



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health & Social Care**

# NHS financial sustainability

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Department of Health & Social Care

# NHS financial sustainability

Report by the Comptroller and Auditor General

Ordered by the House of Commons  
to be printed on 15 January 2019

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

Sir Amyas Morse KCB  
Comptroller and Auditor General  
National Audit Office

14 January 2019

The report examined whether the NHS is on track to achieve financial sustainability.

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## Key facts

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**£991m**

combined deficit of NHS trusts and NHS foundation trusts (trusts) in 2017-18

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**£1bn**

capital budget transferred to revenue budget in 2017-18

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**£3.2bn**

extra funding given to trusts as interest-bearing loans in 2017-18

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**£21 million** net deficit of NHS bodies (NHS England, clinical commissioning groups (CCGs) and trusts) overall in 2017-18

**£213 million** combined deficit of CCGs in 2017-18

**69%** percentage of the combined deficit of trusts in 2017-18 accounted for by the 10 trusts with the largest deficits

**75** CCGs reported overspends against their planned position in 2017-18, up from 57 in 2016-17

**32** number of the 44 sustainability and transformation partnerships that had a financial deficit in 2017-18, when trusts' and CCGs' finances within the partnerships were added together

**£558 million** deficit forecast by the trust sector in 2018-19 based on the first six months of the year

**3.4%** average annual real-terms growth in NHS funding in the five years, 2019-20 to 2023-24

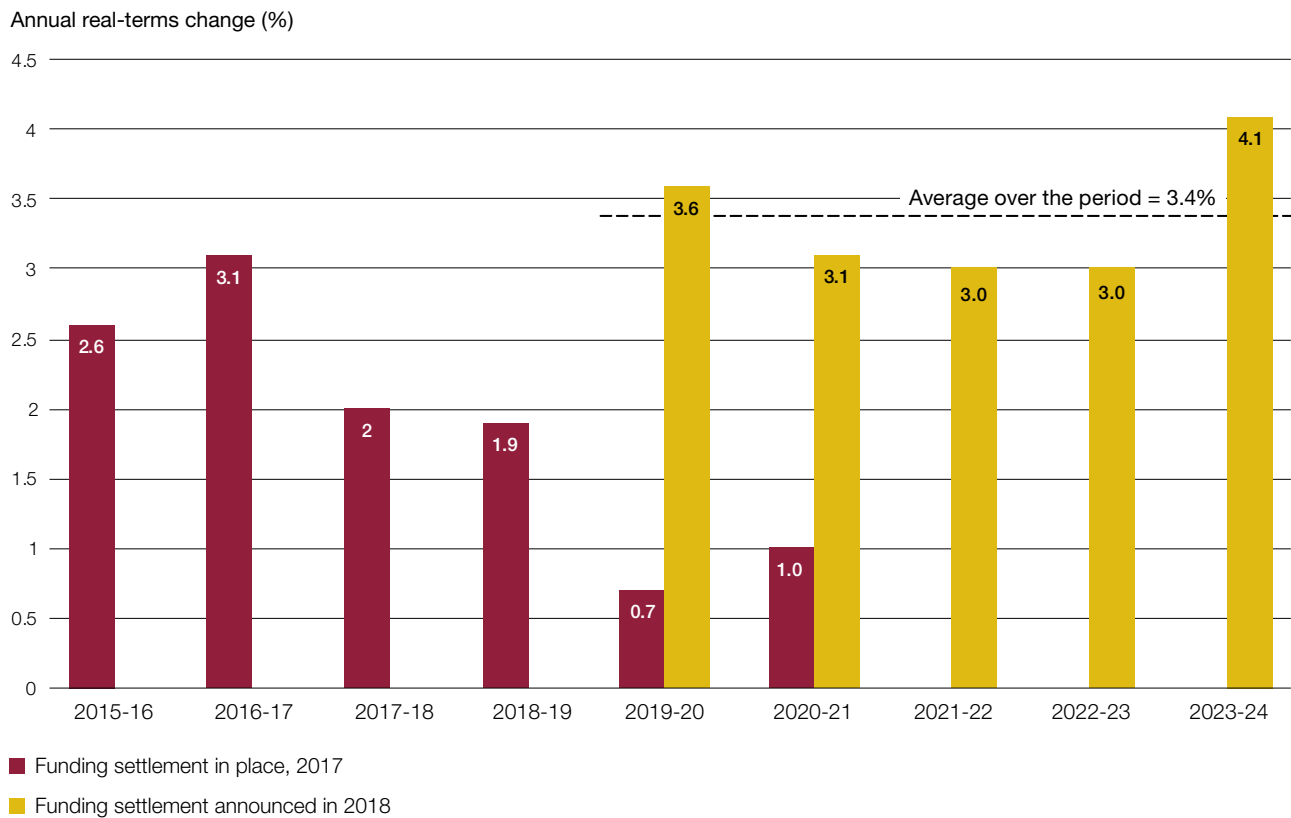
# Summary

- 1** This is our seventh report on the financial sustainability of the NHS. To be sustainable, the NHS needs to manage patient demand, including how long patients wait, 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 has made NHS England and NHS Improvement responsible for ensuring that the NHS balances its budget.
- 3** In our recent reports, in December 2015, November 2016 and January 2018, we concluded that financial problems in the NHS were endemic and that extra in-year cash injections to trusts had been spent on coping with current pressures rather than the transformation required to put the health system on a sustainable footing. To address this, local partnerships of clinical commissioning groups (CCGs), NHS trusts and NHS foundation trusts (trusts) and local authorities were set up to develop long-term strategic plans and transform the way services are provided more quickly. These partnerships take the form of 44 sustainability and transformation partnerships covering England (42 in 2018-19). Within these, there are 14 integrated care systems, in areas where partnership working is most advanced.
- 4** In June 2018, the Prime Minister announced a long-term funding settlement for the NHS, which will see NHS England's budget rise by an extra £20.5 billion by 2023-24. Between 2019-20 and 2023-24, this equates to an average annual real-terms increase of 3.4% (**Figure 1** overleaf). The government asked NHS England to produce a 10-year plan that aims to ensure that this additional funding is well spent. The government's priorities for the plan included: making progress towards achieving agreed waiting times; improving cancer outcomes; better access to mental health services; better integration of health and social care; and focusing on preventing ill-health. In January 2019, NHS England and NHS Improvement published a long-term plan for the NHS. To support the plan, NHS England and NHS Improvement is undertaking a fundamental restructuring of the financial architecture supporting the NHS.

**Figure 1**

Growth in NHS funding, 2015-16 to 2023-24

From 2019-20 to 2023-24, NHS funding will increase by 3.4% a year on average in real terms



**Notes**

- 1 Covers growth in funding for NHS England only.
- 2 Future funding is based on NHS England's 2018-19 budget of £113.8 billion plus an additional £0.8 billion funding for pay awards.
- 3 Percentages rounded to one decimal place.

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

**5** In return for this extra funding, the government has set the NHS five financial tests to show how the NHS will do its part to put the service onto a more sustainable footing. The NHS long-term plan sets out how the NHS aims to meet these tests: (including providers) return to financial balance; achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in front-line 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.



- 6 In this report on financial sustainability in the NHS, we:
- summarise the financial position of NHS England, CCGs and trusts (Part One);
  - look at the financial flows and incentives in the NHS and whether these encourage long-term financial sustainability (Part Two); and
  - examine how local partnerships of health and care organisations are progressing, and what the Department, NHS England and NHS Improvement are doing to support them (Part Three).
- 7 We set out our audit approach in Appendix One, evidence base in Appendix Two, and technical notes explaining how we have used financial data in Appendix Three.

## Key findings

The funding settlement for the NHS long-term plan

**8 The long-term funding settlement does not cover key areas of health spending.** The 3.4% average uplift in funding applies to the budget for NHS England and not to the Department's entire budget. The Department's budget covers other important areas of health spending such as most capital investment for buildings and equipment, 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, especially if funding for these areas reduces. The government will consider proposals in these areas as part of its 2019 Spending Review. In addition, without a long-term funding settlement for social care, local NHS bodies are concerned that it will be very difficult to make the NHS sustainable (paragraphs 2.27 and 2.28).

**9 There is a risk that the NHS will be unable to use the extra funding optimally because of staff shortages.** Difficulties in recruiting NHS staff presents a real risk that some of the extra £20.5 billion funding will either not be used optimally (more expensive agency staff will need to be used to deliver additional services) or will go unspent as even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it (paragraphs 1.19 and 2.29).

**10 From what we have seen so far, the NHS long-term plan sets out a prudent approach to achieving the priorities and tests set by the government, but a number of risks remain.** The long-term plan describes how the NHS aims to achieve the range of priorities and five financial tests, set by the government in return for the long-term funding settlement, which NHS England believes are stretching but feasible. As with all long-term plans, it provides a helpful indicator of the direction of travel, but significant internal and external risks remain to making the plan happen. These risks include: growing pressures on services; staffing shortages; funding for social care and public health; and the strength of the economy. Our reports have highlighted how previous funding boosts appear to have mostly been spent on dealing with current pressures rather than making the changes that are needed to put the NHS on a sustainable footing (paragraphs 2.24 to 2.26).

## Financial and operational performance of NHS bodies

**11 In 2017-18, NHS commissioners and trusts reported a combined deficit of £21 million.** This was made up of:

- NHS England achieving an underspend of £1,183 million, 4.1% of the £28,572 million available for its national functions and centrally commissioned services;
- CCGs together reporting an overspend of £213 million, 0.3% of the £80,964 million available for locally commissioned services; and
- trusts reporting a combined deficit of £991 million, 1.2% of their total income of £82,793 million (paragraph 1.4).

The combined deficit of £21 million does not include adjustments needed to report against the Department's budget for day-to-day resources and administration costs.

**12 It is not clear that funding is reaching the right parts of the system.**

The overspends by trusts and CCGs were broadly offset by the underspend by NHS England. In 2017-18, NHS England's underspend included: £962 million from non-recurrent central programme costs, including efficiencies from vacancies; a £280 million contribution to the risk reserve and £223 million from centrally commissioned services, mostly specialised services (paragraphs 1.4 and 1.8).

**13 Most of the combined trust deficit is accounted for by a small number of trusts, while the number of CCGs in deficit increased in 2017-18.**

The net trust deficit hides wide variation in performance between trusts, with 100 out of 232 trusts in deficit. In 2017-18, 69% of the total trust deficit was accounted for by 10 trusts. NHS Improvement has committed to returning the trust sector to balance in 2020-21, but it is difficult to see how this will be achieved for the worst-performing trusts under current arrangements. Although support provided to trusts in NHS Improvement's financial special measures programme has been successful in improving the position of some trusts (by £49 million in 2017-18), the financial performance of the 10 worst-performing trusts deteriorated significantly in 2017-18. Between 2016-17 and 2017-18, the number of CCGs reporting overspends against their planned position increased from 57 to 75. The NHS long-term plan sets out the national bodies' aim that no NHS organisation is reporting a deficit by 2023-24 (paragraphs 1.6 and 1.11).

**14 There are indications that the underlying financial health in some trusts is getting worse.**

In 2017-18, trusts reported that their combined underlying deficit was £4.3 billion, or £1.85 billion if the Provider Sustainability Fund (which replaced the Sustainability and Transformation Fund in 2018-19) is allocated to trusts in future years. There is no historical data on the underlying deficit that takes account of one-off savings, emergency extra cash and other short-term fixes that boost the financial position of the NHS, so it is not clear whether this position is getting better or worse. However, indicators such as cash support and one-off efficiency savings suggest the position has not improved. For example, in 2017-18, the Department gave £3.2 billion in loans to support trusts in difficulty, up from £2.8 billion in 2016-17. In 2017-18, 26% of trusts' savings were one-off. Trusts will need to make additional savings in 2018-19 to replace these one-off savings (paragraphs 1.13, 1.14, 2.13, 2.17 and 2.18).

**15 Patient waiting times continue to slip.** Overall, the NHS has continued to deliver increasing activity, but performance against key access standards has steadily declined since 2012-13 and fell further in 2017-18. For example, while more than 200,000 additional patients were treated in A&E within four hours, performance against the target that 95% of patients should be seen within four hours fell to 88% (from 92% in 2015-16 and 89% in 2016-17). NHS England is undertaking a clinically led review to consider the current performance standards. However, even though the NHS has treated nearly 1.5 million more non-urgent patients than in 2012-13, there are now 4.1 million patients on waiting lists for non-urgent treatment (up from 2.5 million in 2012-13). We estimate that it would cost an additional £700 million to reduce the waiting list to the level last seen in March 2018, based on current trends. However, trusts told us that even with extra funding, it is unlikely they will meet performance standards, because of difficulties in recruiting staff (paragraphs 1.15 and 1.19).

## Funding flows

**16 The current funding flows in the NHS are complicated and do not support partnership working, integration and the better management of demand.**

For example, NHS tariff payments incentivise more activity in an acute (hospital) setting, while block contracts with community trusts provide an incentive for costs outside of hospital settings to remain as low as possible. The national tariff allows providers and commissioners to agree alternative payment arrangements with different incentives and allocations of risk. In addition, several 'add on' financial mechanisms have been introduced in recent years to provide incentives for the NHS to achieve emerging priorities. These have made the financial structures and mechanisms of the NHS more complex. We have previously reported that NHS England and NHS Improvement could do more to create the right incentives for NHS bodies to collaborate. NHS England and NHS Improvement have taken action intended to address this, including changes to centrally-managed support funds announced in the NHS long-term plan. However, not all details of the financial reforms are yet known, for example, levels of capital funding for investing in assets (paragraphs 2.3 to 2.8).

**17 Sustainability and Transformation Fund payments have helped most trusts improve their reported performance but encourage short-term gains over long-term sustainability.**

The Department initially intended that the Fund would return trusts to aggregate financial balance and give the NHS the stability to improve performance and transform services. However, NHS England and NHS Improvement later clarified that the Fund's objective was to support the trust sector to achieve its target deficit position (£580 million in 2016-17 and £496 million in 2017-18). To incentivise improvements, NHS England and NHS Improvement have set financial targets (control totals) that trusts must meet to access the Fund. The funding has helped most (210 of 232) trusts improve their reported performance. In 2017-18, 46% of fund payments helped trusts reduce or eliminate their in-year deficits. However, the remaining 54% created or increased trust surpluses. This has driven disparity between trusts and the trust sector failed to achieve its target deficit position again in 2017-18. Trusts told us that the Fund had encouraged them to prioritise short-term gains over longer-term financial sustainability, so that they would meet their control totals in that year, and to prioritise their own financial gains at the expense of collaborating with other local bodies (paragraphs 2.11 to 2.13).

**18 Capital budgets have been repeatedly raided to support revenue spending.**

Investment in capital is essential for maintaining quality of care and achieving the transformation required for the NHS to be sustainable in the longer term. Since 2014-15, the Department has used money originally intended for capital projects to cover a shortfall in the revenue budget to fund day-to-day services (£1 billion of its £5.6 billion capital budget in 2017-18). This followed transfers of £1.2 billion in 2016-17 and £950 million in 2015-16. The Department plans to transfer £0.5 billion in 2018-19, £0.25 billion in 2019-20, and intends to stop this practice from 2020-21. The reduction in these transfers has been accompanied by a rise in the annual capital budget available since 2016-17; £1.3 billion more in 2018-19 than 2016-17. Between 2016-17 and 2017-18, the maintenance backlog across all NHS trusts grew by 9% to £6 billion. Trusts and commissioners raised concerns about access to capital funding including inequitable access, and slow and resource-intensive processes. The Department is undertaking a review of NHS capital, which will feed into the capital settlement in the 2019 Spending Review (paragraphs 2.20 to 2.23).

## Supporting local partnerships

**19 Many parts of the NHS do not have sufficient understanding of increasing levels of demand for services.**

Local bodies need a good understanding of the reasons for increasing activity to manage this demand. Regional offices of the national bodies also need a good understanding to support local bodies to manage demand and gain assurance that they are managing demand effectively. However, it is difficult to predict and quantify all variation in demand because of the complex nature of healthcare and drivers of demand. Some initiatives led by national bodies, such as RightCare, have helped to improve local understanding of the factors that drive local variations in changes in demand. However, local partnerships had mixed views about the extent to which they understood what was driving demand in their areas. They noted that combining data from across local bodies, including health and local government, would help to provide a better understanding of demand pressures. NHS England and NHS Improvement are working with partnerships to develop their expertise in understanding demand (paragraphs 3.9 to 3.12).

**20 It is difficult to say how much progress has been made by local partnerships across the system.**

The local partnerships we spoke to are clearly making progress in developing a system-level vision, and in planning and delivery, but are still at very different stages of development. Most areas noted that the pace of change was slow in transforming the way services are provided, with few having yet reached the stage where major service reconfiguration had taken place. However, it is difficult to assess the collective progress of partnerships across England, because NHS England and NHS Improvement have yet to repeat their baseline assessment of sustainability and transformation partnerships' progress, published in July 2017. National bodies plan to develop a new accountability and performance framework for integrated care systems. To support the NHS long-term plan, local partnerships will develop five-year plans by autumn 2019, which aim to set out how they intend to improve services and achieve financial sustainability (paragraphs 3.5 and 3.6, and Figure 12).

**21 Partnership working is vulnerable, given that partnerships are not statutory bodies and face significant challenges.** Three-quarters of partnerships have a deficit when the finances of their constituent trusts and CCGs are added together. Even the most advanced partnerships face significant challenges in managing demand within the resources available. The areas we visited all reported making progress on partnership working within the existing legal framework. However, the need for organisations to meet their own statutory requirements may hinder partnership working. Partnerships are not statutory bodies supported by a legislative framework, and so require the goodwill of all involved. Continued financial pressure will test this goodwill. National bodies, in discussion with NHS colleagues, have developed a provisional list of potential legislative changes for Parliament’s consideration to support better integration in the best interest of patients (paragraphs 3.7 and 3.8).

**22 More progress is needed in the joined-up approach to regulation that NHS England and NHS Improvement are adopting.** It is important that the regulators work closely together otherwise local NHS bodies will be faced with mixed messages and competing priorities. NHS England and NHS Improvement have continued to integrate more of their functions. For example, as well as creating several joint regional posts, such as regional directors, there will be a single chief finance officer, nursing officer and medical director at a national level. Local bodies told us that NHS England and NHS Improvement are making progress in holding systems rather than organisations to account. However, they added that they still receive mixed messages from the two organisations, especially when financial pressures emerge, and regulators may revert to organisation-based working. NHS England and NHS Improvement plan to implement a new shared operating model that aims to support the delivery of the NHS long-term plan (paragraphs 3.15 and 3.16).

## **Conclusion on value for money**

**23** This report covers 2017-18, so we first conclude on financial sustainability for that year. We consider that the growth in waiting lists and 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 can describe as sustainable. Recently, the long-term plan for the NHS has been published, and government has committed to longer-term stable growth in funding for NHS England.

**24** In our view these developments are positive, and the planning approach we have seen so far looks prudent. We will really be able to judge whether the funding package will be enough to achieve the NHS’ ambitions when we know the level of settlement for other key areas of health spending that emerges from the Spending Review later in the year. This will tell us whether there is enough to deal with the embedded problems from the last few years and move the health system forward. Let’s hope there are not too many strings attached.

## Recommendations

**25** These recommendations aim to support national bodies to ensure that the additional funding supporting the NHS long-term plan is spent wisely, and that financial rigour is maintained over this funding settlement period.

- a** **The national bodies should test whether local plans to manage demand are realistic.** Commissioners and trusts now set out the drivers of activity growth between years in their operational plans. The national bodies should test whether local bodies have identified all their local drivers in their plans and have sufficient capacity to meet demand. A better understanding of drivers should allow them to better support local bodies in managing demand and ensure that funding is targeted at the right areas.
- b** **As part of current reforms, NHS England and NHS Improvement should design and implement a simpler payment system.** This system should be better aligned with the new structures in the NHS, reduce transaction costs and promote greater collaboration and better management of demand. National bodies need to identify the behaviours they want to encourage in local bodies and ensure that the payment system and other incentives encourage these behaviours. They should set out a medium-term strategy for redesigning tariffs as part of a wider statement of any intended reform of how money flows around the NHS in relation to demand and costs.
- c** **The national bodies should review local plans to ensure consistency with the national long-term plan.** Once local health systems have developed their five-year plans, national bodies should assess whether these are consistent with the long-term plan, ensuring key risks to delivery are identified and mitigating action put in place to address these risks.
- d** **The Department and NHS Improvement should develop a sustainable long-term plan for supporting the worst financially performing trusts.** Current support and incentives will not alone be sufficient to return these trusts to financial balance. The Department and NHS Improvement should review the underlying cause of the problems experienced by trusts in severe financial difficulty and the Department could consider whether it should restructure the balance sheets in those trusts where there is little or no prospect of loans being repaid.
- e** **The national bodies' review of how capital is allocated needs to ensure that investment is available for essential modernisation of health services.** This review should examine how arrangements for accessing capital can be made simpler for all NHS bodies regardless of their financial position or statutory basis and consider mechanisms for targeting capital in the most effective ways.
- f** **NHS England and NHS Improvement should review how their regulatory and oversight approach is supporting collaborative working locally.** This should include reviewing the changes necessary to support the development of integrated care systems if the legislative changes proposed in the long-term plan are not brought in. NHS England and NHS Improvement should also publish an update on the progress being made by partnerships on integration and system-working.

# Part One

## Financial performance in the NHS

**1.1** This part of the report examines the financial position and performance of the NHS overall and of NHS bodies (clinical commissioning groups (CCGs), NHS trusts and NHS foundation trusts (trusts)). We also look at how trusts have performed against access standards.

**1.2** Since 1974-75, health spending in real terms has increased by 3.7% a year on average in England.<sup>1</sup> Between 2015-16 and 2018-19, NHS England received smaller increases, averaging 2.4% a year. Funding constraints, coupled with an ageing population and higher demand for care, have increased pressures on the health system. In June 2018, the Prime Minister announced a long-term funding settlement for the NHS, which will see NHS England's budget rise by an extra £20.5 billion by 2023-24. Between 2019-20 and 2023-24, this equates to an average annual real-terms increase of 3.4% (Figure 1 on page 6). The funding will be front-loaded with an increase of 3.6% in the first year, which means £4.1 billion extra in 2019-20. In January 2019, NHS England and NHS Improvement published a long-term plan for the NHS that aims to ensure that this additional funding is well spent.<sup>2</sup> In its 2018 Autumn Budget, the government also announced an additional £1.25 billion adjustment to NHS England's budget to cover unavoidable increased costs of NHS staff pensions.

### NHS funding and spending in 2017-18

**1.3** 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 2017-18, this amounted to £109.5 billion.<sup>3</sup> Most of NHS England's budget was spent by 207 CCGs, which purchased healthcare services from 232 NHS trusts.<sup>4</sup> These trusts deliver acute, community, ambulance, specialist and mental health and disability services. **Figure 2** overleaf summarises the financial performance of CCGs and trusts in 2017-18.

1 Historic health spending was measured using total health spending by the Department of Health.

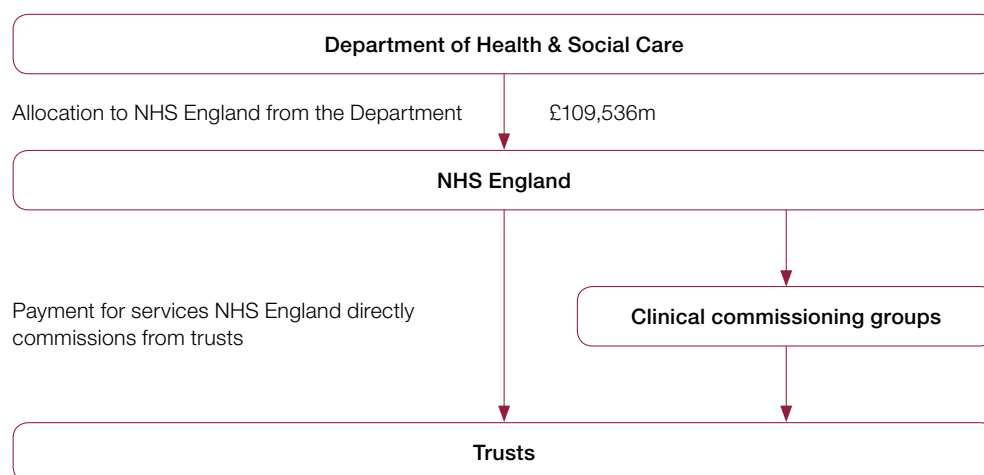
2 NHS England, The NHS Long Term Plan, January 2019.

3 The £109.5 billion excludes the depreciation ring-fence, see table 35 in the Department's Annual Report and Accounts.

4 Number of organisations at 31 March 2018.

**Figure 2**

Summary of financial performance of clinical commissioning groups (CCGs) and trusts, 2017-18



|   | Planned expenditure/income<br>2017-18<br>(£m) | Underspend/overspend<br>2017-18<br>(£m) | Underspend/overspend<br>2016-17<br>(£m) |
|---|---|---|---|
| Centrally commissioned services, including primary care, specialised services and public health | 28,572  | 1,183 underspend (surplus)              | 748 underspend (surplus)                |
| Clinical commissioning groups   | 80,964  | 213 overspend (deficit)                 | 154 underspend (surplus)                |
| Trusts  | 82,793  | 991 overspend (deficit)                 | 791 overspend (deficit)                 |
| <b>Net underspend/overspend by NHS commissioners and trusts</b>                                 |   | <b>21 overspend (deficit)</b>           | <b>111 underspend (surplus)</b>         |

**Notes**

- 1 NHS England's total revenue budget (including depreciation and impairment charges) was £109,702 million. The core measure for NHS England's financial performance is its non-ring-fenced revenue budget of £109,536 million, which excludes depreciation and impairment charges.
- 2 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.
- 3 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 £82,793 million.
- 4 NHS England and CCGs also buy healthcare services from other providers.
- 5 Spend on centrally commissioned services includes underspends or overspends on the legacy NHS continuing healthcare claims programme.
- 6 These figures exclude any central accounting adjustments that the Department makes when reporting its total revenue position to Parliament.

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



**1.4** Overall, the commissioner and trust sectors ended 2017-18 with a deficit of £21 million.<sup>5</sup> This was worse than last year, in which a £111 million surplus was recorded. The deficit in 2017-18 was made up of:

- NHS England reporting an underspend of £1,183 million, 4.1% of the £28,572 million available for national functions, centrally commissioned services and legacy claims;
- CCGs reporting an overspend of £213 million, 0.3% of the £80,964 million available for locally commissioned services; and
- trusts reporting a combined deficit of £991 million, 1.2% of their income of £82,793 million.

### **Trends in the financial performance of CCGs**

**1.5** 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 2017-18, the £213 million overspend was made up of:

- a collective overspend of £321 million on locally commissioned services (compared with an underspend of £117 million in 2016-17);
- an underspend of £71 million on the Quality Premium programme (compared with an underspend of £34 million in 2016-17);<sup>6</sup> and
- technical adjustments of £37 million, which NHS England makes for reporting purposes (compared with £4 million in 2016-17).

**1.6** CCGs' performance was worse in 2017-18 than in 2016-17:

- 132 CCGs had either a balanced position or reported underspends totalling £247 million, compared with 152 in 2016-17 being in balance or reporting underspends totalling £476 million; and
- 75 CCGs reported overspends totalling £568 million, compared with 57 in 2016-17 reporting overspends totalling £359 million.<sup>7</sup>

Significant issues with generic drug pricing set by the Department, which were outside the control of local NHS organisations, resulted in an addition cost of £349 million to CCGs.

<sup>5</sup> The trusts' deficit position does not include £47 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.

<sup>6</sup> This programme rewards CCGs for improving the quality of the services they commission and for associated improvements in health outcomes.

<sup>7</sup> We have defined a balanced position as the difference between the actual and planned positions being zero, to the nearest £1,000. This will include any CCG in each year with an overspend of less than £500.

**1.7** In 2017-18, NHS England required each commissioner to hold 0.5% of their allocation in a reserve (1% in 2016-17), in case it was needed to offset deficits in the NHS. NHS England restricted CCGs from using the reserve, which was used to improve the financial position by about £640 million (£360 million from CCGs and £280 million from NHS England's central programmes).

**1.8** In 2017-18, NHS England underspent by £1,183 million against its central and direct commissioning budget (excluding CCGs), a five-fold increase since 2013-14 (**Figure 3**). It achieved this by spending:

- £962 million less than planned on programmes, administration and other central budgets, for example by delaying funding for transformation, not filling staff vacancies and not allocating some £25 million of winter pressure money to trusts;
- £223 million less than planned on direct commissioning, including for specialised services, where, for example, controls have been put in place regarding the Cancer Drugs Fund; and
- £2 million more than planned on legacy NHS continuing healthcare claims.<sup>8</sup>

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

### **Trends in financial performance of trusts**

**1.9** In 2017-18, NHS England and NHS Improvement continued with the measures introduced in the July 2016 NHS 'financial reset' plan, which aimed to reduce trusts' deficits and strengthen accountability. These measures included the £1.8 billion a year Sustainability and Transformation Fund, which trusts could access if they accepted and achieved the financial targets (control totals) given to them by NHS Improvement.

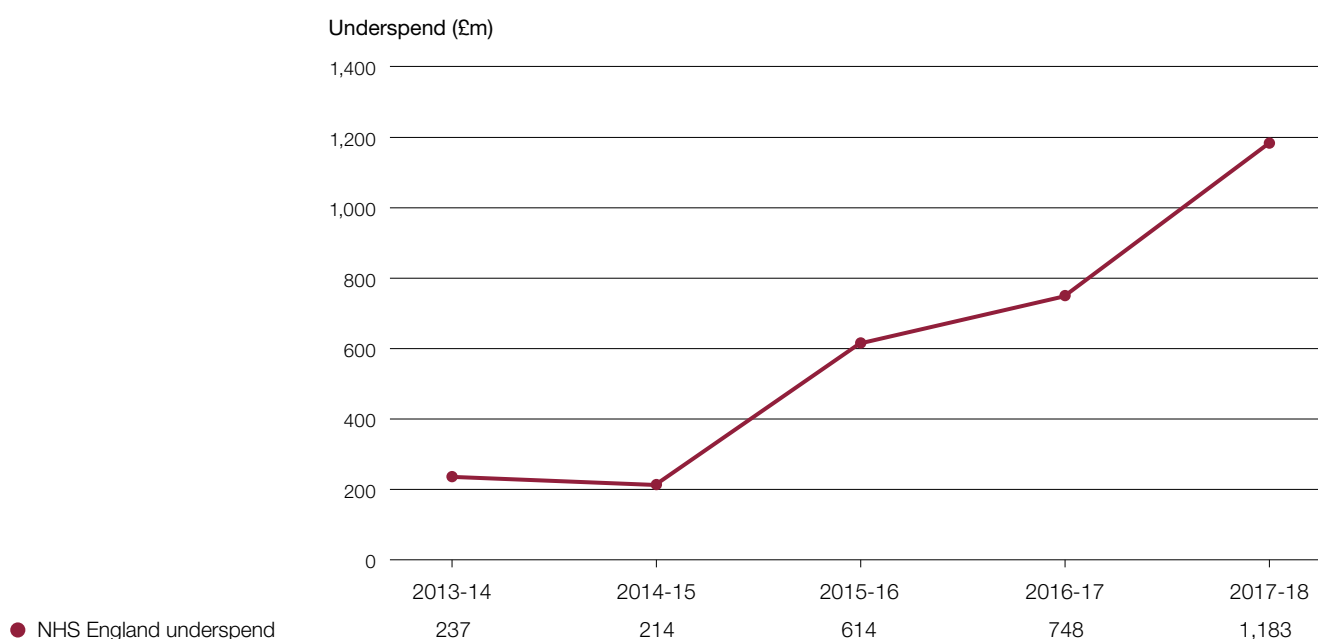
**1.10** Despite these initiatives, the combined trust deficit continued to grow from £791 million in 2016-17 to £991 million in 2017-18 (**Figure 4** on page 18). At the end of September 2018, trusts reported a combined deficit of £1,229 million and a forecast deficit for 2018-19 of £558 million, when the uncommitted Provider Sustainability Fund was included. This fund replaced the Sustainability and Transformation Fund in 2018-19.

<sup>8</sup> NHS continuing healthcare provides free care outside of hospital that is arranged and funded by the NHS. CCGs now provide funding, but NHS England is responsible for claims made before the healthcare system was reorganised following the Health and Social Care Act 2012.

**Figure 3**

## NHS England's central and direct commissioning underspend, 2013-14 to 2017-18

NHS England's underspend has increased significantly in recent years

**Note**

1 Figures are underspends on NHS England's non-ring-fenced revenue budget and do not include performance relating to ring-fenced depreciation, amortisation and impairments.

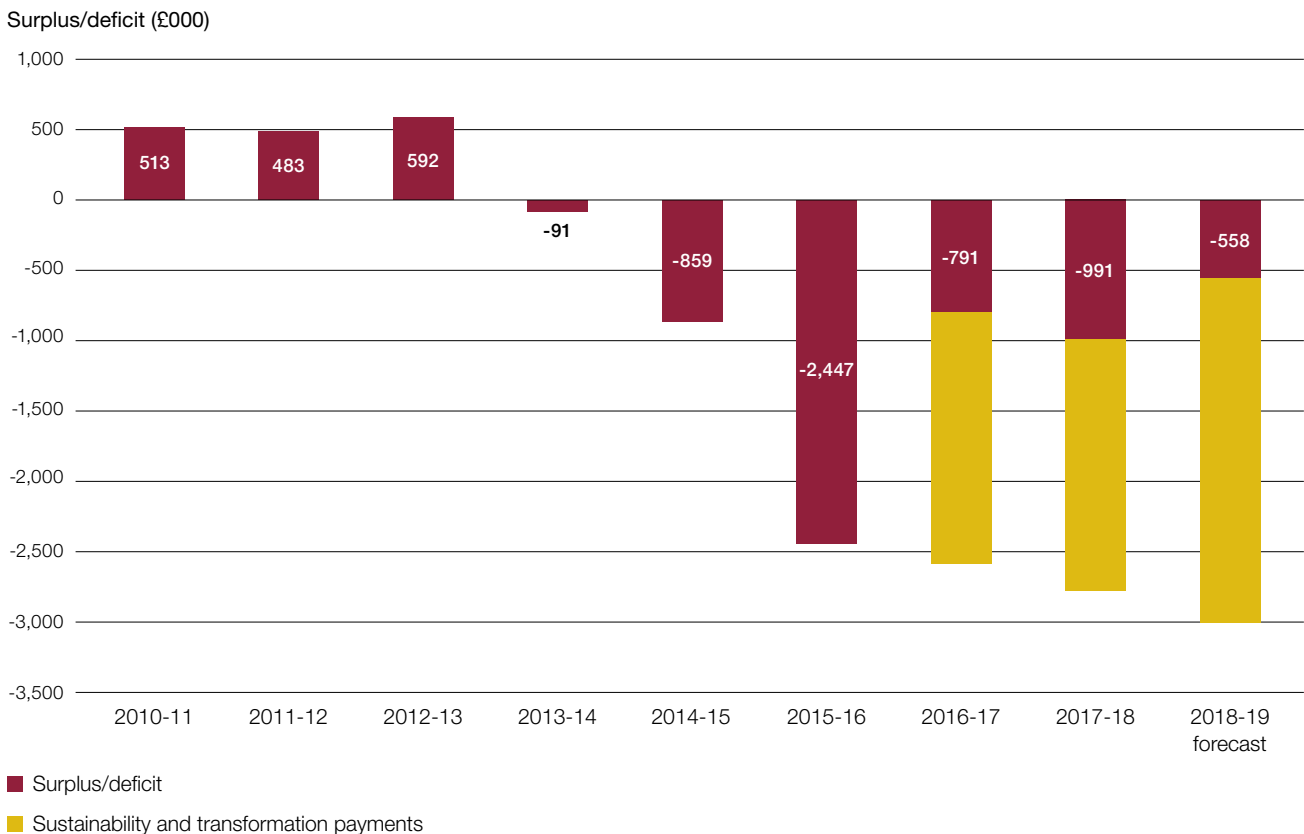
Source: National Audit Office analysis of NHS England data

**1.11** The combined trust deficit hides the wide variation in performance between trusts from a £77 million surplus to a £141 million deficit, with 100 out of 232 trusts in deficit. In 2017-18, the 10 worst-performing trusts reported a combined deficit of £758 million, representing 12% of their income and 69% of the total trust deficit.<sup>9</sup> This was up from a £400 million deficit that these trusts reported in 2016-17, representing 6% of their income. Although support provided to trusts in NHS Improvement's financial special measures programme has been successful in improving the position of some trusts (by £49 million in 2017-18), the financial performance of the 10 worst-performing trusts has been deteriorating over several years, with significant deterioration in 2017-18. This indicates that current plans to return these trusts to financial balance are not working. In addition, the proportion of trusts in deficit remained the same (43%) in 2017-18 as in 2016-17, suggesting that the gulf between the best and worst performers is increasing. NHS Improvement has committed to returning the trust sector to balance in 2020-21. The NHS long-term plan also sets out the national bodies' aim that no NHS organisations are reporting a deficit by 2023-24.

<sup>9</sup> A total trust deficit of £1,095 million was used for this calculation. This is the total of individual trust deficits prior to the central adjustments made that give the combined trust deficit of £991 million reported in the Department's accounts.

**Figure 4**  
Surplus/deficit of trusts, 2010-11 to 2017-18, and forecast for 2018-19

The financial position of trusts worsened in 2017-18



**Notes**

- 1 Sustainability and Transformation Fund payments totalled £1,796 million in 2016-17 and £1,793 million in 2017-18.
- 2 Forecast for 2018-19 is based on expected full-year outturn at the end of quarter 2.

Source: National Audit Office analysis of trusts' financial data

**1.12** The financial position and performance of acute trusts are worse than those of other types of trusts (**Figure 5**). For example, in 2017-18, acute trusts had more than £1 billion in net current liabilities and a combined deficit of £1.7 billion, whereas mental health trusts had net current assets of £898 million and a surplus of £307 million. In 2014-15, acute trusts reported £526 million in net current assets; in 2017-18, they reported £1,069 million in net liabilities. These trusts may have fewer reserves that they can easily draw on in times of need, increasing the risk that they will need financial support from the Department.

**Figure 5**

Average current assets, liabilities and surplus/deficit by trust type for 2017-18, as at 31 March 2018

**The financial position and performance of acute trusts are worse than those of other types of trusts**

| Trusts        | Average current assets (£m) <sup>1</sup> | Average cash and cash equivalents (£m) | Average current liabilities (£m) | Average net assets/ (liabilities) (£m) | Average surplus/ (deficit) (£m) | Surplus/(deficit) as a percentage of income (%) |
|---------------|--|--|----------------------------------|--|---------------------------------|---|
| Acute         | 46                                       | 17                                     | (71)                             | (8)                                    | (13)                            | (2.8)   |
| Mental health | 17                                       | 28                                     | (28)                             | 17                                     | 6                               | 2.5   |
| Specialist    | 39                                       | 26                                     | (38)                             | 27                                     | 16                              | 7.1   |
| Community     | 12                                       | 17                                     | (19)                             | 10                                     | 3                               | 1.8   |
| Ambulance     | 17                                       | 23                                     | (30)                             | 10                                     | 4                               | 1.5   |

**Notes**

1 Figures exclude cash and cash equivalents.

2 Surplus or deficit figures include payments from the Sustainability and Transformation Fund.

Source: National Audit Office analysis of trusts' financial data

**The underlying health of the NHS**

**1.13** The underlying deficit of the NHS provides an indication of the longer-term financial health of the NHS. This figure takes account of one-off savings, emergency extra cash and other short-term fixes that boost the financial position of the NHS. For 2017-18, trusts self-reported that they ended the year with an underlying deficit of some £4.3 billion, using a methodology developed by NHS Improvement.<sup>10</sup> The underlying deficit will be £1.85 billion if the Provider Sustainability Fund is allocated to trusts in future years. As 2017-18 was the first year that NHS Improvement reported the underlying deficit, it is not possible to say whether the position is improving.

<sup>10</sup> Trusts calculated their underlying deficit as their surplus or deficit in 2017-18, less any income and expenditure not expected to occur in future years, plus any income and expenditure expected to reoccur consistently in future years.

**1.14** One component of the underlying deficit is the level of one-off savings. Financial sustainability relies on local NHS bodies making year-on-year savings, rather than one-off savings. Otherwise, these bodies will have to find new savings the following year, to replace any one-off savings, in addition to savings already planned. Examples of one-off savings include leaving staff posts temporarily vacant and selling surplus buildings and land to generate income. In 2017-18:

- trusts saved £3,210 million, 3.5% more than in 2016-17, but only 87% of the savings they planned (**Figure 6**). The proportion that came from one-off savings increased to 26%, up from 25% in 2016-17 and 22% in 2015-16; and
- CCGs made £2,486 million of savings, 25% more than in 2016-17, but only 80% of the savings they planned (Figure 6). The proportion that came from one-off savings was 10%, down from 17% in 2016-17 and the same as in 2015-16.

### **Achieving NHS performance standards and quality requirements**

**1.15** **Figure 7** on page 22 shows that NHS performance against key standards has steadily declined since 2012-13 in most areas. For example, only 88% of accident and emergency patients were seen within four hours in 2017-18, against a target of 95% and a rate of 92% in 2015-16 and 89% in 2016-17. Individual trusts' performance ranged from 71% to 100%. However, NHS data suggest performance has improved in some areas. For example, waiting time standards for the improving access to psychological therapies (IAPT) mental health programme have been met since their introduction in 2014-15. NHS England is undertaking a clinically led review to consider the current performance standards. Between April 2017 and March 2018, the number of patients on waiting lists for non-urgent treatment continued to increase, from 3.7 million to 4.1 million. We estimate that it would cost an additional £700 million to reduce the waiting list to the level last seen in March 2018, based on current trends.

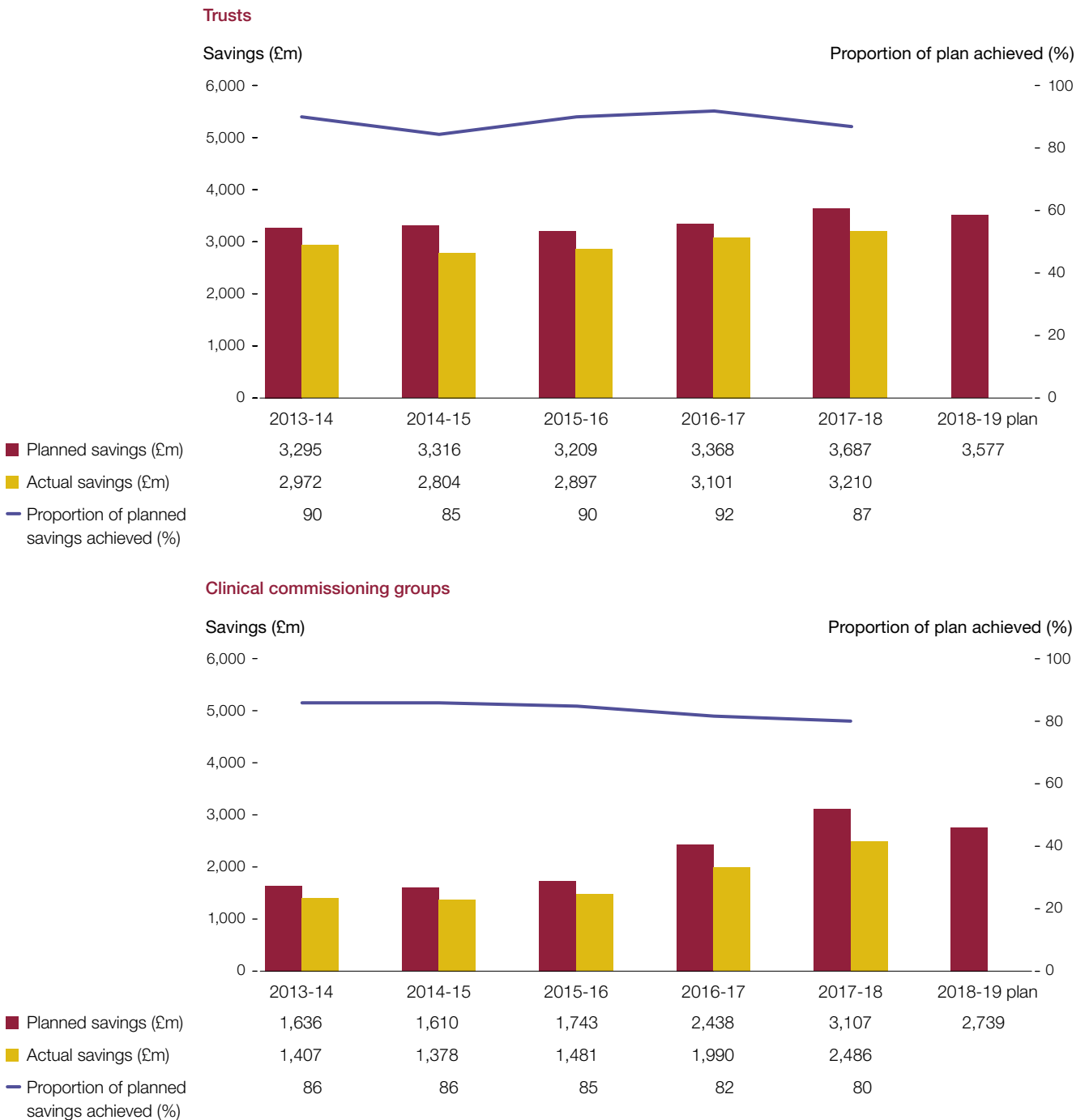
**1.16** High levels of bed occupancy, length of stay and delayed discharges from hospital are also affecting trusts' ability to meet performance standards. In June 2018, general and hospital bed occupancy rates were at 93%, up from 91% in June 2017. In July 2017, NHS England and NHS Improvement recommended that bed occupancy should remain below 92%. Our analysis shows that trusts with higher bed occupancy rates perform worse against the target that patients should be treated within 18 weeks of referral.

**1.17** Long-stay patients account for 8% of admissions requiring an overnight stay and have an average length of stay of 40 days. Nearly 350,000 patients spend more than three weeks in an acute hospital each year. The NHS plans to reduce the number of beds occupied by long-stay patients in acute hospitals by 25% by December 2018, freeing up at least 4,000 beds compared to 2017-18. In the three months to September 2018, the number of occupied long-stay beds was 16,832 against a baseline of 19,301, a 13% reduction.

**Figure 6**

Savings planned and achieved by trusts and CCGs, 2013-14 to 2017-18, and planned for 2018-19

Trusts typically deliver between 85% and 90% of their planned savings and clinical commissioning groups (CCGs) typically deliver between 80% and 86% of their planned savings



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

**Figure 7**

## Trusts' performance against key waiting times standards

**NHS performance against key waiting times standards has steadily declined since 2012-13**

| Percentage point difference to waiting times standards   | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|--|---------|---------|---------|---------|---------|---------|
| A&E: 95% of patients should be admitted, transferred, or discharged within four hours of arrival in accident and emergency                                 | 0.9     | 0.7     | -1.4    | -3.1    | -5.9    | -6.7    |
| Cancer: 85% of patients referred via the urgent suspected cancer route should start definitive treatment within 62 days of receipt of referral at hospital | 2.2     | 1.0     | -1.6    | -2.6    | -3.0    | -2.7    |
| Routine, non-urgent conditions: 92% of patients should start their treatment within 18 weeks of being referred   | 2.2     | 1.7     | 1.1     | -0.5    | -1.7    | -4.8    |
| Improving access to psychological therapies (IAPT): 95% of people referred to IAPT service should start treatment within 18 weeks of referral              | –       | –       | –       | 1.3     | 3.2     | 3.8     |
| Ambulance: 75% of Red 1 calls should result in an emergency response arriving within 8 minutes <sup>2</sup>  | -1.0    | 0.6     | -3.1    | -2.5    | -6.3    | -5.7    |
| Diagnostic: Less than 1% of patients should wait six weeks or longer for a diagnostic test from referral   | 0.0     | -0.1    | -0.8    | -0.8    | -0.4    | -0.9    |

**Notes**

- 1 Figures for accident and emergency departments (A&E), cancer, ambulance and diagnostic are annual data. Figures for routine, non-urgent conditions are reported performance at the end of March each year.
- 2 By December 2017, all ambulance trusts (except the Isle of Wight) had switched to a new categorisation of calls.

Source: National Audit Office analysis of NHS England data

**1.18** Overall, trusts have made progress in reducing delayed discharges from hospital. Between March 2017 and March 2018, more than 30,000 hospital bed days were released by reducing the number of delayed hospital discharges. However, overall bed occupancy has been affected by delays in transferring patients to care in other settings, including social care. Between January 2018 and March 2018, 446,000 bed days across hospital, community and mental health trusts were occupied by patients whose discharge from hospital had been delayed (approximately 4.2% of all beds).

**1.19** Trusts told us that even with extra funding, it is unlikely they will meet their performance standards, because of difficulties recruiting staff. In September 2018, trusts had 41,000 vacancies for nurses (11.6% vacancy rate) and more than 9,000 vacancies for medical staff (7.4% vacancy rate). Vacancy rates vary widely between regions. For example, in September 2018, the nurse vacancy rate was 14.6% in London and 9.3% in the North of England.



## Providing quality services

**1.20** Poor financial performance can affect the quality of a trust's clinical services and may reflect poor leadership. 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. We found a correlation between trusts' well-led rating and trusts' financial performance in 2017-18. Trusts with a larger deficit tended to have a poorer well-led rating.

# Part Two

## Funding flows in the NHS

**2.1** In this part, we examine how the financial flows and funding mechanisms encourage long-term financial sustainability of local NHS bodies (**Figure 8**). We do not cover funding for primary care, public health or adult social care, which all have an impact on the financial sustainability of local NHS bodies.

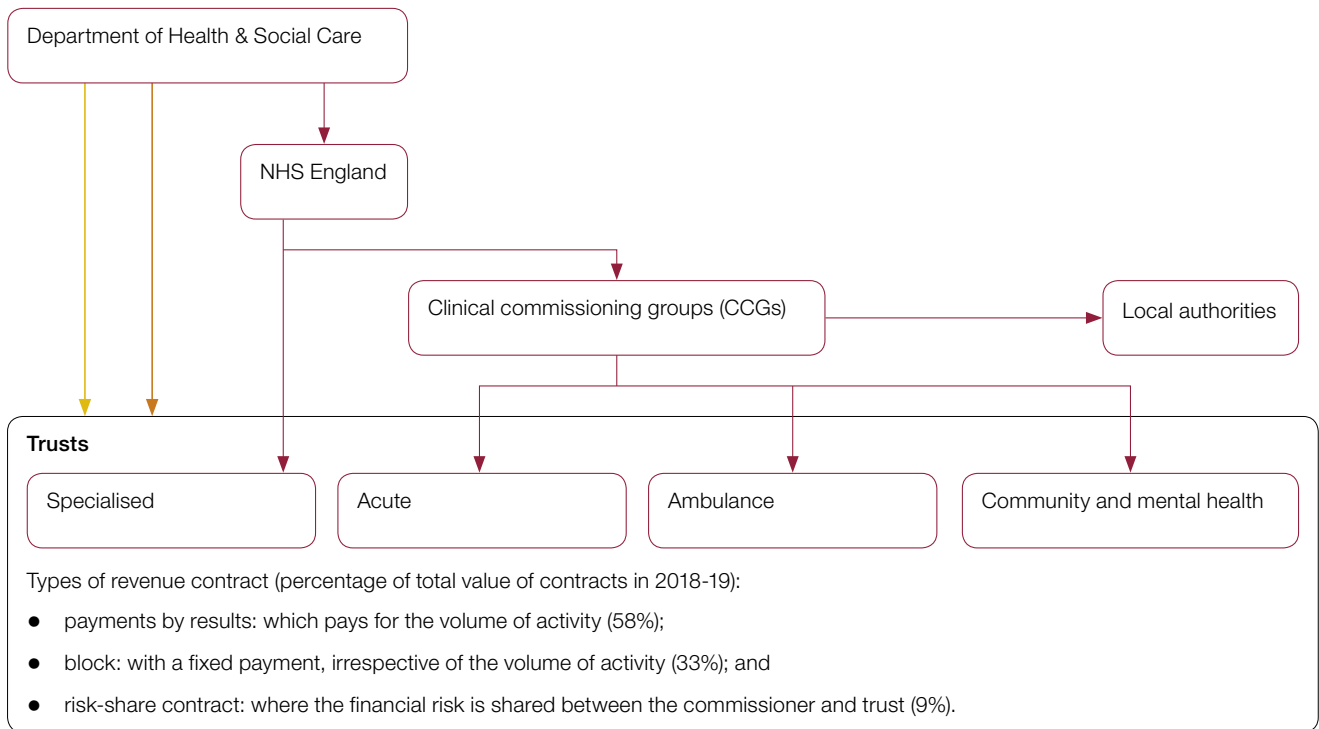
### Revenue funding

**2.2** Revenue funding covers the day-to-day spending that is required to operate an organisation, such as on staff costs. NHS trusts and NHS foundation trusts (trusts) receive most of their revenue funding (82%) from NHS England and clinical commissioning groups (CCGs) to provide NHS healthcare. Trusts also receive income for non-healthcare activities, such as providing education and training, providing non-patient care services for other bodies and undertaking research and development.

**2.3** Payment mechanisms do not currently support the move to partnership working, moving more activity out of hospitals, or long-term financial sustainability:

- Most acute services are covered by the 'payment by results' framework, whereby commissioners pay trusts for each unit of care, with NHS tariff prices set nationally. These incentivise trusts to provide more activity in an acute setting in response to demand but create additional financial pressures for commissioners. The national tariff does allow providers and commissioners to agree alternative payment arrangements with different incentives and allocations of risk.
- Most community and mental health trusts are paid through block contracts, which pay fixed payments that are not related to the number of patients treated. They do not incentivise trusts to increase activity or invest in out-of-hospital services, although these services may be the most cost-effective way of treating patients.
- Acute trusts bear the financial risk of meeting non-elective demand and higher costs of delivery without being able to incentivise delivering care in more cost-effective settings.

**Figure 8**  
Funding flows in the NHS



**A number of additional financial mechanisms to provide incentives for the NHS to achieve emerging priorities have made the financial structures already in place more complicated.** These include:

- the Sustainability and Transformation Fund;
- Commissioning for Quality and Innovation (CQUIN) – makes a proportion of trusts’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care agreed between the trust and CCG;
- the commissioner quality premium – rewards CCGs for improving the quality of the services they commission and for associated improvements in health outcomes;
- the marginal rate emergency tariff – CCGs only pay trusts 70% of the tariff for emergency admissions above an agreed level;
- best practice tariffs – rewards the adoption of best practice by trusts in areas agreed by their CCGs;
- the capped expenditure programme – aims to contain spending in 14 specific areas of the country in 2017-18; and
- the cap and collar mechanisms – where commissioners pay for activity using the national payment by results tariff, but only to a certain contract value.

- ➔ Revenue funding
- ➡ Capital
- ➡ Other sources of financial support

Source: National Audit Office

**2.4** A number of additional financial mechanisms (Figure 8) to provide incentives for the NHS to achieve emerging priorities have added to the complexity of the system. Our analysis showed there is no correlation between acute trusts' reference cost index (a measure of their financial efficiency) and their overall financial position. Additional financial mechanisms have also led to unintended consequences. For example, since 2010-11 a reduced tariff has been applied to emergency admissions above a baseline level established in 2008-09. The tariff was intended to reduce the financial incentive for acute trusts to admit emergency attendances and admissions have stabilised since it was introduced. However, it has made it more difficult for trusts to manage the financial risks of meeting non-elective demand, particularly where capacity is constrained. As demand rises above planned levels, as well as only being paid at the reduced tariff, acute trusts face incurring higher marginal costs for meeting this demand (because of reliance on agency/locum staff) and having to cancel elective work and lose associated income for this work. This reduced tariff will be abolished from 2019-20. Paragraph 2.13 on the Sustainability and Transformation Fund illustrates another example of a financial mechanism that has led to unintended consequences.

**2.5** In September 2016, NHS England and NHS Improvement announced their intention for each sustainability and transformation footprint to have a shared financial control total (financial target) that is the sum of individual trust control totals. They hoped this would encourage local systems to share financial risk, as organisations within the same system would be able to adjust their financial control totals to reflect relative pressures and performance, if they met an aggregate control total. In 2017-18, a number of prospective integrated care systems piloted system control totals. In 2018-19, integrated care systems began operating joint system control totals that link payment of the Provider Sustainability Fund (see paragraph 2.14) to system delivery to better incentivise joint working and pool risk.

**2.6** The current system leads to commissioners and providers spending time and resources (transactional costs) discussing levels of activity and what type of activity was carried out. The national bodies would like local partnerships to spend less time on these transactional discussions and more time on developing better data on the cost of interventions.

## Proposed changes to the financial architecture

**2.7** NHS England and NHS Improvement intend to reform the financial architecture supporting the NHS, but full details of the reforms are not yet known. However, NHS England and NHS Improvement have proposed several changes to the national tariff for 2019-20, including:

- setting the next national tariff for 2019-20 for one year only – in 2017-18 and 2018-19 a two-year tariff was applied, but NHS England and NHS improvement considers that a one-year tariff will provide more flexibility to respond to changes resulting from the NHS long-term plan;
- introducing a 'blended' payment approach for emergency care, comprising a fixed amount linked to expected levels of activity and a volume-related element that reflects actual levels of activity;
- reducing the Provider Sustainability Fund, with the released funds going directly into the urgent and emergency tariff price;
- updating how the funding adjustment to recognise the different costs of operating in certain geographic areas (market forces factor) is calculated, phased in over the next five years; and
- reducing the tariff by 0.35% to fund the overhead costs of NHS Supply Chain.

Stakeholders that we spoke to were concerned about the amount of change that national and local NHS bodies will be required to implement over a short period of time, especially for local health systems where partnership working is less advanced.

**2.8** NHS England and NHS Improvement have also announced:

- the creation of a new Financial Recovery Fund from 2019-20 (see paragraph 2.15); and
- that control totals will be rebased for 2019-20, to take account of distributional effects from any changes to prices. There will also be greater flexibility for local partnerships to agree financially neutral changes to control totals within their systems.

## Progress in moving towards different payment models

**2.9** In December 2014, NHS England and Monitor set out a plan for developing new payment mechanisms to support new models for providing NHS care. It described a range of approaches, including creating 'population-based' payments, in which a group of providers offer a range of care for the whole local population in different care settings. NHS England and NHS Improvement subsequently published a range of guidance on how CCGs and trusts might develop new approaches.

**2.10** Some place-based vanguards developing new care models have begun using new payment models for discrete services, although overall progress has been slow. Vanguards have reported that a lack of alignment of financial incentives across different stakeholders remained a key risk in sustaining their models of care.<sup>11</sup> Some local NHS bodies have experienced complex technical and legal challenges in setting up the structures to support new payment models. NHS England has supported local bodies in addressing these challenges. Following a three-month public consultation in autumn 2018, NHS England plan to introduce a new integrated care provider contract for use from 2019. The NHS long-term plan also announced that reforms to the payment system plan move funding away from activity-based payments to ensure that a majority of funding is population-based.

### The Sustainability and Transformation Fund

**2.11** In April 2016, the national bodies introduced the Sustainability and Transformation Fund (the Fund), to support the financial recovery of trusts and give the NHS stability to improve performance and transform services. The Department of Health & Social Care (the Department) initially intended that the Fund would return trusts to aggregate financial balance and give the NHS the stability to improve performance and transform services. NHS England and NHS Improvement later clarified that the Fund should support the trust sector to achieve its target deficit position (£580 million in 2016-17 and £496 million in 2017-18). They originally committed funding of £1.8 billion each year until 2018-19. Access to the Fund is based on trusts agreeing and meeting target financial positions and performance levels. In 2017-18, 71% of trusts (149) accepted and met their control total targets in all quarters of 2017-18, compared with 79% of trusts (177) in 2016-17.

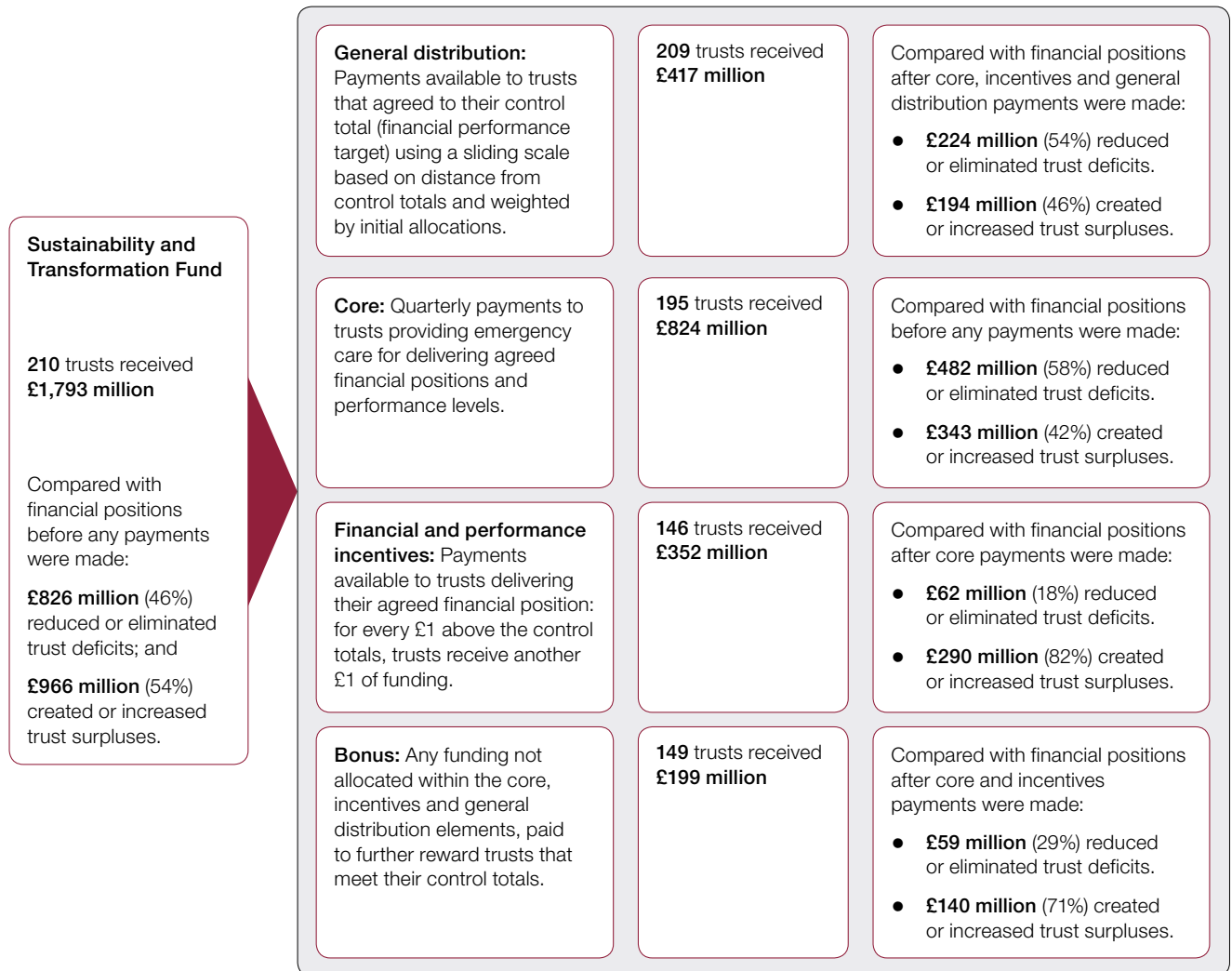
**2.12** In 2017-18, 16% of trusts (36) did not accept or meet their control totals, compared with 25% of trusts (58) in 2016-17. In total, 210 trusts received a total of £1,793 million of funding. Of the Fund payments in 2017-18, 46% (£826 million) helped trusts to reduce or eliminate their deficits and 54% (£966 million) helped to create or increase trusts' surpluses (**Figure 9**). In 2016-17, 60% of the payments reduced or eliminated trust deficits.

**2.13** Trusts told us that the Fund had encouraged them to prioritise short-term gains over longer-term financial sustainability, so that they met their control totals in that year. For example, it had led to a reliance on one-off savings such as from the sale of land and buildings. Trusts also told us that it had encouraged them to prioritise their own financial gains at the expense of collaborating with other local bodies to achieve system-wide financial sustainability.

<sup>11</sup> Comptroller and Auditor General, *Developing new care models through NHS vanguards*, Session 2017–2019, HC 1129, National Audit Office, June 2018.

**Figure 9**  
Sustainability and Transformation Fund payments, 2017-18

In 2017-18, 46% of payments helped trusts to reduce or eliminate their in-year deficits, with the remaining 54% creating or increasing trust surpluses



**Notes**

- 1 Figures may not sum due to rounding.
- 2 Some 22 of 232 trusts received no funding.

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

**2.14** In February 2018, NHS England and NHS Improvement committed an additional £650 million to the Fund to create a larger £2.45 billion Provider Sustainability Fund for 2018-19. It has also introduced a £400 million Commissioner Sustainability Fund, to support CCGs to return to in-year financial balance. National bodies plan to phase out both sustainability funds, rolling this funding into baseline resources. They intend to start this process in 2019-20 (paragraph 2.7) but have stated that they do not plan to move completely away from current mechanisms until they are confident that local systems will deliver financial balance.

**2.15** In January 2019, NHS England and NHS Improvement also announced the creation of a new Financial Recovery Fund from 2019-20. The fund will only be accessible for trusts where deficit control totals indicate a risk to financial sustainability and continuity of services, and where agreed financial recovery plans are in place to deliver significant year-on-year improvement in sustainability and financial performance. The fund will mean the end of the control total regime and Provider Sustainability Fund for all trusts which deliver against their recovery plans by 2021 at the latest.

### **Other sources of financial support**

**2.16** The Department and NHS England may provide financial support to trusts in difficulty. This may take the form of interest-bearing loans, or non-repayable public dividend capital.

**2.17** 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 from the Department and NHS England for trusts in financial difficulty continued to increase to £3.4 billion issued in 2017-18, up from £3.1 billion in 2016-17 and £2.4 billion in 2015-16. To deter trusts from overspending and incurring deficits, the Department has increasingly been offering this support in the form of loans rather than public dividend capital. In 2017-18, 94% of the Department's support (£3.2 billion) was given in this way, up from £2.8 billion in 2016-17.<sup>12</sup> Most of it was given as revenue support (£2.8 billion) to allow trusts to maintain services, rather than as longer-term capital support (£0.5 million).

**2.18** By March 2018, outstanding debt issued by the Department to trusts in financial difficulty reached some £8.0 billion, up from £1.8 billion on 31 March 2013.<sup>13</sup> The Department expects the debt to be repaid by trusts in due course. However, the profile of loan and interest repayments appears unrealistic (**Figure 10**), with some £4.5 billion of loan repayments due in 2020 alone. It is likely, in the short term, that the Department will issue new loans to trusts to meet these repayments, or for the term of the loans to be extended.

<sup>12</sup> These figures exclude loans issued by the Department to trusts in the normal course of business, which totalled £0.25 billion in 2017-18. These provide capital investment or support short-term working capital requirements where there is evidence that the trust is viable in the longer term and can repay the loan.

<sup>13</sup> The £1.8 billion includes normal course of business loans, as data are not available to distinguish the type of loan for previous years.

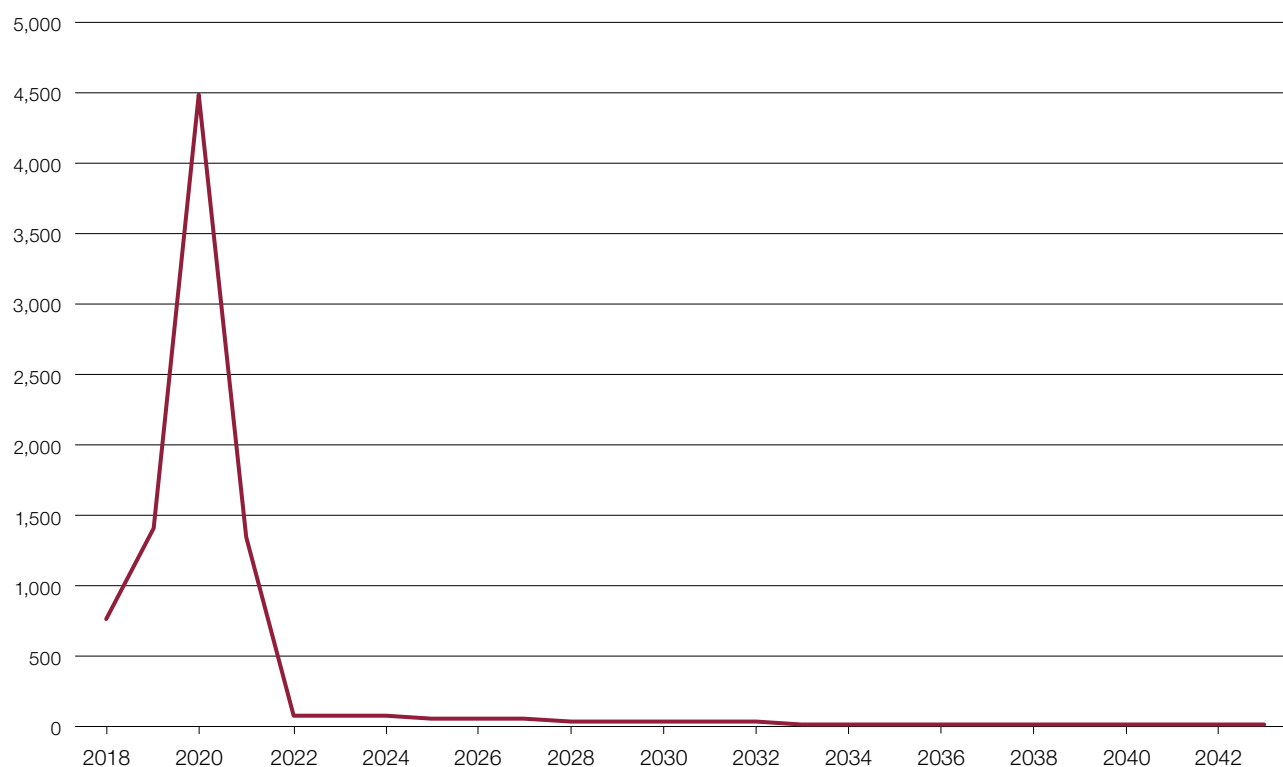


**Figure 10**

## Loan repayments due to be repaid by trusts to the Department

**The profile of loan repayments appears unrealistic**

Loan and interest repayment (£bn)

**Note**

1 Loan repayments comprise principal and interest payments.

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

**2.19** Of the £8.5 billion of loans and interest that are due to be repaid to the Department, £0.5 billion relates to interest payments over the term of the loans. One trust is expected to repay £503 million, of which £48 million relates to interest payments. In 2017-18, trusts paid the Department £124 million in interest. Trusts with the biggest deficits hold the most debt. In addition, the Department has historically imposed higher interest rates on loans to trusts in financial special measures (6% compared with 1.5% for most other trusts). Since October 2018, the Department has reduced the interest rate on all new loans issued to these trusts who deliver three months of benchmarked performance. As of November 2018, only one trust did not meet these criteria. However, it continues to apply a higher interest rate of 3.5% to those trusts that have not accepted their control totals or that are in special measures. The higher interest rate is intended to discourage trusts from getting additional financial support but may add to their financial challenge by pushing them further into deficit.

## Capital funding

**2.20** Capital funding covers spending on buying or improving an asset, such as keeping facilities up-to-date and rolling out new technologies. Investment in capital is essential for maintaining quality of care, improving productivity and achieving the transformation that is required for the NHS to be sustainable in the longer term.

**2.21** Local NHS bodies that we spoke to told us that there was a shortage of capital funding. In 2017-18, trusts estimated that they had accumulated £6.0 billion in maintenance costs that need to be addressed, up from £4.0 billion in 2012-13.<sup>14</sup> These costs would be addressed by a combination of both capital and revenue funds. Within this, required maintenance classified as a high and significant risk increased from £1.4 billion in 2012-13 to £3.1 billion in 2017-18.

**2.22** Since 2014-15, the Department has used money originally intended for capital projects to cover a shortfall in the revenue budget. The government's 2015 Spending Review, set out an indicative profile of capital to revenue switches that would finish before the end of the Spending Review period. In line with this, in 2017-18, the Department decided at the start of the year to transfer £1 billion of its £5.6 billion capital budget to revenue budgets to fund day-to-day services. This followed transfers of £1.2 billion in 2016-17 and £950 million in 2015-16. The Department plans to transfer £0.5 billion in 2018-19, £0.25 billion in 2019-20, and intends to stop this practice from 2020-21. The reduction in these transfers has been accompanied by a rise in the annual capital budget available since 2016-17; £1.3 billion more in 2018-19 than 2016-17. The revenue support reduced the deficit (or increased the surplus) reported by those trusts. But there is a risk that trusts have sacrificed long-term investment to meet the immediate needs of service provision. For example, some trusts may have delayed projects to fund day-to-day running costs. The Department is also undertaking a review of NHS capital, which will feed into the capital settlement in the 2019 Spending Review.

**2.23** Local NHS bodies told us that the capital funding system makes it difficult for them to plan and is acting as a barrier to investment. They told us that:

- long-term decisions about capital investment cannot be made because of the relatively short-term nature of allocations;
- it can take time for the national bodies to make decisions about capital allocations, making planning and managing capital programmes very difficult;
- local partnerships have received extra capital funding for specific projects, but they are unable to pool funding and the projects do not always address the priorities of the partnerships;
- filling in documents to access financial support can be resource-intensive and can require the same amount of effort irrespective of the level of funding; and
- trusts and CCGs reporting deficits do not generate surplus cash, which may mean they have no funds to invest in capital.

<sup>14</sup> These are self-reported figures, taken from the Annual Estates Return Information Collection.

## **The long-term funding settlement for NHS England, 2019-20 to 2023-24**

**2.24** As part of the £20.5 billion settlement, the government asked NHS England to produce a 10-year plan with the following priorities: making progress towards achieving 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. This plan was published in January 2019.

**2.25** The government also set the NHS five financial tests to show how the NHS will do its part to put the service onto a more sustainable footing; (including providers) return to financial balance; achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in front-line 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.

**2.26** The NHS long-term plan sets out how the NHS aims to meet the expectations and tests set out in the settlement, which are described as stretching but feasible. In its 2018 Autumn Budget, the government announced that at least £10 billion (16%) of the settlement would be allocated to mental health services. The long-term plan announced that by 2023-24, £4.5 billion a year of the settlement would be allocated to primary medical and community services. Bringing stability to the system would require £1.85 billion to eliminate the underlying deficit (paragraph 1.13), although NHS Improvement's additional efficiency requirement for trusts with a deficit control total, set out in the long-term plan, of at least 0.5% above the 1.1% trust sector minimum requirement should help to reduce this underlying deficit. Reducing the waiting list to the level last seen in March 2018 would require an estimated £700 million (paragraph 1.15). In addition, the NHS will need to absorb ongoing cost pressures, such as increases in demand for services from a growing and ageing population. We have previously reported that funding boosts appear to have been spent on coping with current pressures rather than making the changes required to put the health system on a sustainable footing.<sup>15</sup>

<sup>15</sup> Comptroller and Auditor General, *Sustainability and transformation in the NHS*, Session 2017–2019, HC 719, National Audit Office, January 2018.

**2.27** The 3.4% average uplift in funding applies to the budget for NHS England and not to the Department's entire budget. The Department's budget covers other important areas of health spending such as most capital investment for buildings and equipment, 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, especially if funding for these areas reduces. The government will consider proposals in these areas as part of its Spending Review 2019. Unless further changes are made, the Department's budget, excluding the budgets for NHS England and capital, will fall by £1 billion in real terms in 2019-20. The 2019 Spending Review will cover the period from 2020-21 onwards.

**2.28** Local NHS bodies are also concerned that, without a long-term funding settlement for social care, it will be very difficult to return the health sector to financial balance, given the links between health and social care. Our report on the adult social care workforce found that the Department could not demonstrate that the sector is sustainable.<sup>16</sup> The government's 2018 Autumn Budget announced an additional £650 million for social care but provided no details about how the sector will be made sustainable in the longer term.

**2.29** There is a risk that the NHS will be unable to use some of the £20.5 billion of funding optimally due to difficulties recruiting staff (paragraph 1.19). We and the Committee of Public Accounts have previously reported that trusts had used temporary staff to fill short-term workforce pressures, which was a costly and inefficient use of resource.<sup>17</sup> There is also a risk that the extra money will not be spent if healthcare providers do not have the staff to meet the demand for services.

16 Comptroller and Auditor General, *The adult social care workforce in England*, Session 2017-2019, HC 714, National Audit Office, February 2018.

17 Comptroller and Auditor General, *Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016 and HC Committee of Public Accounts, *Managing the supply of NHS clinical staff in England*, Fortieth Report of Session 2015-16, HC 731, April 2016.

# Part Three

## Supporting local partnerships

**3.1** In this part of the report, we look at how local partnerships between health and care organisations are progressing, and what the national bodies – the Department of Health & Social Care (the Department), NHS England and NHS Improvement – are doing to support them.

### Local partnerships

**3.2** Sustainability and transformation partnerships bring together clinical commissioning groups (CCGs), NHS trusts and NHS foundation trusts (trusts) and local authorities, along with primary care and voluntary sector representatives, to think collectively through their local challenges and potential solutions (**Figure 11** overleaf). The 44 partnerships 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.

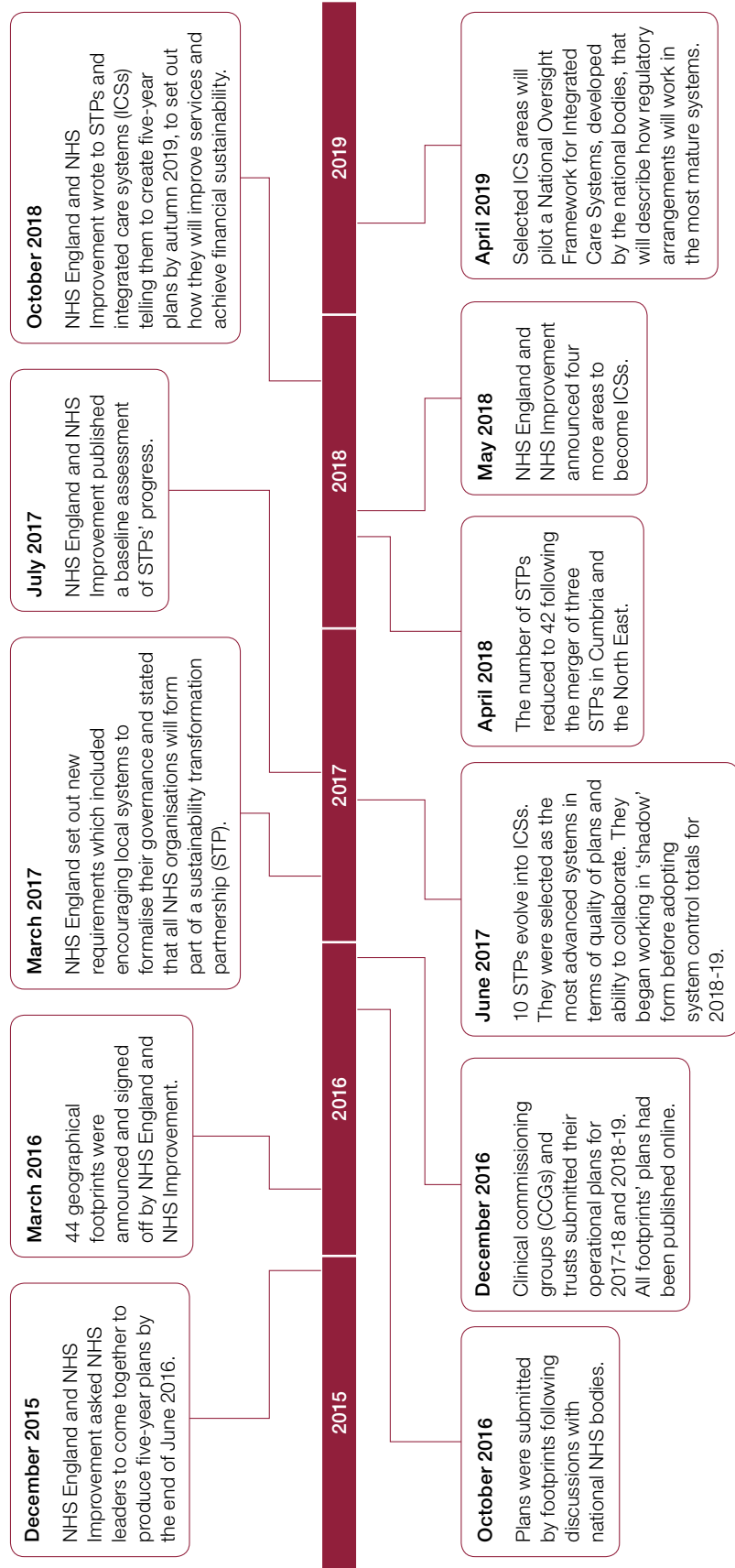
**3.3** Some partnerships have evolved, or are in the process of evolving, into integrated care systems (ICSs), formerly known as accountable care systems. The systems aim to have greater control over spending of funds with less involvement of national regulators. Partnerships and integrated care systems are viewed as the vehicles of change for a more integrated health and care system with emphasis on populations, places and systems. The NHS long-term plan notes the aim to have integrated care systems covering the whole country by April 2021. As neither sustainability and transformation partnerships nor integrated care systems are statutory bodies, the success of the system is determined by the willingness of the bodies within the system to come together.

### Progress to date

**3.4** Last year's report found that partnerships were laying the foundations for more strategic system-wide planning and delivery. In August and September 2018, we visited six areas to gain insight into the progress being made and the key challenges facing partnerships and ICSs.

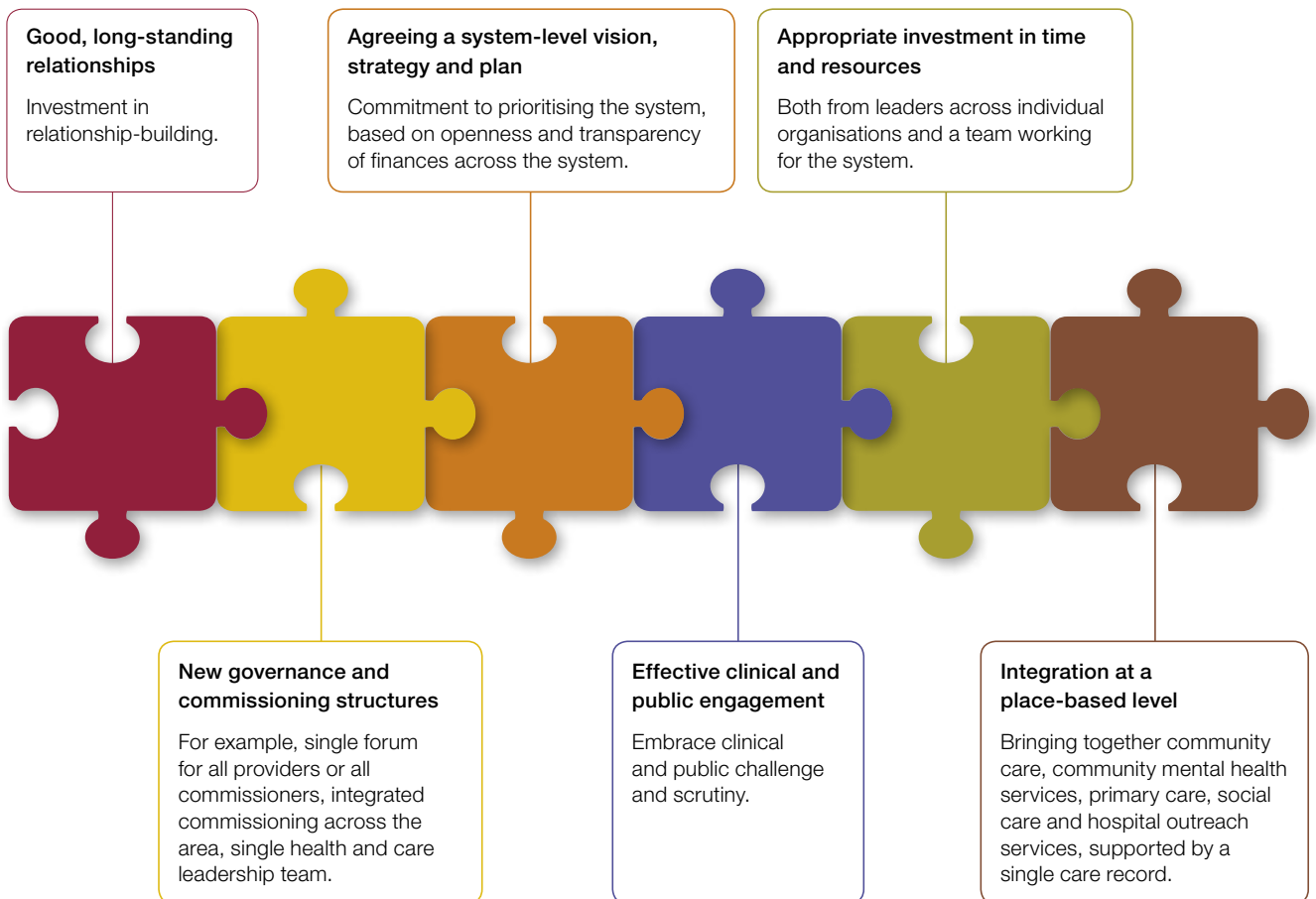
**3.5** All stakeholders reported that progress had been made by their system across some, or all, of the key components for success (**Figure 12** on page 37), depending on the stage the partnerships had reached in their development. However, it is difficult to assess progress across England because NHS England and NHS Improvement are yet to update their baseline assessment of sustainability and transformation partnerships' progress that they published in July 2017. National bodies plan to develop a new accountability and performance framework for integrated care systems.

**Figure 11**  
Timeline of key developments in local partnerships



**Figure 12**

Key components of success in sustainability and transformation partnerships and integrated care systems



Source: National Audit Office

**3.6** Most areas noted that the pace of change was slow in transforming the way services are provided, with few yet to reach the stage where major service reconfiguration had taken place. For example, even when partnerships have agreed on proposals for major service reconfiguration it takes time to consult the public on the proposed changes, deal with any legal challenges and receive approval from all relevant bodies, including in some cases requiring capital, HM Treasury.

## Challenges

**3.7** In 2017-18, most partnerships had deficits, when trusts' and CCGs' finances were added together (**Figure 13** overleaf). Even the more advanced partnerships that we visited reported significant challenges in managing demand within their budget. **Figure 14** on page 39 highlights some of the key challenges faced by partnerships and ICSs, many of which were highlighted in our previous report.

**Figure 13**

Surplus/deficit of sustainability and transformation partnerships, 2017-18

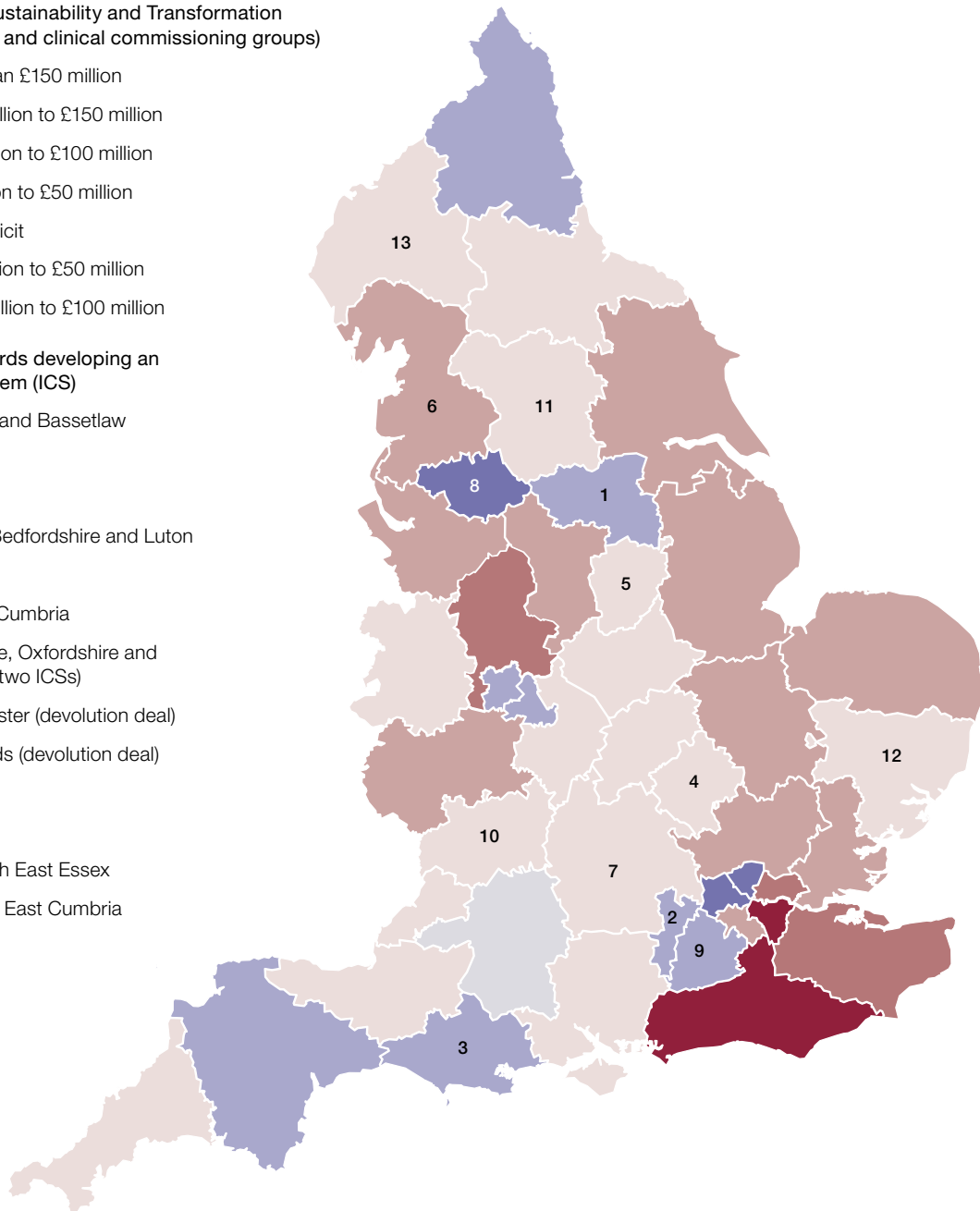
Out of the 44 partnerships, 73% (32) had a deficit in 2017-18, when trusts' and CCGs' finances were added together

Surplus/deficit of Sustainability and Transformation Partnerships (trusts and clinical commissioning groups)

- Deficit greater than £150 million
- Deficit of £101 million to £150 million
- Deficit of £51 million to £100 million
- Deficit of £1 million to £50 million
- No surplus or deficit
- Surplus of £1 million to £50 million
- Surplus of £51 million to £100 million

Areas working towards developing an integrated care system (ICS)

- 1 South Yorkshire and Bassetlaw
- 2 Frimley Heath
- 3 Dorset
- 4 Milton Keynes, Bedfordshire and Luton
- 5 Nottinghamshire
- 6 Lancashire and Cumbria
- 7 Buckinghamshire, Oxfordshire and Berkshire West (two ICSs)
- 8 Greater Manchester (devolution deal)
- 9 Surrey Heartlands (devolution deal)
- 10 Gloucestershire
- 11 West Yorkshire
- 12 Suffolk and North East Essex
- 13 West, North and East Cumbria



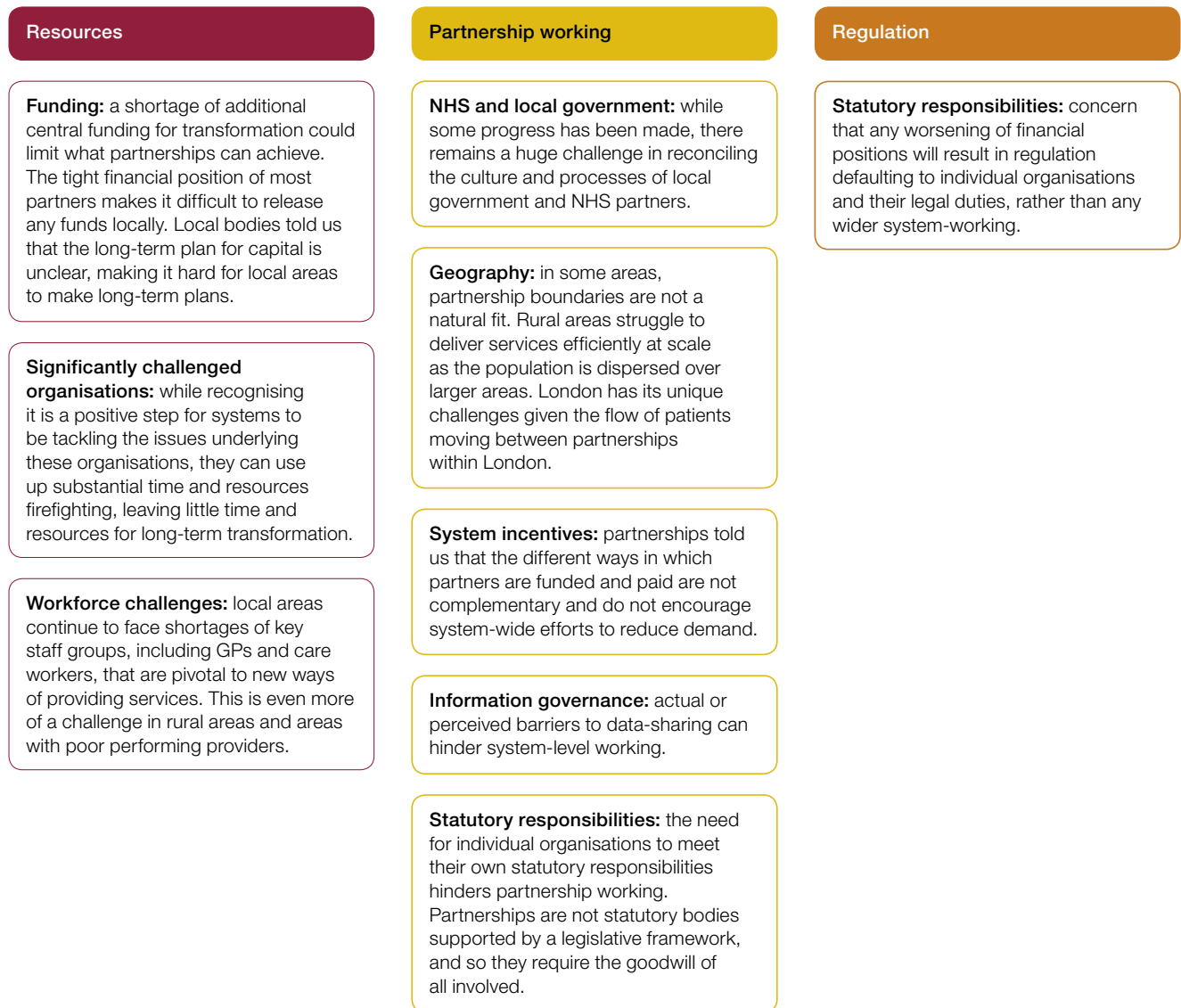
Source: National Audit Office analysis of NHS England and NHS Improvement data



**Figure 14**

Summary of the key challenges raised by sustainability and transformation partnerships and integrated care systems

Key challenges include resources, system incentives and regulatory processes



Source: National Audit Office

**3.8** In response to a formal request from the Health and Social Care Select Committee and the Prime Minister, the national bodies in discussion with NHS colleagues have developed a provisional list of potential legislative changes for Parliament's consideration to support better integration in the best interest of patients. These proposals include: giving trusts and CCGs shared new duties; removing barriers to 'place-based' commissioning and counterproductive competition rules; and supporting the more effective running of integrated care systems and the creation of integrated care trusts.

### **Supporting local NHS bodies**

#### Helping local bodies to understand demand pressures

**3.9** To be sustainable in the long run, the NHS needs to be able to meet the increasing demand for healthcare services within its limited resources. For example, between 2011-12 and 2016-17, the total number of people admitted to hospital grew by an annual average of 3.4%. Local bodies need a good understanding of the reasons for increasing activity to manage this demand. Regional offices of the national bodies also need a good understanding to support local bodies to manage demand and gain assurance that they are managing demand effectively. However, it is difficult to predict and quantify all variation in demand because of the complex nature of healthcare and drivers of demand.

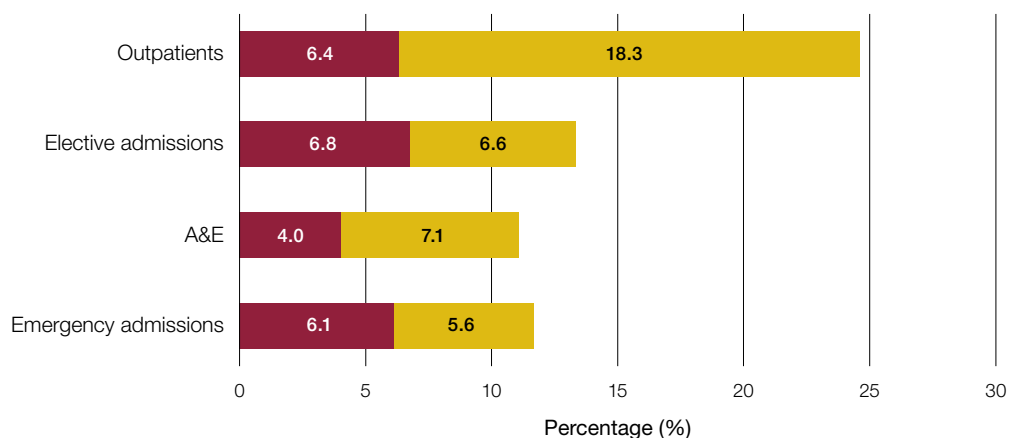
**3.10** Our analysis shows that less than half of the increase in hospital activity between 2011-12 and 2016-17 can be explained by an ageing and growing population (**Figure 15**). Several other factors, such as unmet health needs, and medical advancements, are responsible for the remaining increase. Our previous reports have also highlighted that there is limited understanding of the drivers of demand for some services, such as ambulance services.<sup>18</sup>

**3.11** Activity growth rates vary considerably across regions, after accounting for changes in population size and age (**Figure 16** on page 42). For example, between 2011-12 and 2016-17 the change in outpatient attendances was 5% in South East England but only 1% in the South West. Some initiatives led by national bodies, such as RightCare, have helped to improve local understanding of the factors that drive local variations in changes in demand.

**Figure 15**

Change in hospital activities, 2011-12 to 2016-17

**Less than half of the recent increase in hospital activity can be explained by a growing and ageing population**



- Growth explained by growing and ageing population
- Growth explained by other factors

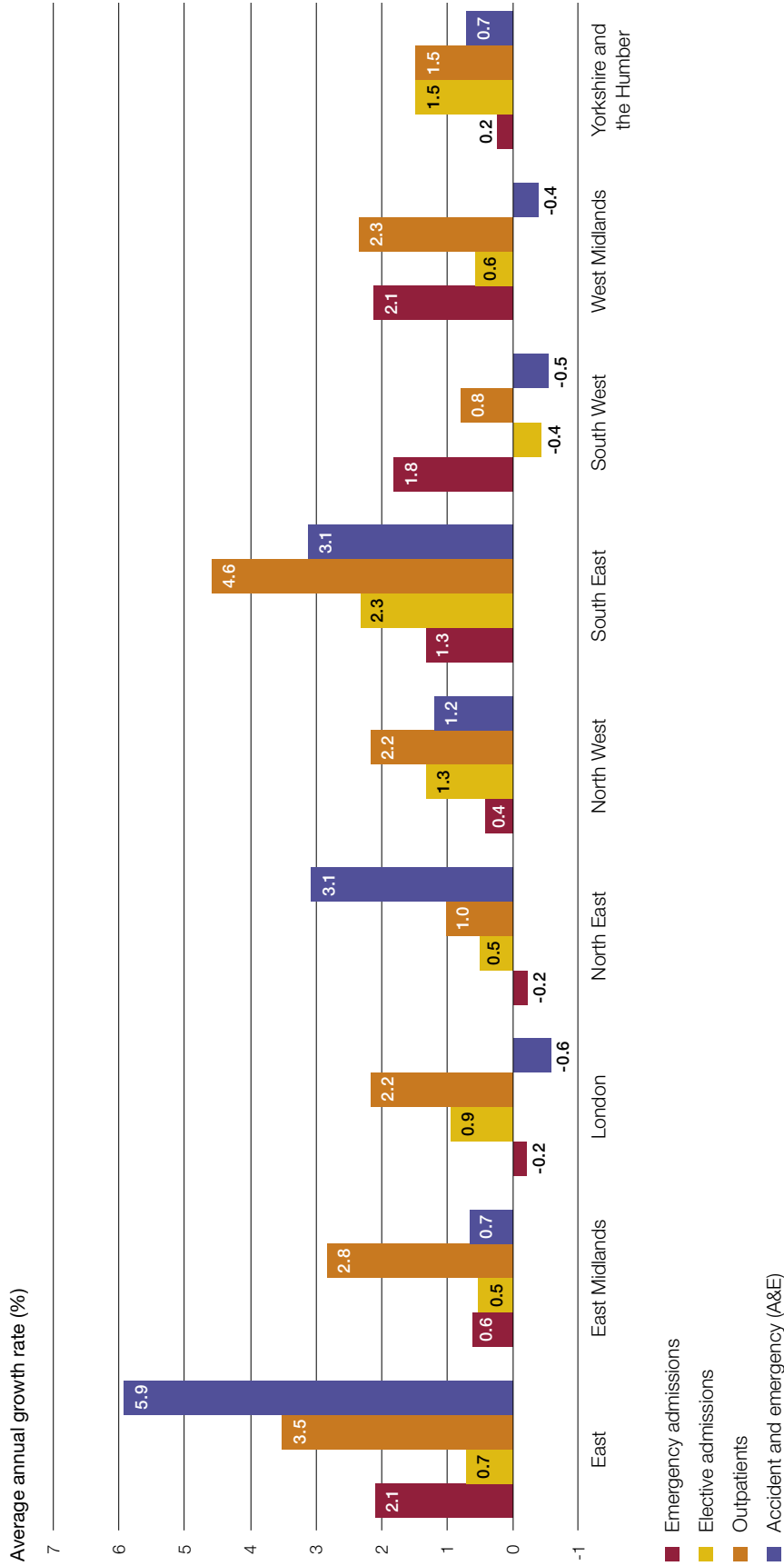
**Notes**

- 1 Accident and emergency (A&E) attendances include only type 1 and 2 A&E departments. Type 1 A&E departments are consultant-led 24-hour services with full resuscitation facilities and designated accommodation for the reception of A&E patients. Type 2 A&E departments are consultant-led single speciality A&E services with designated accommodation for the reception of patients.
- 2 Elective admissions are arranged in advance and do not include emergency admissions, maternity admissions or transfers from hospital beds in other providers.
- 3 Emergency admissions are unpredictable and short notice admissions, because of the clinical need.
- 4 Outpatient appointments are when a GP refers a patient to a consultant or other hospital-based specialist for further advice.
- 5 Other factors include changing patient expectations, technological advancements and changes in medical practices.

Source: NHS England data

**Figure 16**  
Changes in hospital activities by region, 2011-12 to 2016-17

There is considerable variation in changes in activity by region, after adjusting for changes in population size and age



**Note**

1 See notes for Figure 15.

Source: National Audit Office analysis of NHS Digital's Hospital Episodes Statistics data

**3.12** However, local partnerships had mixed views about the extent to which they understood what was driving demand in their areas. They noted that combining data from across local bodies, including health and local government, would help to provide a better understanding of demand pressures. For example, a lack of linked data across health and social care means NHS England cannot assess the impact of out-of-hospital care on hospital activity. Better data in this area would complement the work that national bodies are undertaking with partnerships to develop population health management expertise. This includes a programme that trains providers in demand and capacity modelling techniques and provides support to commissioners to assure demand and capacity planning, and the implementation of a national population health management dashboard, which they aim to launch in 2019. Commissioners and trusts are now required to set out the drivers of activity growth between years in their operational plans.

### National efficiency programmes

**3.13** The national bodies have several programmes to help CCGs and trusts manage demand, deliver savings, reduce costs and develop their population health management (**Figure 17** on pages 44 and 45). Local bodies told us that they have found these initiatives useful, although the lack of up-to-date information can limit the effectiveness of some programmes, such as RightCare.

### Regulation

**3.14** Last year's report found that NHS England and NHS Improvement needed to further develop the way they regulated partnerships and the local bodies within them to become more aligned, as there were issues with duplication of information requests, and conflicting messaging.

**3.15** Since then, the two organisations have continued to make organisational changes to help them to work more closely together. Appointments have been made to a set of shared national director roles, including a single medical director, chief nursing officer, chief financial officer and director for transformation and corporate development. The regional teams of both organisations are also due to merge and will be led by one regional director working for both organisations from April 2019. The teams will be responsible for the quality, finance and operational performance of all local NHS bodies in their region. NHS England and NHS Improvement plan to implement a new shared operating model that aims to support the delivery of the NHS long-term plan.

**3.16** Local areas we visited reported that the approach of national regulators has begun to feel more joined up. Examples included regular local meetings that both regulators attended together, and joint roles between the two regional teams, providing support and liaising on behalf of both regulators. However, local areas also noted areas for further improvement: when local systems are put under financial pressure, regulators often revert to working independently, as they are separate bodies with distinct priorities; national and regional messages provided by each regulator can be inconsistent; and information requests from the two organisations need to be streamlined further.

**Figure 17**

## National initiatives to help bodies to reduce demand, manage costs and improve efficiency

## These initiatives are helping local bodies to deliver efficiency savings

| Programme                    | Description   | Planned savings/reductions in spending  | Achievements in 2017-18  |
|------------------------------|---|---|--|
| Operational productivity     | <p>NHS Improvement's Operational Productivity directorate supports trusts in identifying recurrent and sustainable savings. It includes:</p> <ul style="list-style-type: none"> <li>the Getting It Right First Time (GIRFT) programme, which involves national reviews led by clinicians of medical and surgical specialities; and</li> <li>the Model Hospital, a data portal that shares examples of best practice, allowing trusts to identify savings opportunities and track progress.</li> </ul> | <p>£5.8 billion by 2020-21.<br/>£1.8 billion target for 2017-18.</p>  | <p>£1.45 billion of savings reported attributable to GIRFT and Model Hospital.</p>   |
| Agency costs                 | <p>In October 2015, the Department of Health &amp; Social Care (the Department) introduced specific spending controls on agency staff to help trusts control staff costs. These included approved frameworks for trusts to use, an annual spending limit for each trust, and caps on the rates that trusts can pay. NHS Improvement created a framework to help trusts with workforce planning and provides support for trusts that are struggling to improve.</p>                                    | <p>A national target to reduce medical agency spending, with an initial aim of reducing spending by £150 million in 2017-18.</p> <p>A target for each trust for medical locum spending.</p> | <p>Local bodies credited these measures with helping them to control the costs of agency staff. In 2017-18, trusts spent £2.4 billion of their total staff costs on agency staff, down from £3.0 billion in 2016-17 and a peak of £3.7 billion in 2015-16.</p>             |
| RightCare                    | <p>NHS England's programme supports clinical commissioning groups (CCGs) in reducing wasteful and ineffective spending and improving clinical outcomes, through information designed to show variation in treatment for different conditions.</p>   | <p>£1.7 billion by 2020-21.<br/>84% forecast for delivery between 2018-19 and 2020-21.</p>  | <p>£587 million of CCG efficiency savings and £76 million from commissioning specialised services.</p>   |
| Vanguards/new models of care | <p>NHS England funded 50 pilot sites between April 2015 and March 2018 to develop new models of care to integrate services around the needs of the patient, with the aim of replicating them elsewhere. It invested £329 million over this period to help develop these new models of care and spent £60 million supporting these vanguards.</p>  | <p>£324 million net annual savings by 2020-21.</p>  | <p>Early evidence that emergency admissions to hospitals have grown significantly more slowly in vanguard areas. However, evaluating the impact of the vanguards is challenging because of data quality issues.</p> <p>Vanguards reported net savings of £121 million.</p> |

**Figure 17** *continued*

## National initiatives to help bodies to reduce demand, manage costs and improve efficiency

| Programme                 | Description   | Planned savings/reductions in spending   | Achievements in 2017-18   |
|---------------------------|---|--|---|
| Urgent and emergency care | NHS England's programme is based on the development of networks of hospitals and community services to ensure people are treated in the most appropriate setting. It includes eight of the 50 vanguards, which tested models of care designed to reduce pressure on Accident and Emergency departments (A&E), such as providing clinical advice through NHS 111 services. In March 2017, the government announced it would provide £100 million of capital funding to support this: £90 million was given to 103 trusts to meet A&E access targets, and £10 million to help the system manage winter pressures.   | £790 million by 2020-21.<br><br>73% forecast for delivery in 2019-20 and 2020-21.  | The target of more than 50% of calls to NHS 111 having clinical input was achieved by 31 March 2018.<br><br>2017-18 savings of £458 million.  |
| Elective care             | NHS England's programme is working to redesign patient pathways for non-emergency care; developing tools for health professionals to manage their patients so they see the right person in the right place at the right time.   | £18 million savings from existing high-impact interventions and £56 million savings estimate from further interventions by 2020-21.  | Estimate of £12 million savings.  |
| Medicines value programme | NHS England set up the programme to improve health outcomes from medicines and ensure we are getting the best value from the NHS medicines bill, by supporting people to take medicines as intended and enable access to effective treatment.   | £1,259 million gross savings by 2020-21.   | £909 million savings.   |
| Other programmes          | Other NHS England programmes include: <ul style="list-style-type: none"> <li>● <b>Primary care:</b> savings have been focused around a pay restraint for GPs, pharmacy reforms, freezes on ophthalmic fees, constraining increases to the number of consultations to the rate of population growth, and reducing prescription charge losses through fraud and error.</li> <li>● <b>NHS continuing healthcare</b> (healthcare funded by the NHS for ongoing healthcare needs provided outside hospital): savings against predicted growth in spending, to be achieved by reducing variation between local areas, increasing standardisation and adopting best practice.</li> </ul> | Savings expected by 2020-21: <ul style="list-style-type: none"> <li>● <b>Primary care:</b> £2,190 million.</li> <li>● <b>NHS continuing healthcare:</b> £855 million.</li> </ul> | <b>Primary care:</b> 2017-18 outturn indicates savings exceeded plans by £7 million (1%), to give £992 million, pay capped at 1%; optical fees frozen.<br><br><b>NHS continuing healthcare:</b> £530 million savings. |

**Notes**

1 The savings target is based on Spending Review 2015 targets. The level of ambition is being reviewed as part of the NHS long-term plan.

2 These figures are self-reported by NHS England and NHS Improvement.

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

# Appendix One

## Our audit approach

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

- the headline financial performance of the NHS overall in 2017-18;
- financial flows and incentives within the NHS and whether these encourage long-term sustainability; and
- the progress being made by local partnerships of health and care organisations, and the support that NHS England and NHS Improvement are providing them.

**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.

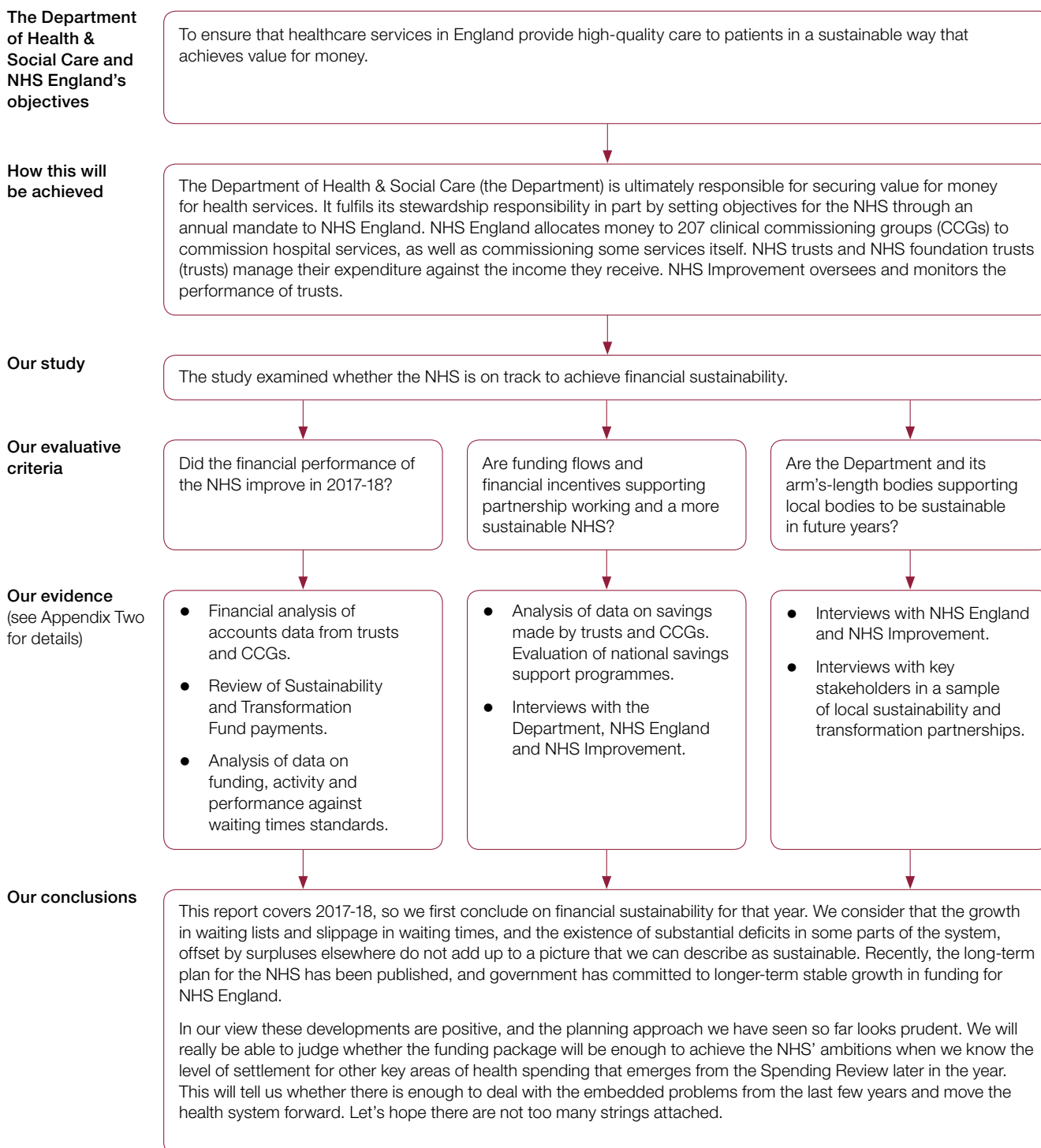
**3** We do not look in detail at primary care, social care, the integration of health and social care, public health or similar services, although the transformation and sustainability of these services are key elements of these new partnerships' work and are important to the sustainability of the NHS.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

**4** The NHS published its long-term plan in January 2018 shortly before we published this report. Our report reflects the commitments described in the long-term plan but we did not examine the costed propositions that support these commitments.

**5** 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 whether the NHS is on track to achieve financial sustainability after analysing evidence we collected between June and October 2017. 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.** Data analysis included:

- the overall financial position of the NHS in 2017-18;
- 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;
- a time series analysis of NHS activity; and
- a time series analysis of performance against key access standards.

**3 We compared existing financial data on trusts with performance against waiting times standards.** We compared the average financial performance across trusts in 2016-17 with waiting times standards for accident and emergency (A&E), cancer treatment and routine, non-urgent referrals.

**4 We carried out a review of the Sustainability and Transformation Fund in 2017-18.** 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.

**5 We evaluated the national support programmes that NHS England and NHS Improvement have put in place to help local bodies deliver savings.** We reviewed:

- data on costs and outcomes from each programme, where available;
- planned and achieved financial savings; and
- support, guidance and best practice shared with local bodies.

**6 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 2017-18, and planned savings for 2018-19;
- levels of recurrent and non-recurrent savings and, for trusts, levels of generated income; and
- analysis of savings achieved and planned across sustainability and transformation partnership areas.

**7 We spoke to a range of staff across the Department, NHS England and NHS Improvement.** 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 NHS England and NHS Improvement's regional offices.

**8** We interviewed a range of stakeholders. This work was designed to obtain views on: financial pressure and challenges within the NHS; oversight by national bodies; support given to local bodies and systems; and progress in partnership working. We consulted with the Care Quality Commission, the Healthcare Financial Management Association, the Health Foundation, the King's Fund, NHS Clinical Commissioners, NHS Providers, the Nuffield Trust, the Royal College of GPs, the Royal College of Physicians and the Royal College of Surgeons.

**9** We conducted interviews at a sample of six sustainability and transformation partnerships in August and September 2018. This work was designed to understand:

- progress in implementing plans to transform services;
- the challenges faced by local systems in building effective partnerships; and
- the support provided by national bodies to tackle these challenges.

**10** 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;
- a range of rural and non-rural partnerships; and
- a range of leaders, including where the partnership lead was from a trust, CCG or local authority.

**11** Overall, we met with 74 individuals representing 58 different organisations.

# Appendix Three

## 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.
- 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 Sustainability and Transformation 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.

### **Adjusting for the effects of organisational changes during 2017-18**

**8** This report refers to 232 trusts in existence on 31 March 2018. This figure excludes Mid Staffordshire NHS Foundation Trust, which ceased to provide healthcare services on 1 November 2014 and formally dissolved on 1 November 2017. Mid Staffordshire NHS Foundation Trust recorded a deficit of £77,000 in 2017-18. The costs relate to the payment of historical liabilities and the overhead costs of the shell company. Our analysis throughout the report does not include any balances relating to Mid Staffordshire NHS Foundation Trust in 2017-18.

**9** One merger between two trusts occurred in 2017-18. Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust merged to become Manchester University NHS Foundation Trust. For this merger, we have totalled the former organisations' income, expenditure and surplus/deficit arising between 1 April 2017 and the date of merger and added it to the income, expenditure and surplus/deficit of the post-transaction trust. This has the effect of treating the merger as if it had occurred on 1 April 2017.

## Adjustments to trusts' figures

**10** 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.

**11** The adjustments made to trusts' performance have been aligned for 2017-18 to ensure that the surplus or deficit of both NHS trusts and NHS foundation trusts are measured on a consistent basis. The calculations for the 2016-17 and years prior to this include additional adjustments for:

- additional charges associated with bringing private finance initiative assets on to the balance sheet due to the introduction of International Financial Report Standards accounting in 2009-10 (IFRIC 12);
- the impact of changes in accounting for donated assets and government grant reserves; and
- the impact of the change in discount rate.

**12** If the surplus or deficit for trusts had included the adjustments outlined above, the overall deficit for the provider sector would have been £1,088 million (compared with £991 million). Conversely, if the calculations for 2016-17 were calculated on the aligned basis, the deficit for that year would have been £876 million (compared with £791 million).

**13** 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**

**14** 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.

**15** 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: 006331-001

£10.00

ISBN 978-1-78604-237-8



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