end of March 2020. Its initial findings were published in March 2019.⁶ NHS planning guidance for 2018-19 set an ambition to maintain or reduce the number of patients on waiting lists for non-urgent treatment in March 2019, compared with March 2018. However, the number of patients on waiting lists for non-urgent treatment increased from 3.85 million in March 2018 to 4.23 million in March 2019.⁷

⁶ NHS England, *Clinically-led Review of NHS Access Standards: Interim Report from the NHS National Medical Director*, March 2019.

⁷ The number of patients waiting is based on data published by NHSE&I for NHS commissioners. In previous years, we have used the data published by NHS Improvement in its reports on the quarterly performance of the NHS provider sector.

1.9 As they did last year, trusts told us that even with extra funding, it will be challenging to meet performance standards, because of difficulties recruiting staff. In March 2019, trusts had 40,000 vacancies for nurses (11.1% vacancy rate) and more than 9,000 vacancies for medical staff (7.2% vacancy rate), about 3,300 more than the combined number of vacancies in March 2018. Vacancy rates vary widely between regions. For example, in March 2019, the nurse vacancy rate was 14.0% in London and 9.0% in the North of England.

Providing quality services

1.10 The Care Quality Commission 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 quality rating. Between September 2018 and September 2019, the percentage of trusts rated as good or outstanding increased from 56% to 60%, and the percentage for acute trusts also increased from 50% to 52%. However, the percentage of A&E departments rated good or outstanding at 31 July 2018 decreased to 48% from 52% at 31 July 2017.

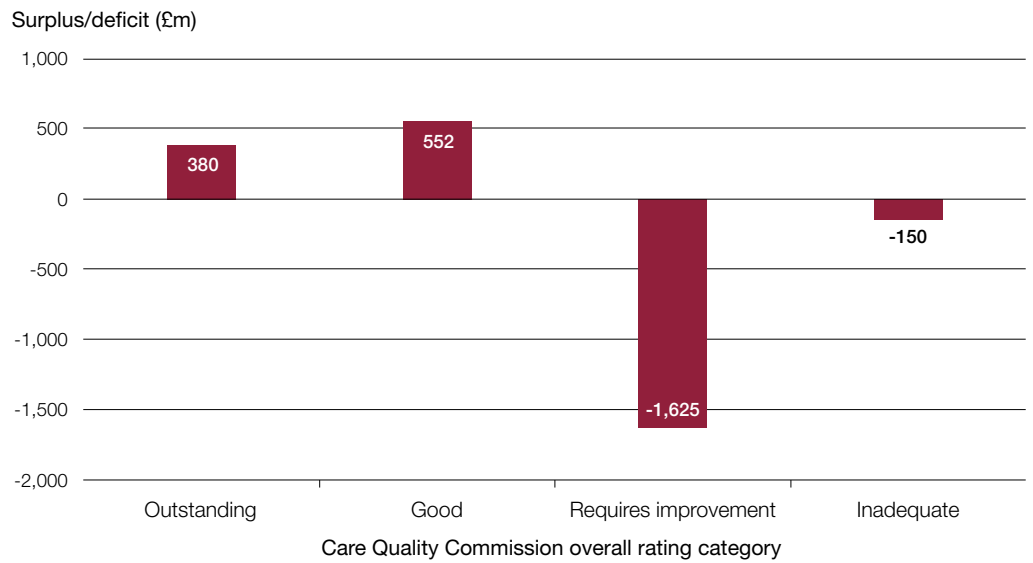
1.11 Poor financial performance is associated with the quality of a trust’s clinical services and may reflect poor leadership. Overall, trusts with larger deficits tended to have a poorer ‘well-led’ rating. **Figure 4** shows that trusts with an overall rating of good or outstanding reported an aggregate surplus in 2018-19 whereas trusts rated as inadequate or requiring improvement reported an aggregate deficit.

1.12 The Department introduced a ‘use of resources’ rating in 2018 to measure NHS providers’ management of resources alongside the overall quality rating. Our analysis shows that 60% (49) of the 82 acute trusts that had been rated by August 2019 were rated as either inadequate or requiring improvement.

Figure 4

Care Quality Commission ratings and the surplus/deficit of NHS trusts and NHS foundation trusts (trusts) in England, 2018-19

The trust sector's deficit is concentrated in trusts with poorer Care Quality Commission ratings



Note

1 Financial performance represents the total adjusted surplus/deficit, including Provider Sustainability Fund payments for all trusts within the same rating category as at September 2019. Seven trusts without a Care Quality Commission rating at that time were excluded from this analysis.

Source: National Audit Office analysis of NHS trusts' and NHS foundation trusts' financial data and Care Quality Commission data

Part Two

Financial performance of local NHS organisations

2.1 In this part we examine the financial performance of clinical commissioning groups (CCGs) and NHS trusts and NHS foundation trusts (trusts).

Trend in financial performance of clinical commissioning groups

2.2 The financial performance of CCGs is measured against the planned position at the end of the financial year agreed between each group and NHS England. Any differences between the actual and planned position are reported as either underspends or overspends. In 2018-19, CCGs reported a £150 million overspend, made up of:

- a collective overspend of £264 million on locally commissioned services (compared with an overspend of £321 million in 2017-18). This included £384 million provided through the Commissioner Sustainability Fund and £8 million funded through historic surpluses;
- an underspend of £61 million on the Quality Premium scheme (compared with an underspend of £71 million in 2017-18);⁸ and
- technical adjustments of £53 million, which NHS England makes for reporting purposes (compared with £37 million in 2017-18).

2.3 CCGs' performance was better in 2018-19 than in 2017-18, showing that:

- 162 CCGs had either a balanced position or reported underspends totalling £27 million, compared with 132 in 2017-18 being in balance or reporting underspends totalling £247 million; and
- 33 CCGs reported overspends totalling £291 million, compared with 75 in 2017-18 reporting overspends totalling £568 million.

⁸ This scheme rewards CCGs for improving the quality of services they commission.

2.4 The Commissioner Sustainability Fund was introduced by NHS England in 2018-19 to support CCGs that would otherwise be unable to live within their means. Control totals were set so that any CCG that overspent in 2017-18 was required to improve its in-year financial performance by at least 1% of its overall allocation. With the Commissioner Sustainability Fund and an increase in allocations to CCGs, NHS England expected all CCGs to live within their means in 2018-19. Any CCG that was set a financial deficit target (control total) was eligible for a payment from this fund that would bring it back to a position of in-year financial balance if the control total was delivered. Out of the £400 million planned in 2018-19, £384 million was distributed to CCGs. *The NHS Long Term Plan* commits to reducing year-on-year the number of CCGs (and trusts) in deficit, so that all NHS organisations are in balance by 2023-24.

Trend in financial performance of trusts

2.5 In 2018-19, NHS England and NHS Improvement (NHSE&I) continued with the measures introduced in the July 2016 NHS 'financial reset' plan, which aimed to reduce trusts' deficits and strengthen financial performance and accountability. These measures included the £2.45 billion a year Provider Sustainability Fund (which replaced the £1.8 billion a year Sustainability and Transformation Fund), which trusts could access if they accepted and achieved the control totals given to them by NHS England and NHS Improvement. The reported financial position of trusts only improved by £164 million in 2018-19, with an increase in support payments of £650 million (**Figure 5** overleaf). NHSE&I has committed to returning the trust sector to balance in 2020-21.

2.6 The combined deficit includes a wide variation in performance (**Figure 6** on page 23) across the trust sector from a £102 million surplus to a £180 million deficit. At the end of 2018-19:

- 104 out of 227 trusts (46%) reported a deficit, compared with 100 out of 232 trusts (43%) in 2017-18; and
- the 10 worst-performing trusts reported a combined deficit of £844 million (up from £758 million in 2017-18), representing 12% of their income and 31% of this gross deficit.⁹

2.7 The financial performance of the 10 worst-performing trusts each year has continued to deteriorate over several years. NHSE&I plans to deploy an accelerated turnaround process in the 30 worst-financially performing trusts.

2.8 NHSE&I aims to provide central funding to cover trusts' deficits for the next few years by transferring the remaining Provider Sustainability Fund and Commissioner Sustainability Fund into the Financial Recovery Fund from 2020-21. It recognises that a better understanding is needed of how much of these deficits can be tackled by the trusts or the local health systems themselves through improving operations, compared with issues outside of their control that may require adjustments to funding flows. It is undertaking a piece of analytical work to provide a more detailed picture of the deficit drivers within provider trusts.

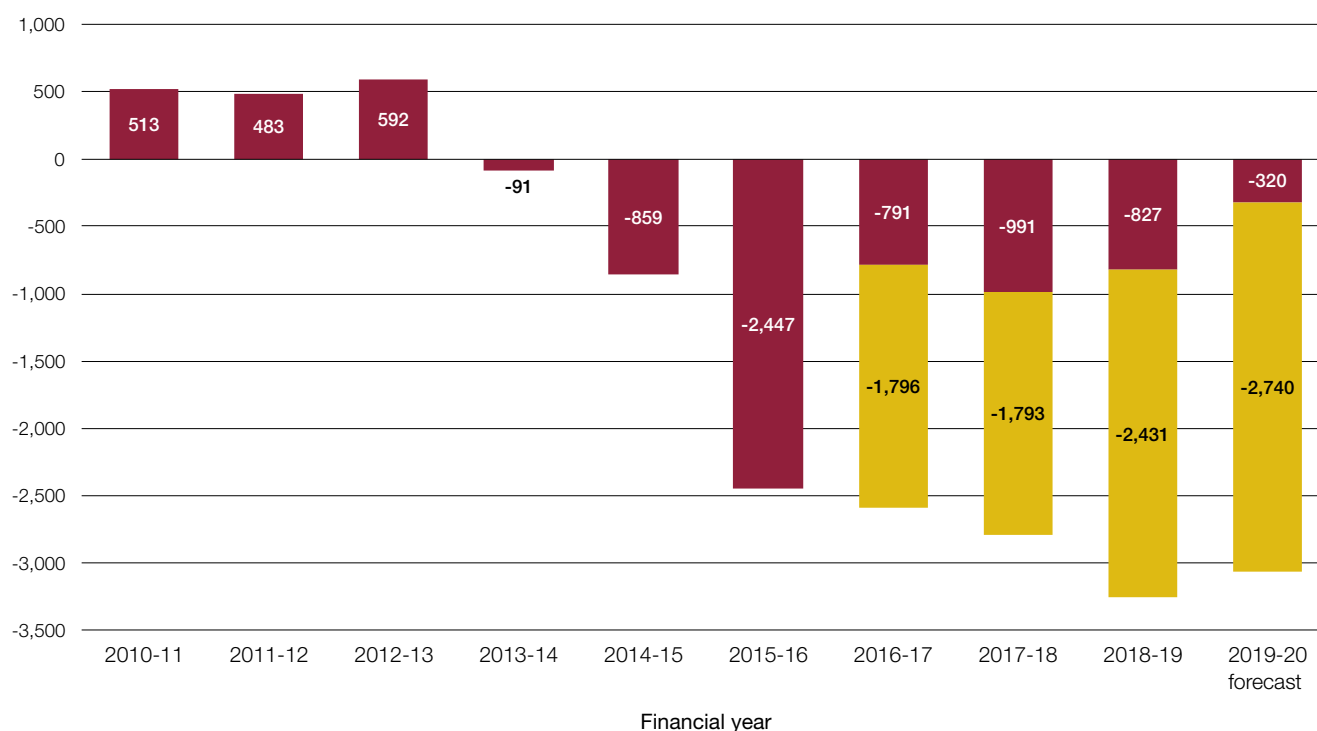
⁹ The 10 worst-performing trusts may differ from year to year.

Figure 5

The combined surplus/deficit of NHS trusts and NHS foundation trusts (trusts) in England between 2010-11 and 2018-19, and forecast for 2019-20

The combined deficit of trusts only improved by £164 million in 2018-19, despite an increase in support payments of £638 million

Surplus/deficit (£m)



■ Surplus/deficit

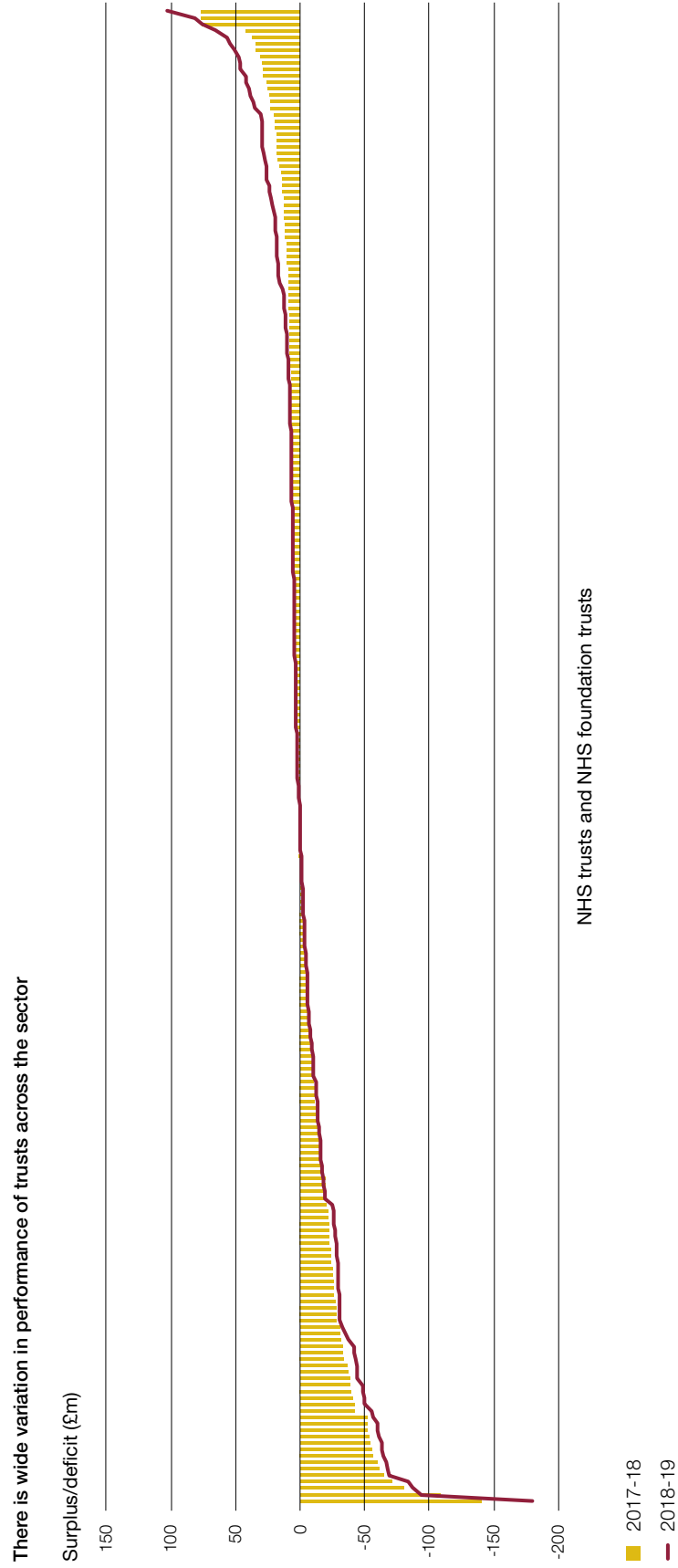
■ Support payments

Notes

- 1 Support payments: Sustainability and Transformation Fund payments totalled £1,796 million in 2016-17 and £1,793 million in 2017-18; Provider Sustainability Fund payments totalled £2,431 million in 2018-19, and for 2019-20, support payments comprise £1,250 million from the Provider Sustainability Fund, £1,048 million from the Financial Recovery Fund and £442 million from marginal rate emergency tariff (MRET) funding. This marginal rate reduced the rate paid to trusts if emergency admissions exceeded a set threshold. For 2019-20, NHS England and NHS Improvement abolished it and introduced funding for trusts to cover the cost of each admission, if they agreed to their control totals.
- 2 In 2018-19, trusts planned to contain their combined deficit to £394 million.
- 3 The combined deficit of £827 million in 2018-19 does not include £256 million of exceptional technical adjustments due to the financial collapse of Carillion. After Carillion's liquidation, two provider finance initiative (PFI) hospitals were brought onto providers' books as part-donated assets (Sandwell and West Birmingham Hospital NHS Trust – £149 million, and Royal Liverpool and Broadgreen NHS Trust – £107 million).
- 4 Forecast for 2019-20 is based on expected full-year outturn at the end of quarter two.

Source: National Audit Office analysis of NHS trusts' and NHS foundation trusts' financial data

Figure 6
The spread of surpluses and deficits of NHS trusts and NHS foundation trusts (trusts) in England, in 2017-18 and 2018-19



Notes

- 1 The graph shows the distribution of surpluses and deficits across the trust sector, illustrating the variation in 2017-18 and 2018-19 for the sector as a whole. The figure presents the ranked performance for trusts in existence as at 1 April 2018. The data-points represent trusts ordered by their ranking in each year (from best to worst), and trusts may change rank between years.
- 2 Surpluses and deficits include payments from the Sustainability and Transformation Fund in 2017-18 and the Provider Sustainability Fund in 2018-19.
- 3 The range between the largest surplus and the largest deficit was £218 million in 2017-18 and £282 million in 2018-19.

Source: National Audit Office analysis of NHS trusts' and NHS foundation trusts' financial data

2.9 Local bodies referred to a number of factors which they considered have contributed to their financial difficulties but over which they may have limited control. These include: location and size of their hospitals; the use of agency and bank staff often due to difficulties in recruiting staff; tariffs (prices) used to pay for their activities which do not reflect the true costs of their operations; their patients' profiles (deprivation, age and severity of their patients); and the level of exposure to emergency activities. These factors are complex and often interact with each other. Our explorative analysis (see Appendix Three), using routinely collected NHS administrative data, indicates that many of these factors do correlate with trusts' level of deficits at a national level.

Financial support and incentives

2.10 In recognition of ongoing funding challenges, the Department of Health & Social Care (the Department) and NHSE&I have introduced, or used, several schemes to provide financial support to trusts alongside mainstream funding arrangements through contracts (**Figure 7** on pages 26 and 27). These schemes are intended to provide the financial support that trusts need to maintain their services while incentivising them to become more financially sustainable.

Provider Sustainability Fund

2.11 Access to the Fund is based on trusts agreeing and meeting control totals set by NHS Improvement. In 2018-19:

- 87% of trusts (198) accepted their control total targets in 2018-19 and received a total of £2,431 million of funding between them;¹⁰
- 75% of trusts (149) reported positions at or better than their plan at the end of the year compared with 71% in 2017-18; and
- 13% of trusts (29) did not accept or meet their control totals, compared with 16% in 2017-18.

2.12 The distribution of the Fund (**Figure 8** on page 28) increased the levels of variation in trusts' financial performance, as payments were conditional on the delivery of control totals, to provide incentives to deliver the best position nationally. In 2018-19, only 38% (£922 million) of payments from the Fund helped trusts to reduce or eliminate their deficits, compared with 46% of payments in 2017-18 and 60% in 2016-17.¹¹ The rest helped to create or increase trusts' surpluses. In 2018-19, 44% (£1,072 million) of payments were allocated to trusts already reporting a surplus.

¹⁰ This excludes three trusts dissolved in-year that had initially accepted their control totals.

¹¹ Comptroller and Auditor General, *NHS financial sustainability*, Session 2017–2019, HC 1867, National Audit Office, January 2019; and Comptroller and Auditor General, *Sustainability and transformation in the NHS*, Session 2017–2019, HC 719, National Audit Office, January 2018.

2.13 NHSE&I has recognised that the Provider Sustainability Fund, and its predecessor, did not focus funding on those trusts most in need, as it could be accessed by trusts planning a surplus, breakeven or a deficit. For 2019-20, it reduced its size to £1.25 billion to make more money (£1 billion) available for urgent and emergency care. It also set up a £1 billion Financial Recovery Fund, which will be directed to support those trusts in deficit in 2019-20, with more being directed to those in financial distress in future years. These changes should help to reduce the variation in financial performance described in paragraph 2.6. In 2019-20, it allocated £155 million of the Provider Sustainability Fund to the non-acute sector and used the remaining £1.095 billion to support the provision of emergency services in acute and specialist trusts.

2.14 As a result of this funding, NHSE&I expects variation in trust financial performance to reduce, the number of trusts reporting a deficit in 2019-20 to reduce by more than half, and by 2023-24 no trust to be reporting a deficit. The Financial Recovery Fund is only accessible to trusts where deficit control totals indicate a risk to financial sustainability and continuity of services, and where financial recovery plans, agreed with NHSE&I regional teams, are in place. To receive payments, trusts will have to deliver their financial improvement trajectories. However, a proportion of these allocations will be linked to the achievement of system financial improvement trajectories to encourage system working. The Financial Recovery Fund should mean the end of the control total regime and the Provider Sustainability Fund for all trusts which deliver against their recovery plans by 2021.

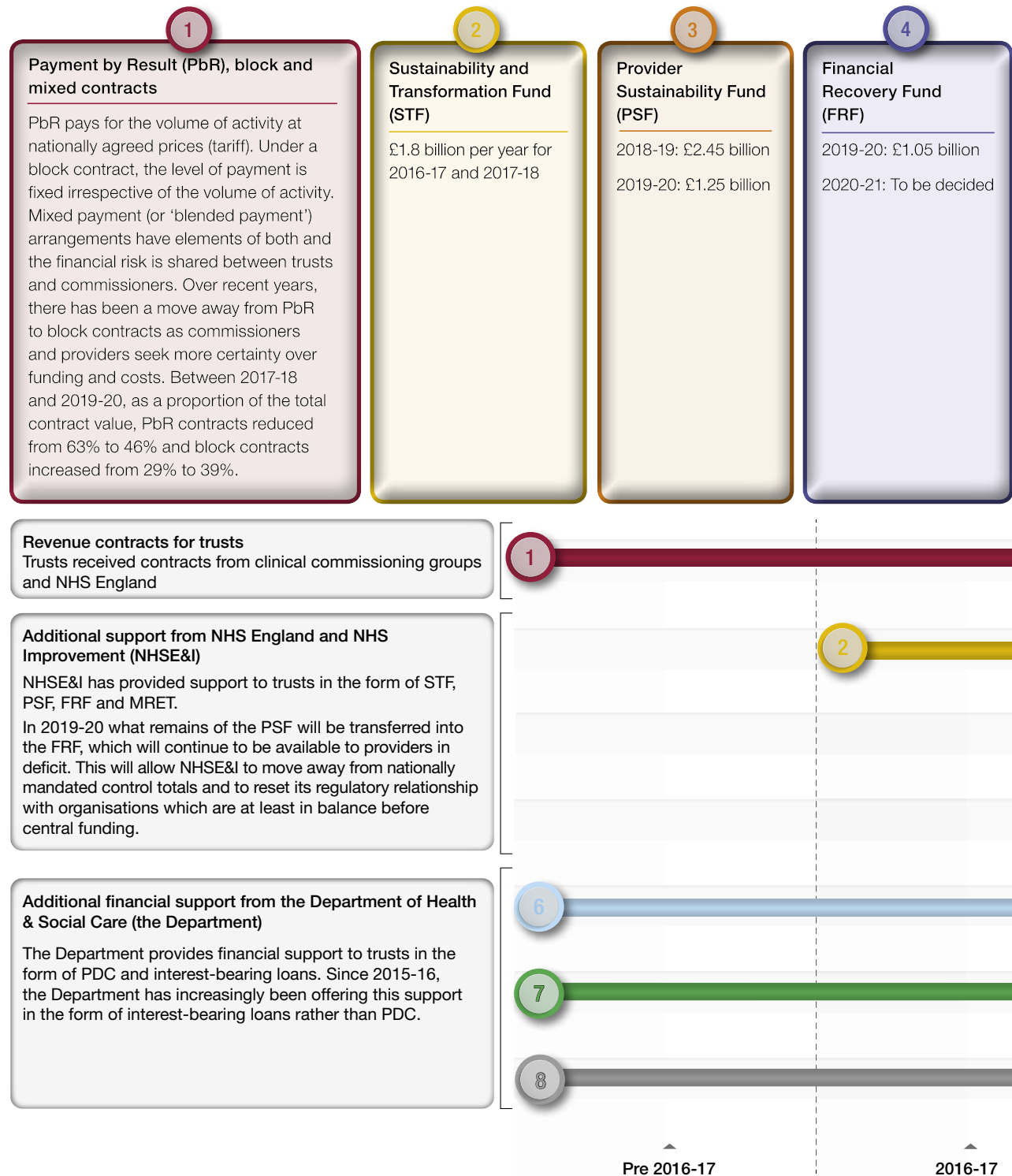
2.15 Trusts achieving breakeven or a surplus may benefit from a new incentive scheme introduced by NHSE&I comprising two elements:

- a one-year transitional reward payment worth 0.5% of income for trusts in surplus (before sustainability funding) that deliver a surplus again in 2020-21; and
- a reward for trusts in deficit that reach breakeven during the planning period. They will receive a 0.5% reward at the end of the year in which they achieve breakeven and at the end of the next year, if financial performance is maintained.

Figure 7

The main funding arrangements for NHS trusts and NHS foundation trusts (trusts) in England

In recognition of ongoing funding challenges, the Department of Health & Social Care, NHS England and NHS Improvement have introduced, or used, several schemes to provide financial support to trusts alongside mainstream funding arrangements



5

MRET funding

£442 million for 2019-20 from marginal rate emergency tariff (MRET) funding. This marginal rate reduced the rate paid to trusts if emergency admissions exceeded a set threshold. For 2019-20, NHSE&I abolished it and introduced funding for trusts to cover the cost of each admission, if they agreed to their control totals.

6

Pubic Dividend Capital (PDC)

A form of investment provided to trusts when they were formed – in a similar way that a company would have share capital. PDC has been issued for strategic capital investment but also provided exceptional revenue support to trusts in financial difficulty before 2014-15. Trusts that hold a PDC reserve must pay a dividend to the Department equivalent to 3.5% of its net assets. Between 2015-16 and 2018-19, the balance of PDC increased by 6% from £25.8 billion to £27.4 billion.

7

Interim support loans

Interest-bearing loans to support the ongoing provision of services and essential capital expenditure for trusts experiencing financial difficulty. Since 2014-15, the Department has increasingly used this type of loans to support trusts. NHS Improvement hoped that the Sustainability and Transformation Fund would replace the need for most direct cash funding from the Department to trusts. However, extra financial support to trusts in difficulty has continued to increase year-on-year. The outstanding interim loans increased by 386% from £2.25 billion to £10.94 billion between March 2016 and March 2019.

8

Normal course of business loans

Interest-bearing loans to support local investments in infrastructure or liquidity support to solvent trusts. Between 2015-16 and 2018-19, the balance of this type of loans remained stable at £3 billion.

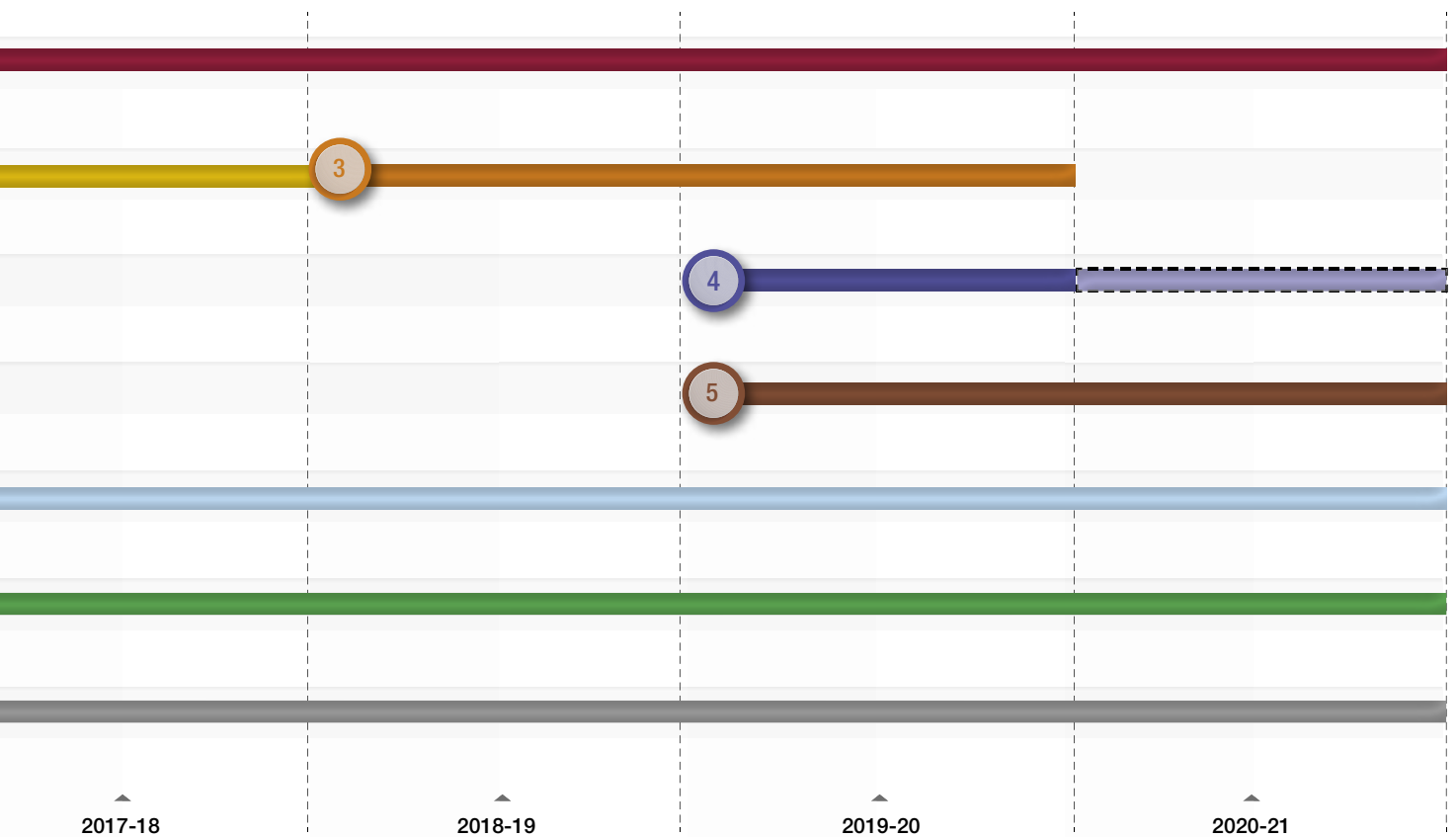
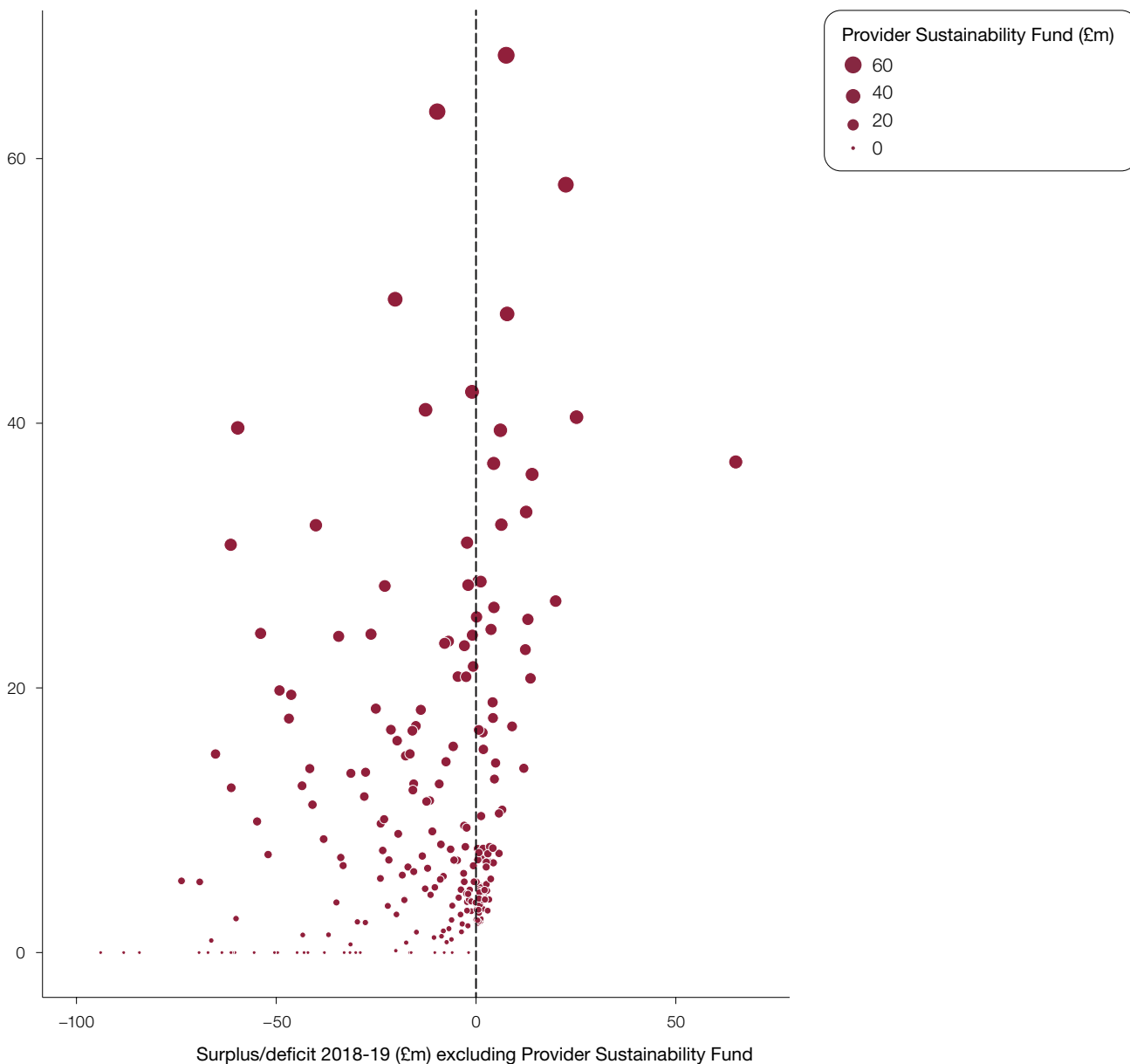


Figure 8

NHS trusts' and NHS foundation trusts' (trusts') financial performance and Provider Sustainability Fund payments in England, 2018-19

Trusts with weaker surplus/deficit performance have received less support funding on average than trusts with stronger surplus/deficit performance

Provider Sustainability Fund received 2018-19 (£m)



Note

1 The graphic excludes King's College Hospital NHS Foundation Trust, which reported a £190 million deficit and received £10 million in payments from the Provider Sustainability Fund.

Source: National Audit Office analysis of NHS trusts' and NHS foundation trusts' financial data and NHS Improvement data

Other financial support

2.16 The Department and NHSE&I may also provide financial support to trusts in difficulty (Figure 7). This can take the form of interest-bearing loans or non-repayable public dividend capital.¹² To deter trusts from overspending and incurring deficit, the Department has increasingly been offering this support in the form of loans rather than public dividend capital. NHS Improvement hoped that the Sustainability and Transformation Fund would replace the need for most direct cash funding from the Department to trusts. However, extra financial support to trusts in difficulty has continued to increase year-on-year, as has the loans balance.

2.17 In 2018-19, £3.6 billion was drawn down by trusts as interest-bearing short-term loans compared with £3.4 billion in 2017-18.¹³ Most of these loans (£3.3 billion) were interim revenue support loans, intended to pay for their day-to-day running costs and maintain services while they developed a financial recovery plan, rather than 'normal course of business' loans to trusts with evidence of longer-term viability and ability to repay the loans. The Department expects interim revenue support loans to transition into planned-term support after three years, when trusts have put in place an agreed recovery plan. Interim revenue support was introduced to incentivise trusts to improve their financial positions, but trusts told us that this has not worked in practice and no trusts have transitioned to planned-term support.

2.18 By 31 March 2019, outstanding debt issued by the Department to trusts in financial difficulty (interim support) was £10.9 billion, up from £8.0 billion on 31 March 2018 (Figure 9 overleaf). Outstanding debt relating to normal course of business loans to all trusts has remained relatively constant at around £3 billion. Since 2016-17, trusts have drawn almost £3 billion more than they have repaid each year, meaning that trusts drew down almost six times the value of their repayments in 2018-19. As in previous years, the profile of the loans and interest repayments indicates that there is no realistic prospect of this debt being repaid (Figure 10 on page 31). For example, 17 trusts in deficit are scheduled to make repayments that exceed 20% of their 2018-19 turnover. The Department aims to reduce trusts' reliance on interim revenue support through payments from the Financial Recovery Fund. The level of the payments that trusts receive depends on their agreed financial recovery trajectories.

2.19 Where trusts have been unable to repay loans in line with their initial agreements, they have been able to agree new repayment plans, moving loans from 'current' (expected within one year) to 'non-current' (expected after one year). The amounts moved from current to non-current increased from £4 million to £1,357 million between 2016-17 and 2018-19.

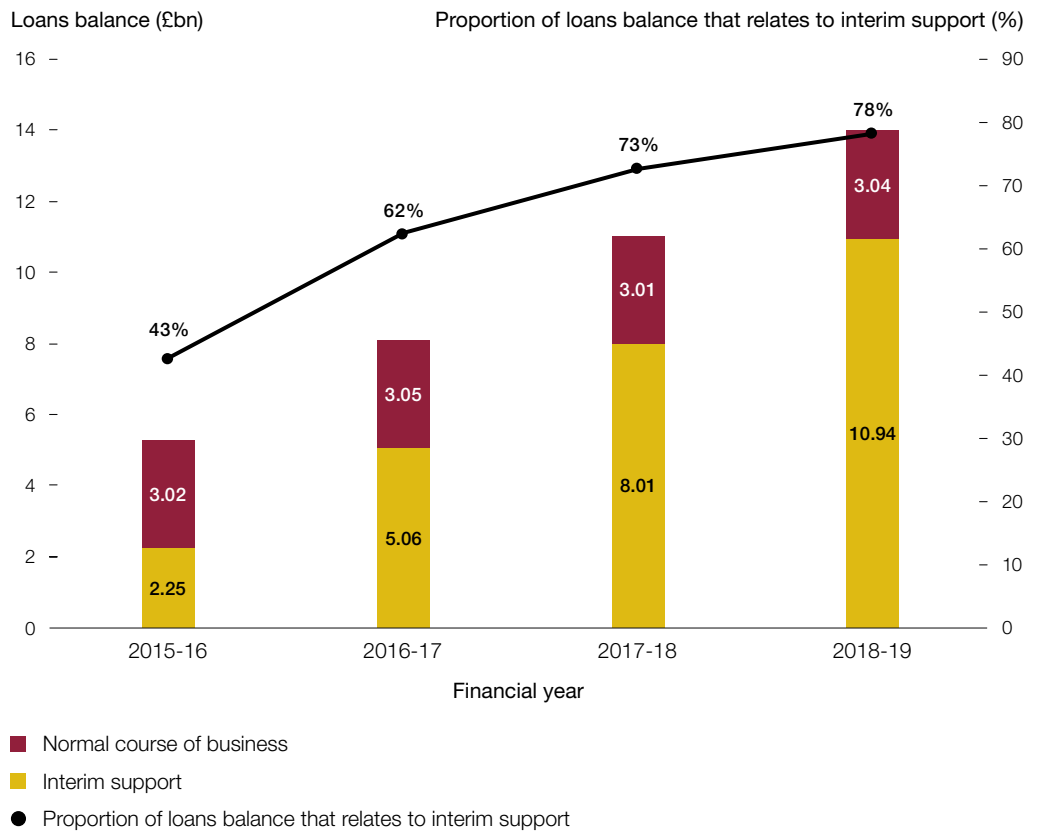
¹² Unlike interest-bearing loans, trusts do not have to pay back the public dividend capital they receive. However, it attracts a 3.5% annual charge on the net assets of trusts, but those in deficit with negative net assets do not need to pay this charge. Most interim support loans have been charged at 1.5% and the Department told us that providing support through loans rather than through public dividend capital has reduced finance costs for some providers.

¹³ In 2018-19, the Department also issued £759 million in public dividend capital and £50 million in planned-term support.

Figure 9

Closing balances for interim support and normal course of business loans to NHS trusts and NHS foundation trusts (trusts) in England, between 2015-16 and 2018-19

In 2018-19, interim support loans to trusts in difficulty accounted for more than three-quarters of the loans balance



Notes

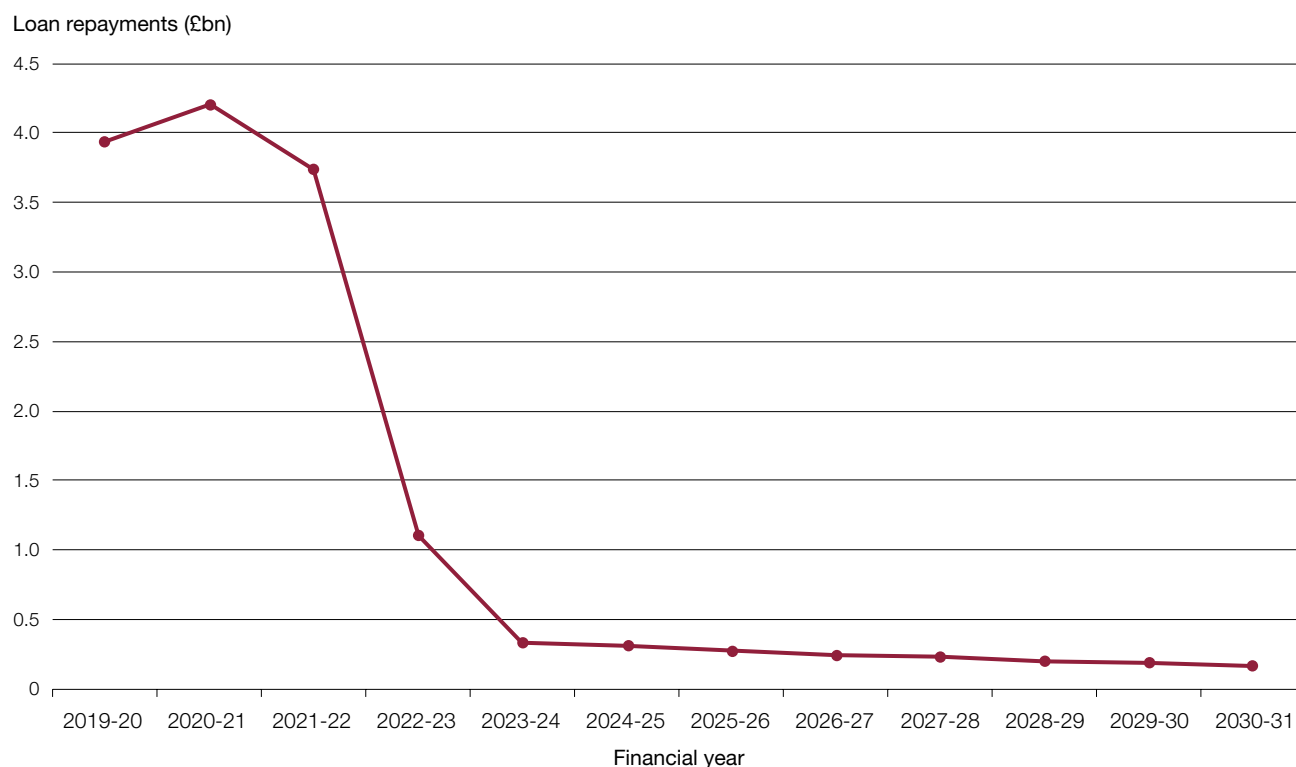
- Both interim support and normal course of business loans comprise capital and revenue financing, but because of their nature, interim support is predominantly revenue-based and normal course of business is predominantly capital-based (both more than 90% across all years considered).
- The loans balance represents the closing balances of the loans held by trusts prior to any adjustments at group level. The sum totals will therefore not be the same as the loans balance disclosed in the Department of Health & Social Care's accounts as financial assets.

Source: National Audit Office analysis of Department of Health & Social Care data

Figure 10

Loan repayments due to be repaid by NHS trusts and NHS foundation trusts (trusts) in England to the Department of Health & Social Care (the Department), 2019-20 to 2030-31

The current repayment profile is frontloaded with £11.9 billion of the £16.2 billion due to be repaid by 2021-22

**Notes**

- 1 Loans include all departmental interim and normal course of business loans for capital and revenue. The time series up to 2030-31 covers £15.1 billion of the £16.2 billion loans due. The last instalments are due in 2046.
- 2 Loans due for repayment represent principal and interest payments due by trusts reported at trust level, prior to any adjustments at group level. The sum totals will therefore not be the same as the loan balance disclosed in the Department's accounts as financial assets.

Source: National Audit Office analysis of Department of Health & Social Care data

2.20 Financing activity through loans is costly. Managing and servicing these interim loans is time-consuming and the interest accrued generates more costs to trusts that are already in deficit. The Department has moved away from punitive high-interest rates of 6% but interest rates still contribute to a significant amount of the balance owed. Of the £16.2 billion to be repaid, £1.3 billion relates to interest. The Department is reviewing its policy for interim revenue support, exploring options for refinancing existing debt and new financing.

Capital

2.21 Capital investment is essential for modernising and improving the quality of care and for achieving the changes that will make the NHS sustainable in the longer term. It is used to maintain existing assets, construct new buildings, replace medical and other equipment and to develop the infrastructure for transforming services. In recent years, the UK invested less capital in its healthcare services than other Organisation for Economic Co-operation and Development (OECD) countries. The OECD compares countries' net capital spend on healthcare assets as a percentage of gross domestic product (GDP) and placed the UK 26th out of 34 OECD countries in 2015.¹⁴ When controlling for population size, it invested the least in capital per head across the OECD. To bring capital spending in line with the OECD average would require an annual uplift of £5.6 billion by 2020-21.¹⁵

2.22 Since 2014-15, the Department has transferred £4.3 billion from capital to revenue spending. Transfers peaked at £1.2 billion in 2016-17 and have since decreased to £0.5 billion in 2018-19. These transfers mean that the Department has foregone longer-term investment in buildings and other long-term assets to support day-to-day spending on current services. In March 2019, the Department was unable to give a definitive measure of the impact on patients' services of repeatedly making these transfers. However, total backlog maintenance work was around £6.5 billion in October 2019 (**Figure 11**). High-risk backlog maintenance grew by 139% in cash terms between 2014-15 and 2018-19,¹⁶ much faster than the backlog as a whole, indicating an increased risk of harm to patients. Individual trusts told us about specific risks from failing operating theatres and dangerous ligature points.¹⁷

2.23 NHS providers' assessment of their need for capital funding has been consistently greater than the funding available. Local NHS bodies told us that the current capital regime does not address the challenges local economies face and expressed a need for a long-term capital strategy and settlement. They also repeated messages from previous years such as the difficulties accessing capital. For example, those most in need of capital investment may not be able to self-finance this investment and may need to apply to the Department for capital loans, which has an impact on their financial position.

¹⁴ Organisation for Economic Co-operation and Development, *Health Statistics 2017*, OECD National Accounts.

¹⁵ Chris Thomas, *The 'make do and mend' health service: solving the NHS' capital crisis*, Institute for Public Policy Research, September 2019.

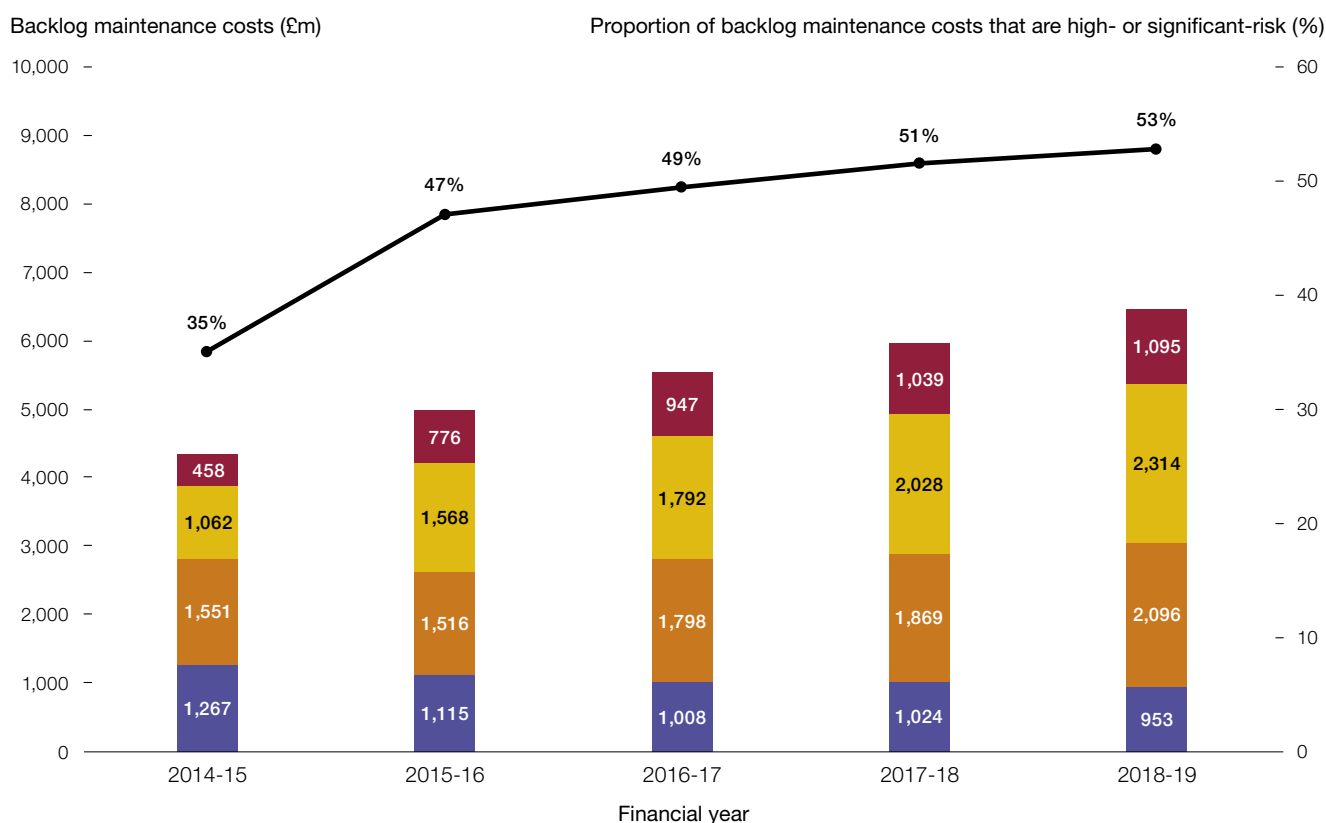
¹⁶ In real terms the high-risk backlog grew by 123% between 2014-15 and 2018-19.

¹⁷ Comptroller and Auditor General, *Review of capital expenditure in the NHS*, Session 2019-20, HC 43, National Audit Office, February 2020.

Figure 11

Backlog maintenance costs of NHS trusts and NHS foundation trusts (trusts) in England, between 2014-15 and 2018-19

The maintenance backlog has been growing with and increasing proportion being deemed significant- and high-risk



- High-risk
- Significant-risk
- Moderate-risk
- Low-risk
- Proportion of backlog maintenance costs that are high- or significant-risk

Notes

- 1 Significant-risk is where repairs or replacement require priority management and expenditure in the short term to avoid undue concern to statutory enforcement bodies or risk to healthcare delivery or safety. High-risk is where repairs or replacement must be addressed with urgent priority to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety, which are liable to cause serious injury and/or prosecution.
- 2 Data are taken from the annual Estates Returns Information Collection.
- 3 In real terms, the total backlog has grown from £4.6 billion in 2014-15 to £6.5 billion in 2018-19 (39%).

Source: National Audit Office analysis of NHS Digital data

2.24 The Department has acknowledged that parts of the NHS estate do not meet the demands of a modern health service and that there is a significant unmet need for capital in the NHS. It has also acknowledged that: the current approach to allocating capital funding is outdated; the approvals process is bureaucratic and difficult to navigate through; the lack of budget certainty over many years does not help to deliver projects effectively; and the capital regime has become disconnected from revenue and cash systems. A number of our reports in recent years have highlighted the government's failure to invest in other areas such as transport infrastructure and defence estate.¹⁸

2.25 In September 2019, the Department published the *Health Infrastructure Plan*, that seeks to deliver a five-year programme of investment in health infrastructure. It includes reforms to the capital system with clearer capital controls and a streamlined approvals process. It also plans to implement six new hospital projects. However, the strategy is contingent on a multi-year capital settlement which has yet to be set.

The underlying health of the NHS

2.26 Financial sustainability relies on local NHS bodies making year-on-year savings, rather than one-off savings. Relying on one-off measures means that bodies must find new savings each year in addition to savings already planned. Examples include leaving staff posts temporarily vacant and selling surplus buildings and land to generate income. In 2018-19:

- trusts saved £3,232 million, roughly the same as in 2017-18, but only 90% of their planned savings (**Figure 12**). The proportion that came from one-off savings increased to 31%, from 22% in 2015-16; and
- CCGs made £2,421 million of savings, 2.6% less than in 2017-18, and only 88% of the savings they planned (Figure 12). The majority (£313 million) of this shortfall arose from a failure to reduce unavoidable demand to the extent planned. The proportion that came from one-off savings decreased to 7%, from 10% in 2015-16.

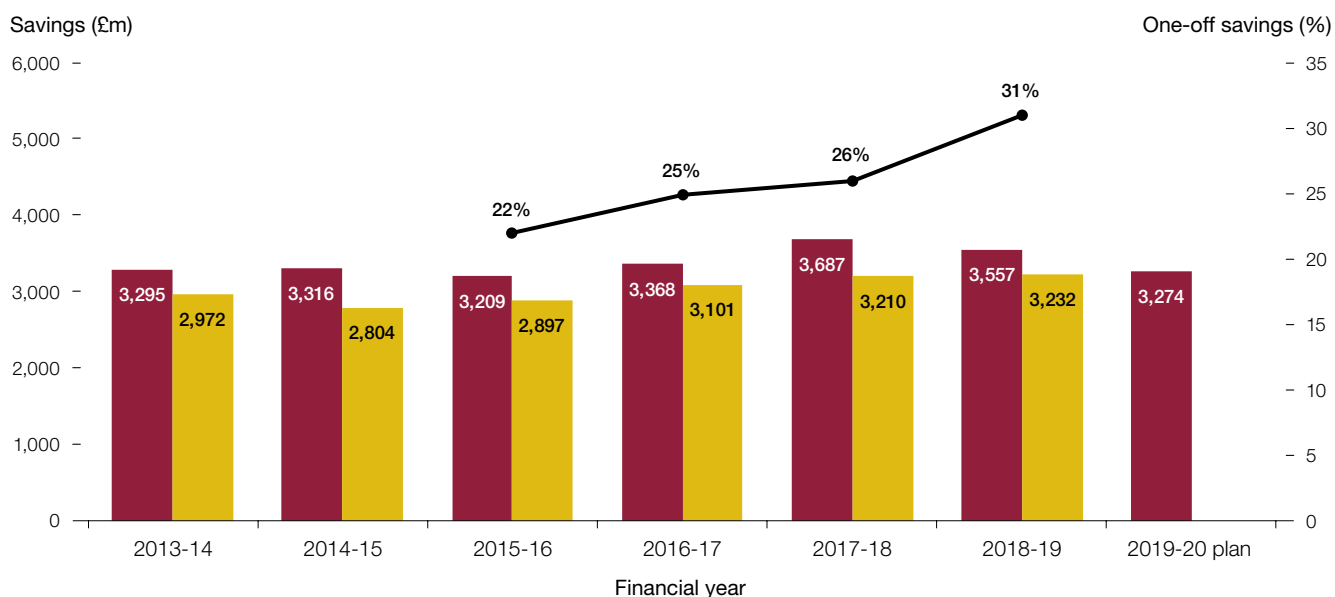
¹⁸ Comptroller and Auditor General, *Delivering the defence estate*, Session 2016-17, HC 782, National Audit Office, November 2016; and Comptroller and Auditor General, *Progress with the Road Investment Strategy*, Session 2016-17, HC 1056, National Audit Office, November 2017.

Figure 12

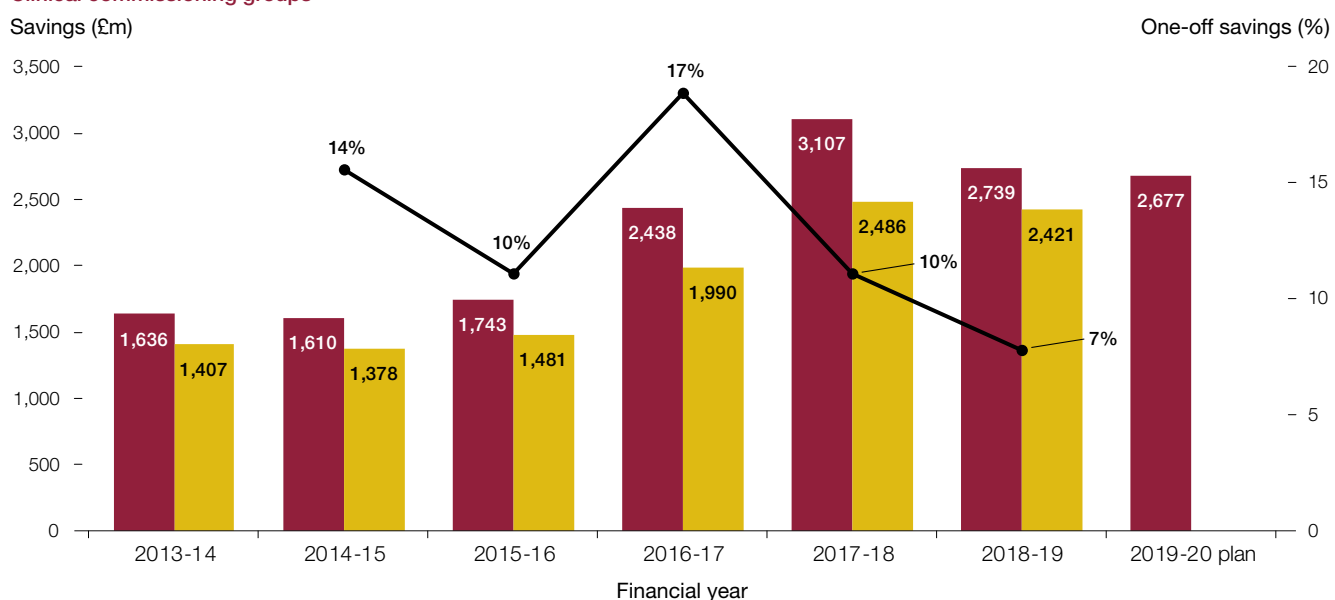
Savings planned and achieved by NHS trusts and NHS foundation trusts (trusts) and clinical commissioning groups in England between 2013-14 and 2018-19, and planned for 2019-20

Trusts are increasingly relying on one-off savings compared with clinical commissioning groups who are becoming less reliant on them

Trusts



Clinical commissioning groups



■ Planned savings (£m) ■ Actual savings (£m) ● Proportion of savings that were one-off (%)

Note

1 One-off savings, such as selling surplus buildings, do not generate future savings and need to be replaced with new savings in future years, in addition to savings already planned.

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

Part Three

Service transformation and sustainability

3.1 In this part we look at: what the NHS's last long-term strategy, the *Five Year Forward View*, has achieved;¹⁹ how local partnerships (sustainability and transformation partnerships and integrated care systems) between health and care organisations are progressing, and what NHS England and NHS Improvement (NHSE&I) are doing to support them to deliver the NHS's current long-term strategy, *The NHS Long Term Plan*.

NHS Five Year Forward View

3.2 Since 1974-75, health spending in real terms increased by 3.7% a year on average in England. Between 2015-16 and 2018-19, NHS England received smaller increases, averaging 2.4% a year. In 2014, the NHS published the *Five Year Forward View*, which set out its vision and strategy to help address the £30 billion gap it identified between patients' needs and the resources available to meet them by 2020-21. The strategy aimed to achieve better health, better care and financial sustainability by:

- moderating growth in demand for services through engaging with and empowering patients and wider communities to focus on public health and prevention; and
- strengthening care out of hospitals, with out-of-hospital care (primary and community) to become a much larger part of what the NHS does.

3.3 To deliver these changes and redesign NHS services, NHS England focused on developing and rolling out new care models to provide integrated services, including mental health and social care, around patient needs, through its 'vanguards' programme and on encouraging local health systems to work in partnership and think collectively through their local challenges and potential solutions (**Figure 13** on pages 38 and 39).

Focus on public health, primary and community services

3.4 The health and social care sector has not been able to focus as much on prevention and public health as expected, because of financial constraints in the NHS and local government. Although progress has been made in individual areas, such as the Diabetes Prevention Programme funded by NHS England, between 2015-16 and 2018-19 funding for public health interventions in local authorities has decreased in real terms (**Figure 14** on page 40). For example, the public health grant to local authorities decreased by £0.5 billion (12%) in real terms over this period.

19 NHS England et al, *Five Year Forward View*, October 2014.

3.5 The *Five Year Forward View* also aimed to strengthen care out of hospitals, with primary and community care becoming more integrated and a much larger part of what the NHS does. However, between 2015-16 and 2018-19, the percentage of the NHS's total expenditure accounted for by hospitals increased from 62.7% to 65.2%, while the percentage accounted for by primary medical and community health services decreased from 20.0% to 19.4%.²⁰ In addition, ongoing pressures in social care provision presented challenges for NHS services. In 2018-19, real-terms expenditure on adult social care was less than it was in 2009-10. The number of clients receiving long-term care has decreased each year since 2015-16, to 841,850 in 2018-19. The government made a commitment to ensure that adult social care funding is such that it does not impose any additional pressure on the NHS over the period 2019-20 to 2023-24.

Developing new care models

3.6 In 2015, NHS England selected 50 sites to act as 'vanguards' (Figure 13) to lead the development of five new care models that could later be replicated rapidly across England. NHS England's original intention to expand the vanguard programme, with a further five waves of vanguards, was not realised because funding was reallocated to reducing NHS trusts' and NHS foundation trusts' (trusts') financial deficits.²¹

3.7 In 2015, the Department of Health & Social Care (the Department) mandated that NHS England should spread the population-based new care models (three of the five models) to cover 50% of the population by 2020-21. When the vanguards programme ended, 9% of the population was covered by these new care models. In addition, a further 15% of the population were covered by more than 200 'primary care homes', a smaller-scale care model developed outside the vanguards programme but supported by its funding. These led to the development of primary care networks, which have been rolled out across the country (see paragraph 3.13). NHSE&I told us that the responsibility for implementing new care models will in future fall to integrated care systems.

3.8 Evaluation of the programme found that while there were signs that some new care models had a positive impact on moderating growth in demand for urgent care, the programme had not provided the evidence needed at a system level on what worked and what did not work. It also concluded that evidence on the cost-effectiveness of the new care models tested was inconclusive and that access to routine shared data was a challenge in local evaluations.²²

20 The total expenditure in primary medical and community services increased by 9.0% in cash terms over this period.

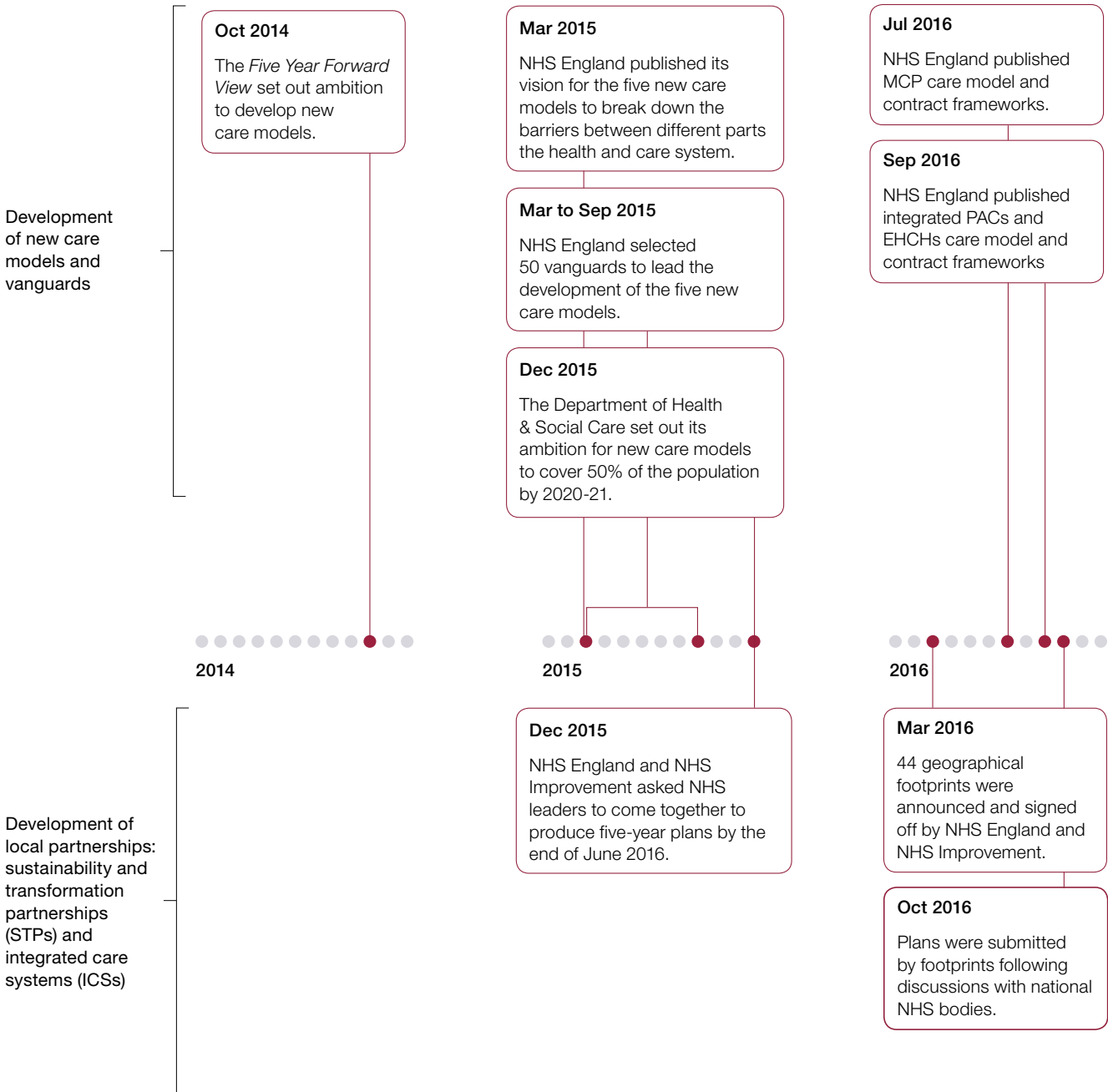
21 Comptroller and Auditor General, *Developing new care models through NHS Vanguards*, Session 2017-2019, HC 1129, National Audit Office, June 2018.

22 Checkland et. al., *Interim report: understanding the national support programme*, March 2019 and Checkland et. al., *Investigating locally commissioned evaluations of the NHS Vanguard Programme*, August 2019.

Figure 13

Timeline of key developments in new care models and local partnerships

Five new care models: multispecialty community providers (MCPs); integrated primary and acute care systems (PACs); enhanced health in care homes (EHCHs); acute care collaborations (ACCs) and urgent and emergency care (UECs)



Source: National Audit Office literature review

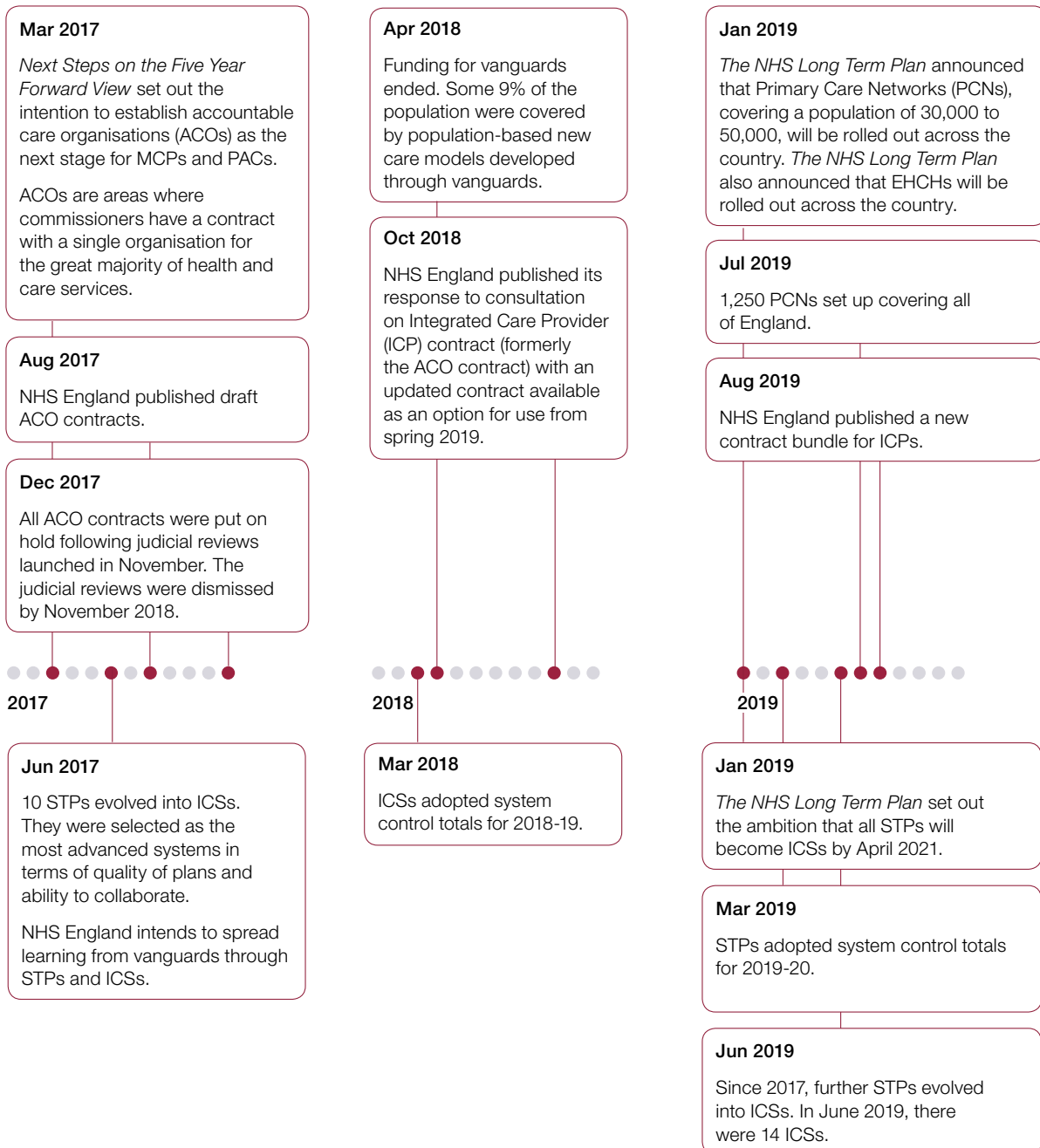


Figure 14

Spending on public health, primary care and community services, and hospital services in England, 2015-16 and 2018-19

Between 2015-16 and 2018-19, there was a real-term reduction in public health grant to local authorities and an increase in hospital expenditure as a percentage of total NHS expenditure

	2015-16	2018-19
Public Health England's budget ¹ (£m)	962	1,002
Public health grant given to local authorities (£m)	3,676	3,219
Primary medical and community health services expenditure as a percentage of total NHS expenditure (excluding community services expenditure incurred by hospitals) (%)	20.0	19.4
Hospitals' expenditure as a percentage of total NHS expenditure (%)	62.7	65.2

Notes

- 1 Public Health England's budget excludes the public health grant given to local authorities that is shown separately in this table.
- 2 All budgets are in 2018-19 prices.

Source: National Audit Office analysis of Department of Health & Social Care and NHS Digital data

Overall progress

3.9 Although the *Five Year Forward View* did not achieve as much as it set out to transform services, most stakeholders we spoke to believed that it has laid the foundations from which *The NHS Long Term Plan* can build on. Improvement was also made in several service areas that the NHS has chosen to prioritise, including access to mental health services and cancer services. Stakeholders welcomed the vision and the direction of travel commenced in the *Five Year Forward View*, including the focus on prevention, public health, mental health services and integration. They told us that it has helped to establish a consensus for the need to work collaboratively across local systems with an emphasis on populations, places and systems.

Establishing local partnerships

3.10 Sustainability and transformation partnerships bring together clinical commissioning groups (CCGs), trusts and local authorities, along with primary care and voluntary sector representatives, to think collectively through their local challenges and potential solutions (see Figure 13). Our previous work found that the 44 original partnerships (there are now 42) started from very different positions. For some, strong partnership working already existed, but in other areas, organisations had never come together to work collaboratively this way before.²³

²³ Comptroller and Auditor General, *NHS financial sustainability*, Session 2017–2019, HC 1867, National Audit Office, January 2019.

3.11 Local partnerships continue to progress at different rates, with 14 areas having evolved into integrated care systems, with an aim to have more closer joint working and to take a more strategic approach to health spending with less involvement of national regulators. NHSE&I has committed to having integrated care systems covering the whole country by April 2021. As we reported last year, it is difficult to assess progress of the partnerships across England because no national assessment has been carried out since July 2017. NHSE&I has developed a maturity matrix against which local partnerships can rate themselves against five objectives: system leadership and change capability; system architecture and strong financial management and planning; integrated care models; track record of delivery; and coherent and defined population.

3.12 Most partnerships continue to face significant challenges in managing demand within their budget. In 2018-19, 64% of partnerships had deficits when all their constituent trusts' and CCGs' finances were added together, down from 73% in 2017-18 (**Figure 15** overleaf). **Figure 16** on page 43 highlights some of the main challenges faced by local partnerships, many of which have been highlighted in our previous reports. Some of these challenges may affect partnerships' ability to deliver *The NHS Long Term Plan*. Local bodies we visited told us that partnerships remain 'coalitions of the willing' as they are constrained by the existing legislative framework. They cannot form joint decision-making committees and rely primarily on the goodwill of participating organisations. NHSE&I, with the support of a wide range of stakeholders, has recommended amendments to legislation in September 2019 to help promote collaboration and service integration.

3.13 As of October 2019, 1,250 primary care networks had been established. They were designed to cover populations of between 30,000 and 50,000, but there are variations to this standard model that are driven by local factors.²⁴ They are groupings of local general practices that aim to drive transformation and sustainability within primary care by facilitating the sharing of non-GP staff and greater collaboration while maintaining the independence of individual practices. The networks will receive funding to employ up to 20,000 non-GP staff such as pharmacists and paramedics and will give primary care more influence within sustainability and transformation partnerships and integrated care systems. Networks will be responsible for the delivery of some of the commitments in *The NHS Long Term Plan* through the introduction of seven service specifications. These service specifications are: a structured medications review and optimisation; enhanced health in care homes; anticipatory care; personalised care; supporting early cancer diagnosis; cardiovascular disease prevention and diagnosis; and tackling neighbourhood inequalities. The first five service specifications will be introduced in full or partially in 2020-21, with the remaining specifications coming into force in 2021-22.

²⁴ For example, Barnsley's 'super-network' comprises six primary care networks, covering a population of 260,000, whereas some rural networks cover a population size of 20,000.

Figure 15

The surplus/deficit of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) in England, 2018-19

Out of the 42 partnerships, 27 had a deficit in 2018-19, when all their constituent NHS trusts' and NHS foundation trusts' (trusts') and clinical commissioning groups' (CCGs)' finances were added together

Surplus/deficit of sustainability and transformation partnership (STPs) and integrated care systems (ICSs) (trusts and CCGs)

- Deficit greater than £150 million
- Deficit of £101 million to £150 million
- Deficit of £51 million to £100 million
- Deficit up to £50 million
- No surplus or deficit
- Surplus of up to £50 million
- Surplus greater than £50 million

Areas working towards developing an ICS

Wave 3

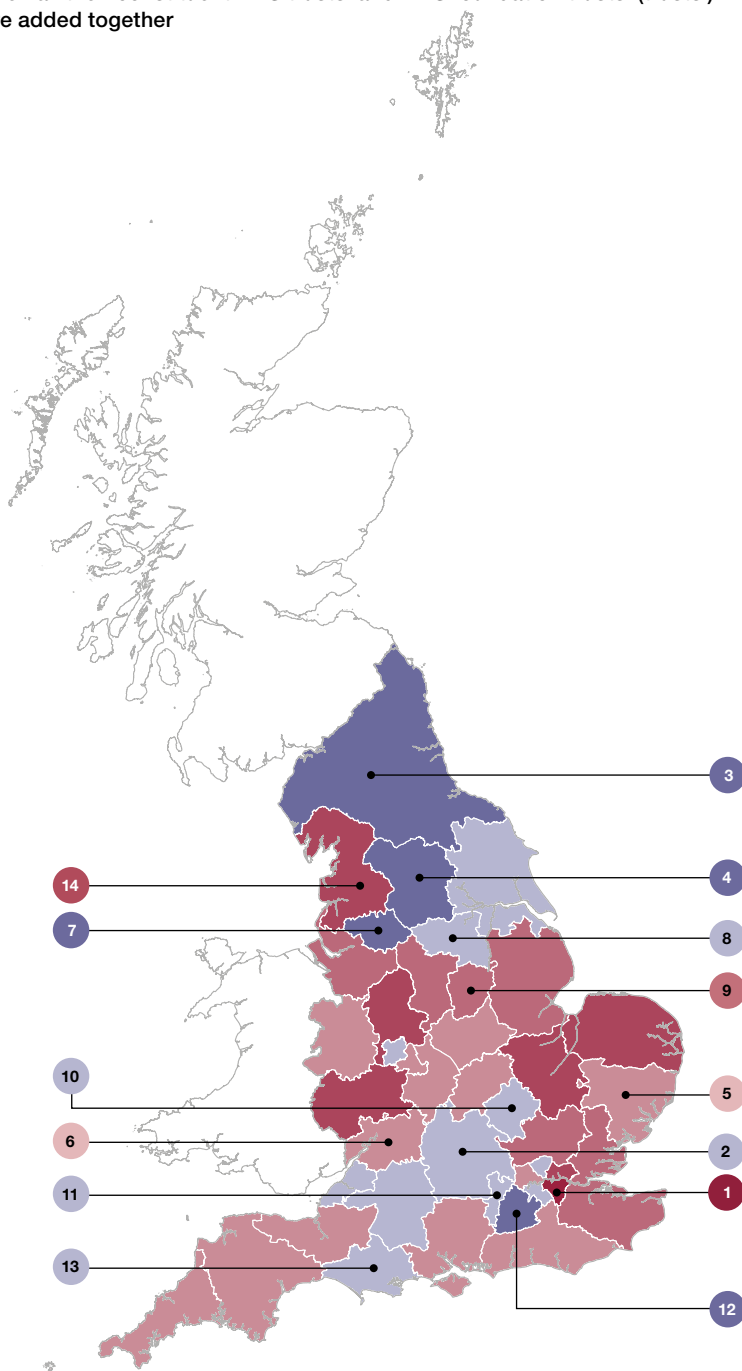
- ① South East London
- ② Buckinghamshire, Oxfordshire and Berkshire West
- ③ North East and North Cumbria

Wave 2

- ④ West Yorkshire
- ⑤ Suffolk and North East Essex
- ⑥ Gloucestershire

Wave 1

- ⑦ Greater Manchester
- ⑧ South Yorkshire and Bassetlaw
- ⑨ Nottinghamshire
- ⑩ Milton Keynes, Bedfordshire and Luton
- ⑪ Frimley Health and Care
- ⑫ Surrey Heartlands
- ⑬ Dorset
- ⑭ Lancashire and South Cumbria

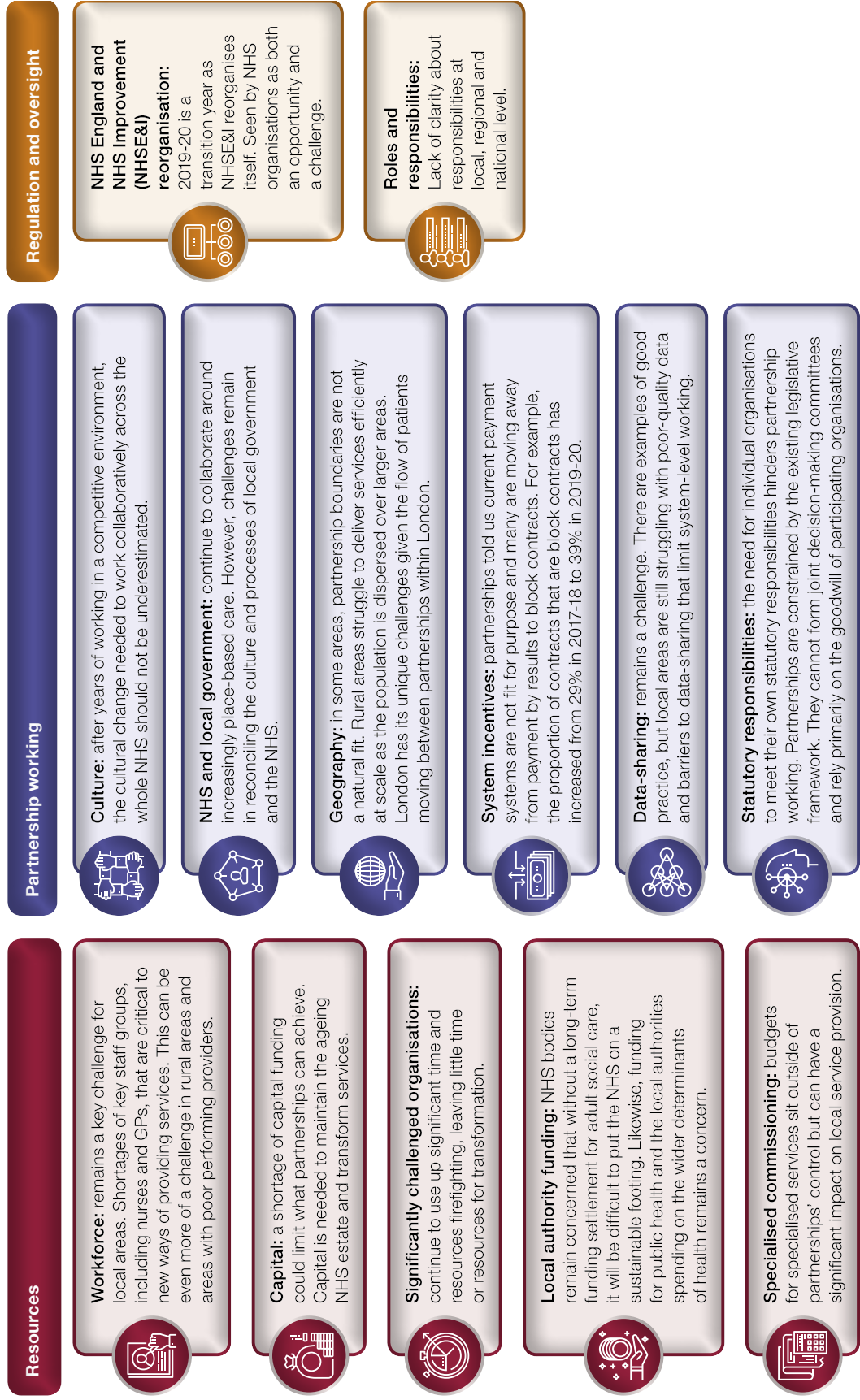


Note

1 There were no sustainability and transformation partnerships in the category 'no surplus or deficit', which we have defined as having a surplus or deficit less than £1,000.

Figure 16 Summary of the main challenges raised by sustainability and transformation partnerships and integrated care systems in England

The main challenges include resources, system incentives and regulatory processes



The NHS Long Term Plan

3.14 In June 2018, the Prime Minister announced a long-term funding settlement for the NHS, which will see NHS England's budget grow by an average 3.4% a year in real terms between 2019-20 and 2023-24. This amounts to a £33.9 billion increase in cash terms by 2023-24 (**Figure 17**). In January 2019, NHS England published its long-term plan for the next 10 years that sets out how the NHS aims to achieve the range of priorities and five financial tests, set by the government in return for the five-year funding settlement. The government's priorities included:

- making progress towards agreed waiting times;
- transforming cancer care, better access to mental health services;
- better integration of health and social care; and
- focusing on preventing ill-health.

3.15 For the five financial tests, the NHS will:

- return to financial balance;
- achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;
- reduce the growth in demand for care through better integration and prevention;
- reduce variation across the health system, improving providers' financial and operational performance; and
- make better use of capital investment and its existing assets to drive transformation.

3.16 The plan builds on, and learns lessons from, the *Five Year Forward View*.

For example, the plan:

- continues a focus on the integration of health and social care services, prevention and partnership working;
- continues to encourage collaboration and risk-sharing in contracts between commissioners and trusts;
- sets more realistic expectations for health systems due to the additional funding. For example, it does not expect the level of savings from service transformation that the *Five Year Forward View* did and has set a more prudent target for efficiencies from trusts (1.1% plus an additional minimum of 0.5% for trusts in deficit), compared with the 2% trusts were set over recent years;

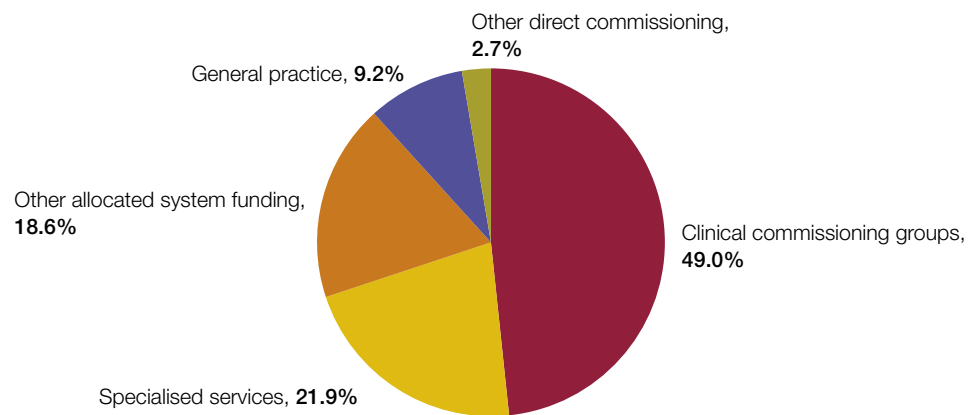
- commits investment to priority areas such as primary care and community health services (£7.1 billion) and mental health (£3.4 billion), representing 31% of the total increase in funding between 2019-20 and 2023-24; and
- recognises the importance of the workforce required to deliver the plan as one of its biggest risks. NHS Improvement published an *Interim NHS People Plan* in June 2019, with a focus on the actions needed for 2019-20. A final people plan is due to be published in spring 2020.

Figure 17

Breakdown of the £33.9 billion cash increase in NHS England's budget between 2019-20 and 2023-24

Almost half of the additional funding will be allocated to clinical commissioning groups

Breakdown by commissioning stream



More than 30% of the additional funding will be allocated to mental health and primary medical and community services.

Notes

- 1 Other direct commissioning includes public health, armed forces and health and justice.
- 2 Other allocated system funding includes funding for commitments in *The NHS Long Term Plan* and service development.
- 3 Percentages do not sum due to rounding and because some allocations will decrease over this period, such as NHS England's central administration and programme costs.

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

3.17 Figure 16 sets out some of the main challenges raised by local partnerships. Many of these could impact their ability to deliver *The NHS Long Term Plan*. Key risks to its delivery:

- **Ambition:** Local bodies told us that the funding settlement may not be enough to deliver all the ambitions set out in the plan. The plan contains more than 500 general ambitions and more than 100 commitments. Local partnerships have substantial freedoms to define their pace of delivery for most commitments with only about half needing to be delivered in line with nationally defined timetables.²⁵ However, local bodies told us that they will still need to deliver all the commitments over the life of the plan, which will be very challenging.
- **Workforce shortages:** Local NHS bodies told us this was one of the biggest risks to the delivery of the plan. The NHS continues to struggle to fill vacancies for nurses and clinicians. NHS's own estimates indicate that demand for nurses is likely to outstrip supply for some years to come.
- **Key areas of health spending are excluded from the funding settlement:** There is still a lack of clarity over areas of spending not covered by the long-term funding settlement. This includes prevention initiatives run by Public Health England and local authorities and funding for doctors' and nurses' training, which have reduced in recent years. For example, Health Education England's budget, which covers the costs of education and training clinical staff and staff development, has reduced by 15% since 2015-16 in real terms. The 2019 Spending Review originally intended to set day-to-day budgets for three years. However, it only provided budgets for one year.
- **Capital:** A long-term capital settlement for the NHS has yet to be announced. The 2019 Spending Review initially planned to set capital budgets for four years. However, it only provided budgets for one year.
- **Adult social care:** There is a lack of clarity regarding a funding settlement for adult social care. *The NHS Long Term Plan* assumes that adult social care funding does not impose additional pressure on the NHS over the coming five years. Local NHS bodies remain concerned that without a long-term funding settlement for adult social care, it will be very difficult to make the NHS sustainable. Some cited this as the biggest problem facing the NHS, ahead of workforce shortages.
- **Prevention:** Reduced local authority funding and government spending over the past decade is likely to have an impact on the future demand for health services through the wider determinants of a person's health, such as education, housing and work.

Support and oversight

3.18 Last year's report highlighted that NHS England and NHS Improvement had continued to make organisational changes to help them work closer together.²⁶ From 1 April 2019, they have been working together as a single organisation (NHSE&I), aligning the way they work to support system working. The NHS oversight framework for 2019-20 set out a new approach to oversight where NHSE&I's regional teams review performance and identify support needs across sustainability and transformation partnerships and integrated care systems with a single voice, a greater emphasis on system performance, working with and through system leaders, and greater autonomy for systems with evidenced capability for collective working and a track record of successful delivery of NHS priorities.

3.19 NHSE&I is also working with the Care Quality Commission to ensure the special measures regime continues to work effectively. This includes developing an early warning system to help identify organisations or health systems that may be slipping into difficulties. NHSE&I is also exploring how the focus of the intensive support previously provided to individual organisations will need to be broadened to support local health systems.

3.20 Local areas we visited reported that NHSE&I's approach continued to feel more joined-up but that regional teams were still in a state of transition. Local bodies told us that NHSE&I's regional teams were working more in collaboration with local partnerships than before and that more honest conversations were being had, for example, the different nature of different footprints within regions. Local partnerships told us that regional teams are broadly considered as partners and that this has been a positive development. However, local bodies told us that it is not clear where responsibilities will sit between the national and regional NHSE&I teams, but also between regional teams and local partnerships.

Developing implementation plans for *The NHS Long Term Plan*

3.21 NHSE&I published an implementation framework in June 2019, alongside an interim workforce implementation plan, to support local bodies to develop their local implementation plans. Local partnerships submitted their draft plans to national bodies in September 2019 and their final plans were due to be published in November 2019. As of January 2020, these plans were yet to be released. Once these local plans are published, NHSE&I intends to publish its national implementation plan. The Department required these plans to have "detailed, costed annual milestones and trajectories for key commitments and reforms to deliver *The NHS Long Term Plan*, both at a national and local level", and "the NHS England and NHS Improvement Boards must fully assure themselves that the national implementation programme is affordable, realistic and deliverable as well as within the agreed financial settlement".

²⁶ See footnote 23.

Appendix One

Our audit approach

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

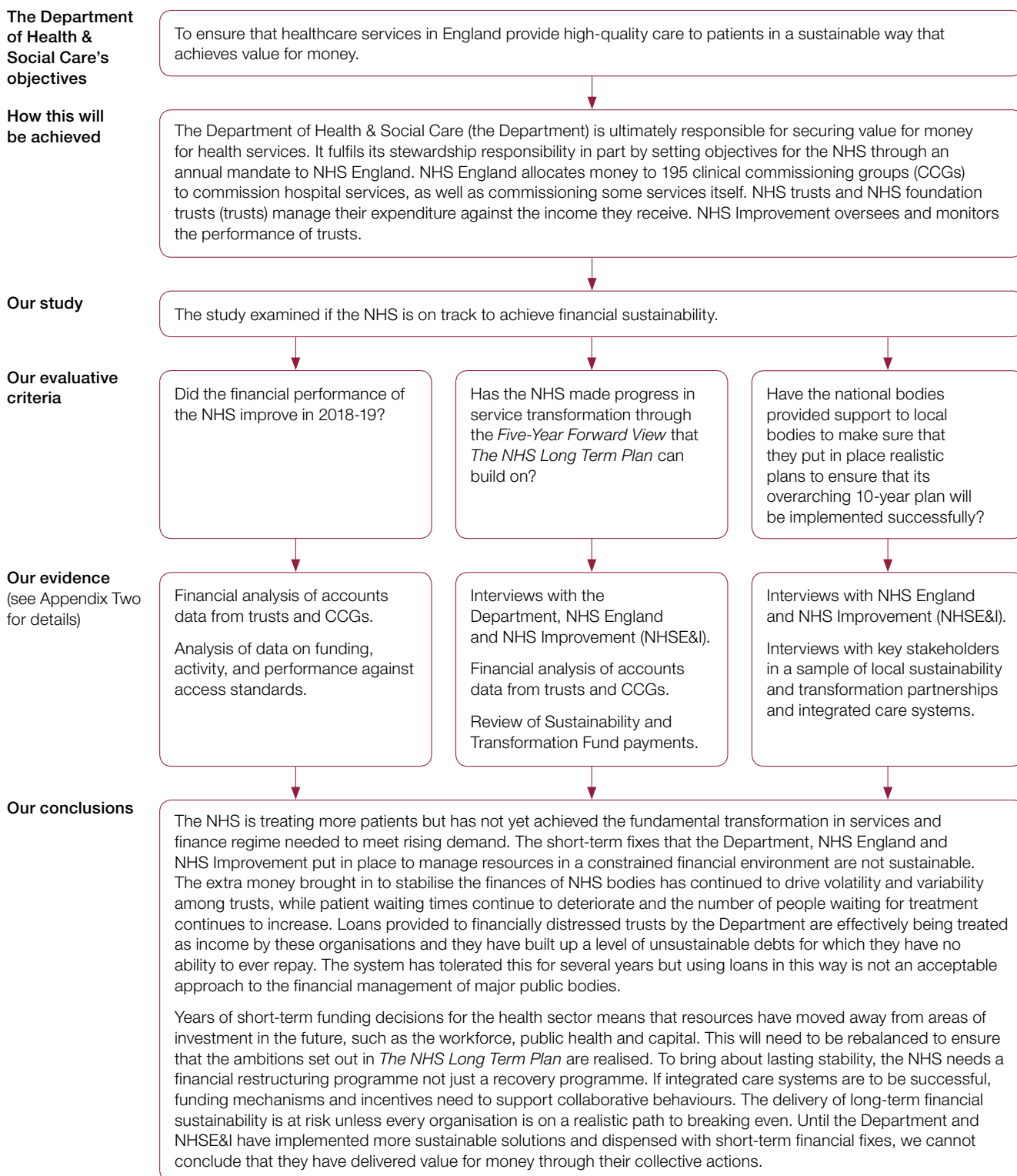
- headline financial performance of the NHS overall in 2018-19;
- financial performance of NHS organisations; and
- progress with NHS service transformation and sustainability.

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

3 We do not look in detail at primary care, social care, the integration of health and social care, public health or similar services, although the transformation and sustainability of these services are main elements of these new partnerships' work and are important to the sustainability of the NHS. However, this report draws on our previous work in these areas.

4 Our audit approach is summarised in **Figure 18**. Our evidence base is described in Appendix Two.

Figure 18
Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on if the NHS is on track to achieve financial sustainability after analysing evidence we collected between July and November 2019. Our audit approach is outlined in Appendix One.

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

- the financial position of the NHS in 2018-19;
- a time series analysis of clinical commissioning groups' (CCGs') finances against their planned and actual year-end positions;
- a time series analysis of the financial position of NHS trusts and NHS foundation trusts (trusts) against surplus/deficit, income, current assets and current liabilities;
- additional financial support compared with previous years and the profile of loans repayments;
- a time series analysis of backlog maintenance costs;
- a time series analysis of budget and expenditure for different areas of the health and social care services, including social care, public health, primary medical and community health services, hospitals, and health education;
- a time series analysis of NHS activity; and
- a time series analysis of performance against key access standards.

3 We carried out a review of the Provider Sustainability Fund and Commissioner Sustainability Fund in 2018-19. For the Provider Sustainability Fund, we assessed: the outcomes of the Fund against NHS England and NHS Improvement's stated objectives; the distribution of general, core, incentive and bonus payments to trusts; and the impact on trusts' financial positions at the end of the year. For the Commissioner Sustainability Fund, we assessed the size of the Fund and the distribution of payments to CCGs.

4 We analysed data on quality, innovation, productivity and prevention savings made by CCGs and cost improvement programme savings made by trusts. This included:

- trends in achieved savings against planned savings between 2013-14 and 2018-19, and planned savings for 2019-20; and
- levels of recurrent and non-recurrent savings and, for trusts, levels of generated income.

5 We reviewed a range of key policy documents, board papers and reports. These included documents published by the Department, NHS England and NHS Improvement, the Care Quality Commission, Health Education England, think tanks and academic organisations. The documents reviewed include the *Five Year Forward View*, *Next Steps for the Five Year Forward View*, *The NHS Long Term Plan*, NHS planning documents and implementation frameworks, performance reports and evaluations of NHS vanguards published by both NHS and non-NHS bodies.

6 We spoke to a range of staff across the Department and NHSE&I.

This was to understand the support that they have given to local bodies to make savings and financial improvements, and the support they are giving to sustainability and transformation partnerships and integrated care systems. We also spoke to a selection of staff from NHSE&I's regional offices.

7 We interviewed a range of stakeholders. This work was designed to get views on: financial pressure and challenges within the NHS; oversight by national bodies; the support given to local bodies and systems; and progress in partnership working. We consulted with the Academy of Medical Royal Colleges, the Association of Directors of Adult Social Services, the Care Quality Commission, the Healthcare Financial Management Association, Healthwatch, the Health Foundation, the King's Fund, the Local Government Association, NHS Clinical Commissioners, NHS Providers, the Nuffield Trust, the Shelford Group and the University Hospitals Association.

8 We conducted interviews at a sample of six sustainability and transformation partnerships between August and November 2019. This work was designed to understand the:

- progress in implementing plans to transform services;
- challenges faced by local systems in building effective partnerships and delivering *The NHS Long Term Plan*; and
- support provided by national bodies to tackle these challenges.

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

- a range of progress as assessed by NHS England's July 2017 ratings, including two integrated care systems;
- a broad geographic spread across England; and
- a range of rural and non-rural partnerships.

10 We met with 78 individuals representing more than 40 different organisations.

Appendix Three

Regression analysis

1 From our literature review and discussions with stakeholders, we identified several factors that could be related to trusts' financial performance. These included: the price paid (tariff) for NHS services; staff composition; productivity and efficiency; patient profiles including age, severity and level of deprivation; level of exposure to emergency activity; location and size of a trust; and management and leadership of a trust. We carried out a range of regression analyses to explore whether and to what extent the association between these factors and the financial performance could be supported by existing data.

Data sources and limitations

2 Many of the datasets we used were collected for existing administrative purposes and not specifically for our regression analysis. These datasets included financial accounts, Hospital Episode Statistics and NHS staff data published by NHS Digital, and ratings data published by the Care Quality Commission (CQC). These datasets are of variable quality and completeness. We reviewed, but did not validate, these datasets. Where there are known data issues, we have taken a conservative approach wherever possible, for example, by comparing results including, and excluding, outliers from our analysis.

3 Given the limitations in the data used, both in terms of quality and availability, we explored a range of model constructs and indicators to ensure that our findings were not skewed by a particular model selection. Our analysis was explorative in nature and aimed primarily at stimulating further analysis and debate on the topic. Findings from these analyses should not be considered as conclusive.

4 The analysis covers a panel of acute trusts that reported financial performance in 2015-16 2016-17 and 2017-18. Trusts that merged in-year or that did not report performance in all three years were excluded. The data exclude acute specialist and multi-service trusts. The final data selected comprised 393 observations, 359 of which were included in the model.

5 The analysis was first undertaken using two types of models: multilinear regression with robust standard errors covering all trusts irrespective of year but controlling for prior year financial performance; and a fixed effect panel model estimating correlations grouped by year. We decided to drop the fixed effect panel regression analysis due to the limited number of years (three) covered. The final model controlled for year and trust-specific characteristics such as demographics (deprivation decile) and overall quality performance (CQC ratings). The model was run with robust and clustered robust standard errors.

6 The dependent variable used to estimate provider performance was operating margin, calculated as the operating balance of a trust as a percentage of its total operating income. We excluded incomes from various support funding in our calculations as they were not directly linked to the costs of day-to-day operations.

7 To ensure that we selected the best indicators available, we explored a number of variables that were not included in our final model selected, either because they are not significantly correlated with operating margin at a statistically significant level or were too closely related with each other to build a robust model. This included case complexity (using the Charleston Comorbidity Index derived from Hospital Episode Statistics for admitted patients), pressures on emergency services (accident and emergency activity as proportion of overall activity, and beds taken up by emergency cases) and the relative rurality of provider trusts.

8 The model controls for trust-specific characteristics that are hypothesised to influence financial performance, controlling for trust size (NHS Improvement's breakdown of small, medium, large and large-teaching), demographics (Index of Multiple Deprivation), overall care quality (CQC ratings), and exposure to non-elective services (proportion of A&E activity of total activity). Finally, prior year deficit was introduced as a dummy to control for prior year deficit.

9 **Figure 19** summarises the findings from our regression analysis. We reported findings using the initial robust standard errors and the final model using clustered robust standard errors to address the potential correlation of error terms within trusts over time. If a factor is significantly correlated with operating margin tested at a 10%, 5% and 1% confidence level, we described it as "significant" and indicated the significance level for each model.

Figure 19

Statistical association between factors relating to an NHS trust's or NHS foundation trust's financial performance

Some factors are significant with a trust's financial performance, controlling for trust-specific characteristics

Factors correlated with operating margin	Statistically significant (using clustered and robust standard errors)		Direction of association with financial performance (operating margin)
	Clustered	Robust	
Exposure to income based on national tariff	Significant at 10%	Significant at 5%	Trusts with a higher proportion of income subject to national tariff tend to have a lower level of operating margin.
Expenditure on agency staff	Significant at 1%	Significant at 1%	Trusts with a higher proportion of spending on agency staff tend to have a lower level of operating margin than trusts with a lower proportion.
Patient age	Significant at 5%	Significant at 1%	Trusts with a higher proportion of older patients (using either mean age or the proportion of patients aged over 65) tend to have a lower operating margin.
Consultants as proportion of qualified staff	Not significant	Significant at 10%	Trusts with a higher proportion of consultants employed tend to have a higher operating margin than trusts with a lower proportion.

Note

1 The regression excludes trusts labelled as multi-service (three unique trusts in the panel).

Source: National Audit Office analysis of NHS trusts' and NHS Foundation trusts' financial data, NHS England and NHS Improvement data, NHS Digital data and Office for National Statistics data

Appendix Four

Technical notes

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

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

Presentation of figures

3 Except where otherwise noted, figures are presented in nominal terms and have not been adjusted for inflation. June 2019 gross domestic product (GDP) deflators are used to adjust for inflation unless otherwise noted.

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

5 Income figures for trusts include:

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

6 Expenditure figures for 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 a share of profit or loss of associates and joint arrangements, gains and losses on disposals of assets, and other movements in fair values of assets;

- corporation tax expenses; and
- premiums payable for clinical negligence liabilities.

7 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, to reflect the impact on trusts which could not have been planned at the start of the year.

Organisational changes during 2018-19

8 On 31 March 2018, there were 232 trusts in existence. On 1 April 2018, Heart of England NHS Foundation Trust was taken over by University Hospitals Birmingham NHS Foundation Trust, and Liverpool Community Healthcare NHS Trust was taken over by Mersey Care NHS Foundation Trust. Three further mergers occurred in 2018-19, bringing the final number of trusts at the end of the financial year to 227:

- Staffordshire and Stoke-on-Trent Partnership NHS Trust was taken over by South Staffordshire and Shropshire Healthcare NHS Foundation Trust and became Midlands Partnership NHS Foundation Trust;
- Burton Hospitals NHS Foundation Trust was taken over by Derby Teaching Hospitals NHS Foundation Trust and became University Hospitals of Derby and Burton NHS Foundation Trust; and
- Ipswich Hospital NHS Trust was taken over by Colchester Hospital University NHS Foundation Trust and became East Suffolk and North Essex NHS Foundation Trust.

Adjustments to trusts' figures

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

- before net impairments;
- before the impact of absorption, accounting for bodies that merged or were acquired by other organisations;
- before the consolidation of trusts' charitable fund subsidiaries; and
- after the effects of any income support provided by the Department and NHS England.

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

Reporting of clinical commissioning groups' figures

11 NHS England monitors the performance of individual clinical commissioning groups (CCGs) based on the underspend or overspend calculated by comparing their planned outturn and actual outturn for the year. No adjustments are made to the outturn reported by individual CCGs in their annual report and accounts when calculating the underspend or overspend.

12 NHS England also monitors the combined performance of CCGs after technical adjustments to exclude:

- non-cash transactions such as depreciation, amortisation and impairments of assets;
- capital grants expenditure incurred; and
- the movement in provisions and any payment of provisions.

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National Audit Office

Design and Production by NAO External Relations
DP Ref: 007698-001

£10.00

ISBN 978-1-78604-299-6

