The King's Fund

BRIEFING

Deficits in the NHS 2016

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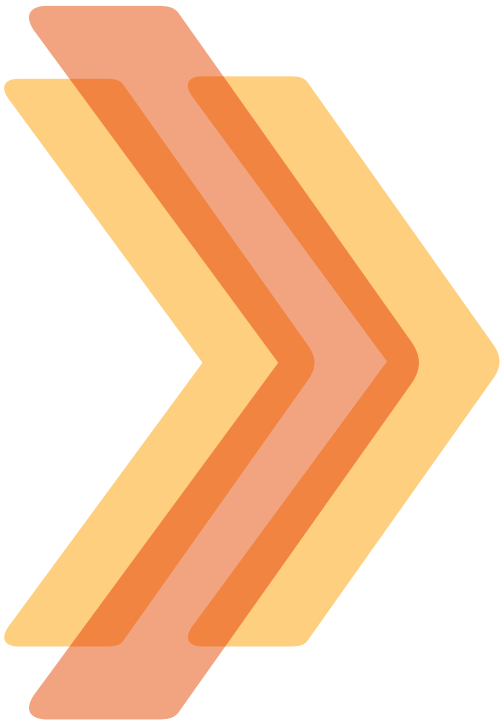


Key messages

- NHS providers and commissioners ended 2015/16 with an aggregate deficit of £1.85 billion (unaudited), a threefold increase on the previous year. This is the largest aggregate deficit in NHS history.
- Deficits among acute providers have been well documented, but less attention has been paid to the impact of financial pressures on other parts of the NHS. There is evidence to suggest that, in recent years, the relatively strong financial performance by mental health and community services providers may have been delivered at the expense of cuts in staff and risks to patient care, while the overall financial position of local commissioners has deteriorated sharply over the past two years.
- The scale of the aggregate deficit makes it clear that overspending is largely not attributable to mismanagement in individual organisations – instead it signifies a health system buckling under the strain of huge financial and operational pressures. The recent strategy of driving efficiencies by cutting the tariff has placed disproportionate strain on providers and is no longer sustainable.
- The principal cause of the deficit is the fact that funding has not kept pace with the increasing demand for services. Financial pressures have also been exacerbated by the recruitment of additional staff to improve quality of care in hospitals following the Francis report into the failures of care at Mid Staffordshire NHS Foundation Trust (**Mid Staffordshire NHS Foundation Trust Public Inquiry 2013**).
- It is touch and go whether the Department of Health has managed to stay within the budget voted by parliament for 2015/16. If it has, this will be due to the introduction of stringent financial controls and a series of one-off measures that mask the size of the underlying deficit. Some of these short-term fixes – particularly cutting capital spending – risk storing up problems for the future.
- With the underlying deficit among providers much worse than the figure reported and performance against key targets deteriorating, cuts in staffing and reductions in quality of care are inevitable if the government's priority is to restore financial balance.

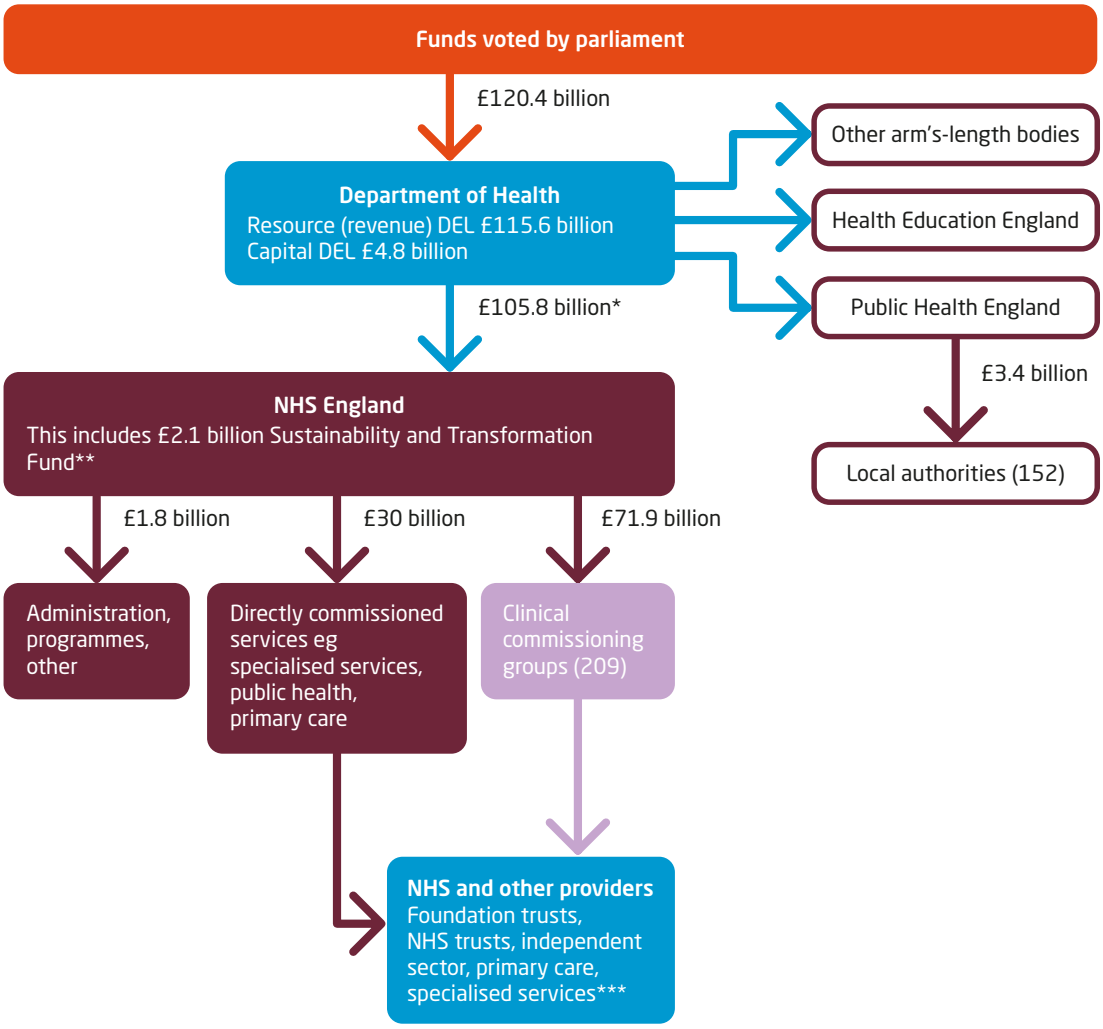
- The NHS must redouble its efforts to improve productivity. There are significant opportunities to deliver better value by improving clinical practice and reducing waste, although these cannot be achieved at the pace or on the scale needed to meet the target to deliver £22 billion of efficiency savings by 2020/21.
- Looking to the future, programmes to implement new models of care and transform services offer significant opportunities to improve care. These initiatives must be given the time and investment needed to deliver results, but they will not deliver savings in the short term.
- The political and economic uncertainty following the UK's vote to leave the EU adds to the risks facing the NHS. A prolonged fall in the value of sterling could lead to higher costs and increase financial pressures. If warnings about a major economic shock prove to be correct, this could have significant implications – any reduction in health or social care funding as a result of spending cuts would pose a serious risk to patient care.
- Regardless of this, the government must review its priorities for the NHS to ensure these can be delivered within the resources available. This includes revisiting the feasibility of the commitment to seven-day services and may mean reviewing key waiting times targets. There must be realism about what the NHS can achieve with the funding allocated to it and there should be an honest debate with the public about this.

Introduction

Unaudited figures indicate that NHS commissioners (clinical commissioning groups and NHS England) and providers in aggregate ended 2015/16 in deficit for the second year running. Attention has so far largely focused on acute providers, and much less emphasis has been placed on the growing financial pressure on commissioners and on the impact of deteriorating NHS finances on other providers.

This briefing draws on data from our quarterly monitoring reports, secondary research and interviews with health care leaders to consider commissioner and provider finances in the round and to provide an overview of the factors that have led to the NHS going into deficit. It goes on to outline some of the strategies being employed to restore financial balance, before drawing together our thoughts on the implications of these strategies for the NHS this year and in the longer term.

Figure 1 Main funding flows in the health care sector, 2016/17



*** This figure includes £0.9 billion for screening/immunisation programmes – granted under the Section 7A agreement that goes via Public Health England**

**** The Sustainability and Transformation Fund consists of a £1.8 billion sustainability strand for providers (mainly of acute emergency care) and £0.3 billion for transformation**

***** In 2016/17, a total of 114 CCGs will have assumed full responsibility for the commissioning of primary medical services under delegated commissioning arrangements. NHS England has also committed to give CCGs stronger leadership of the collaborative commissioning of specialised services during 2016/17**

Sources: NHS England 2016f; Department of Health 2016; HM Treasury 2015

What does it mean to be in deficit and what financial support is available?

- Running a deficit means that an organisation's outgoings (costs) are greater than its income (or revenue). In the private sector, a sustained deficit would most likely force an organisation into bankruptcy.
- This does not happen in the NHS. Instead, a range of financial assistance is available from the Department of Health that enables the organisation to pay creditors and staff, ensuring that there is no interruption to services.
- In 2014/15, NHS trusts and foundation trusts received £1.8 billion of additional financial support, more than twice as much as in 2013/14.*
- Two main forms of interim revenue-based support are:
  - loans to meet day-to-day running costs where there is a reasonable expectation that they will be repaid
  - Public Dividend Capital (PDC), which covers cash shortages where a loan is considered unaffordable or unsustainable; trusts pay an annual fixed dividend, set by the Department, instead of paying back the money in full.
- Although most of the support in 2014/15 came in the form of PDC, during the course of 2015 interest-bearing loans became the first choice of short-term support to trusts.
- Although these forms of support are intended to be short term, some NHS organisations have received additional funding over many years.
- PDC and loans are also used to support capital investment.
- If the Department of Health does not want to offer financial support, it can force NHS organisations to tackle their deficit. However, any measures that organisations take – eg, to reduce numbers of staff – will take time to affect their balance sheet.

Sources: Murray *et al* 2014; Department of Health 2014b; National Audit Office 2015

* We expect details of the support provided in 2015/16 to be provided in the Department of Health's audited accounts, likely to be published in July 2016.

Current context

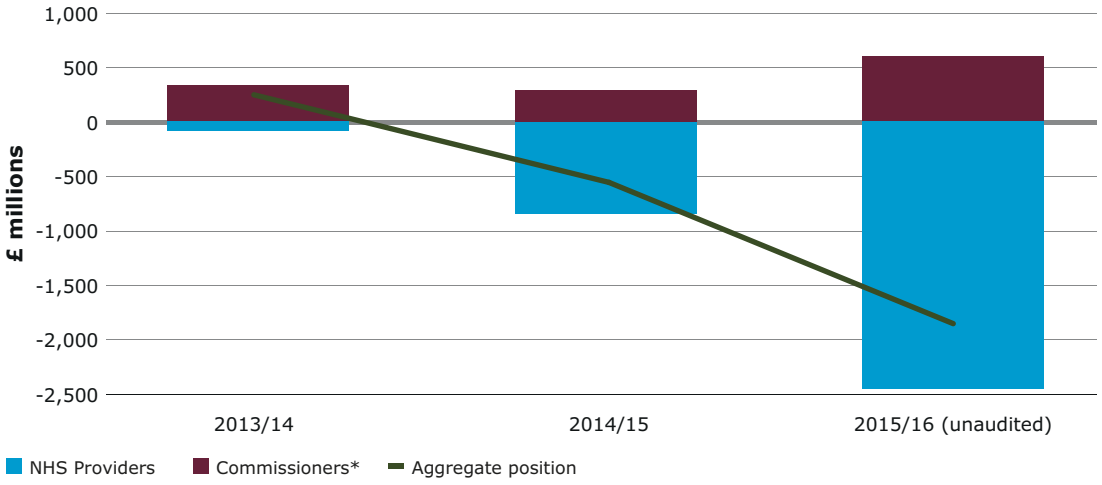
The aggregate deficit among NHS providers and commissioners increased from £554 million in 2014/15 to £1.85 billion in 2015/16 (*see* Figure 2).[1] Analysis by the *Health Service Journal* shows that only one area of the country (Gloucester) reported a combined surplus among providers and commissioners (Dunhill 2016b).

According to the latest figures released by NHS Improvement (**2016e**):

- NHS providers will record a deficit of £2.45 billion for 2015/16, around £650 million more than was planned and nearly three times higher than in 2014/15; the underlying position (discounting one-off moves that only reduce the in-year deficit) is likely to be considerably higher, at around £3 billion (Dowler 2016)
- nearly two-thirds of all providers reported a deficit last year (*see* Figure 3), of whom more than 75 per cent were acute providers, while mental health, community and specialist providers collectively reported a surplus for the year
- 20 per cent of all providers reported a deficit of more than £20 million, with 11 overspending by more than £50 million; the largest individual deficit (£135 million) was reported at Barts Health NHS Trust (Clover 2016a).

1. Unaudited figure, calculated by adding the commissioning sector's underspend to the provider sector deficit.

Figure 2 Financial position of NHS bodies, 2013/14 to 2015/16



*** this reflects non-ringfenced RDEL outturn**

The 2013/14 provider figure excludes NHS Direct

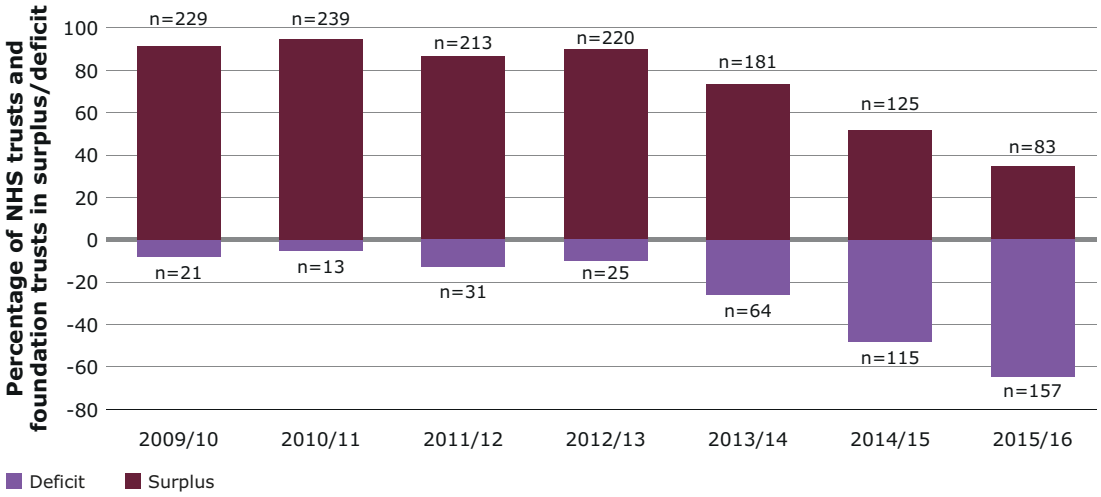
Sources: Department of Health 2014a, 2015b; NHS Improvement 2016e; NHS England 2016c

To date, deficits have been concentrated in the provider sector. This is largely because the NHS payment system (especially the Payment by Results (PbR) tariff) has been operated to shift financial risk away from commissioners and towards providers (*see* p 12). However, there are signs that the commissioning sector is coming under increasing financial pressure: 19 per cent of clinical commissioning groups (CCGs) reported overspends totalling £151 million, resulting in a collective overspend across all CCGs of £16 million in 2015/16. However, this was offset by underspends in NHS England's commissioning budget and central programmes, enabling NHS England to report an underspend of £599 million for 2015/16 (unaudited) for the commissioning sector as a whole.

Until the Department of Health publishes its audited accounts later this month we cannot be sure whether it has managed to live within the expenditure limit voted by parliament (*see* box). Last year, the Department was able to offset the aggregate deficit among NHS providers and commissioners by deploying savings of £662 million against its central budgets and transferring £640 million from the capital budget to the revenue budget; it was also given an additional £250 million in revenue funding by HM Treasury. As a result, the Department narrowly avoided overspending its key revenue budget (by just £1.2 million, or 0.001 per cent of the

total budget) (Department of Health 2015b). Failure to achieve financial balance in 2015/16 would be a first for the Department of Health and would result in reports to the House of Commons by the Comptroller and Auditor General (likely to be in the autumn), followed by a statement to parliament from HM Treasury seeking retrospective authorisation for any excess spending.

Figure 3 Number of trusts and foundation trusts in deficit or surplus, 2009/10 to 2015/16



Data source: The King's Fund analysis of Monitor, NHS Trust Development Authority and Department of Health data

Experiences from across the provider sector

As previously mentioned, in stark contrast to acute providers, community and mental health trusts have delivered overall surpluses year on year (*see* table below).

Table 1 Net financial position by provider sector, 2013/14 to 2015/16

	Net position					
	Acute	Mental health	Ambulance	Specialist	Community	Total
2013/14	-£421m	+£163m	+£15m	+£112m	+£39m	-£92m
2014/15	-£1,014m	+£87m	+£13m	+£56m	+£15m	-£843m
2015/16 unaudited	-£2,583m	+£54m	-£12m	+£74m	+£20m	-£2,447m

Sources: NHS Improvement 2016e; NHS Trust Development Authority 2015; Monitor 2015; NHS Trust Development Authority 2014; Monitor 2014b

While these surpluses may be seen as a positive, closer examination suggests they may have come at the expense of patient care (*see* box below).

Maintaining financial balance in mental health – at what cost?

Our analysis of annual accounts showed that 44.8 per cent of mental health trusts experienced a reduction in income between 2012/13 and 2013/14 and 38.6 per cent between 2013/14 and 2014/15 (**Gilburt 2015**).

Largely driven by pressure to reduce costs, mental health providers have embarked on transformation programmes to implement large-scale changes to services (**Gilburt 2015**).

While these programmes have delivered financial stability in the short term, they may have come at the expense of patient care. There is evidence of increased variation in care and reduced access to services as a result of the changes (**Mental Health Taskforce 2016**; **Gilburt 2015**). In its evaluation of crisis care, the Care Quality Commission (**2015**) described finding 'far too many' examples of people in crisis having 'poor experiences due to service responses that fail to meet their needs and lack basic respect, warmth and compassion'.

This has also resulted in far-reaching changes to the workforce, with a significant reduction in the number of experienced nurses, leading to staff shortages and insufficient skill mix in some areas. This undermines the commitment to parity of esteem, and may be building up workforce problems for the future (**Health Education England 2016**).

Evidence also suggests that financial constraints are increasing pressures on general practice and community health services.

The number of community nurses declined significantly between 2009 and 2014 (particularly among the most senior district nurses, whose numbers fell by 30 per cent), while some community providers have expressed concerns about ensuring adequate staffing numbers, skill mix and caseload (**Addicott *et al* 2015**; **Foot *et al* 2014**). This is particularly worrying given the focus on increasing out-of-hospital care, which might have led us to expect a rapid growth in the community workforce over this period.

The volume and complexity of GP workloads have increased substantially in recent years, with consultations growing by more than 15 per cent between 2010/11 and 2014/15. This has not been matched by growth in either funding – spending on general practice in England fell by 0.4 per cent over the same period – or workforce. As pressures have grown, there is evidence to suggest that patient experience has suffered, and that it is increasingly difficult to recruit and retain GPs, leading to the conclusion that 'general practice is in crisis' (**Baird *et al* 2016**).

So while deficits are clearly undesirable, the alternative – putting patient care at risk – can be much worse. In the acute sector, performance is already suffering, with the NHS currently failing to meet more than half of its performance measures (eg, the four-hour A&E and 62-day referral-to-treatment cancer waiting standards).

Key definitions

Government budget

- Departmental expenditure limits voted by parliament: most of the Department of Health's spending (as with other government departments) is voted annually by parliament. Any expenditure outside these limits results in an 'Excess Vote', whereby parliament is retrospectively asked to authorise the excess amount.

Spending

- Capital: spending that adds to the public sector's fixed assets – including, for example, investment in new buildings and equipment.
- Revenue: money spent on day-to-day running costs – such as staff costs, procurement and prescribing.

Savings strategies

- Cost improvement programme (CIP): sets out the savings that an individual provider plans to achieve over a set period of time, essentially bridging the gap between income and expenditure.
- Quality, innovation, productivity and prevention (QIPP): a programme led by NHS England that encourages commissioners to drive forward quality improvements alongside efficiency savings, largely focused on demand management.

What do we know about the underlying drivers of this position?

The drivers of the deteriorating financial position in the NHS broadly result from funding not keeping pace with rising demand.

It should be noted at the outset that there are two factors (the PbR tariff and commissioners' fines on providers for breaches of performance standards) that drive up deficits among providers but do not have an impact on the aggregate position of commissioners and providers overall. When the tariff rate fails to reflect the cost of delivering services, providers must either find more efficient and less costly ways of providing care or risk losing out financially. In recent years, the tariff has been repeatedly cut, failing to keep pace with provider costs. This is in part because, as budgets tightened, more of the financial pressure has been intentionally distributed to providers over commissioners, in the belief that they may be more able to respond. Increasing the efficiency factor in the tariff has been one means of ensuring that providers take on greater financial responsibility (Nicholson 2015). Raising the tariff would not address the overall deficit, as it would simply move the deficit from providers to commissioners and leave the NHS overall in the same place. Similarly, the system of fining providers, used by commissioners to incentivise provider compliance with national performance standards, does not affect the aggregate position as money withheld from providers remains with commissioners.

Separately, private finance initiative (PFI) schemes are often cited as a major driver of deficits among NHS providers. However, research undertaken by the Health Foundation found that PFI is a significant factor in a small number of places; although PFI payments accounted for more than 5 per cent of total spending for nine trusts in 2014/15, across all providers they accounted for only 1 per cent of total operating costs (Lafond *et al* 2016). Further, research from Monitor found that having a PFI scheme was correlated with better financial performance (Monitor 2014a).

Slower growth in funding

The NHS is half way through the most austere decade in its history. Total health spending in England will rise by £4.5 billion in real terms between 2015/16 and 2020/21, an increase of around 0.85 per cent a year,[2] almost identical to the rate of increase over the last parliament. However, the context is very different this time. It follows a sustained funding squeeze, with waiting times rising and several key performance targets being regularly missed. It is also markedly lower than at any other time in the history of the NHS – funding has risen by 3.7 per cent a year on average – and will barely cover 'NHS inflation' (estimated to be 3.1 per cent this year) over the next few years (**Monitor and NHS Trust Development Authority 2016a**).

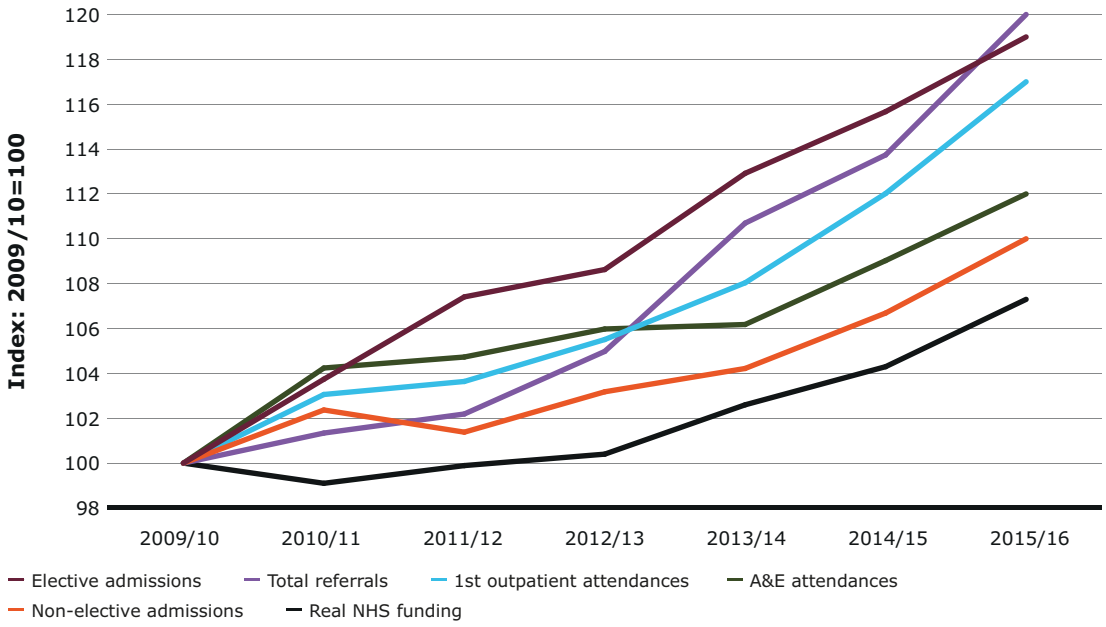
Rising demand

Factors such as the growing and ageing population, patients' rising expectations and an increased prevalence of long-term conditions have increased demand for NHS services but without an equivalent growth in spending to pay for it. *See,* for example, Figure 4, which plots hospital activity against funding.

For commissioners, rising and more complex demand results in increased spending on drugs and treatments. This is a particular challenge for the specialised commissioning budget and the Cancer Drugs Fund, both of which have been overspent in recent years. Despite the budget for specialised services being increased more rapidly than other areas, it remains under considerable pressure (**NHS England 2016f**).

[2] These figures are based on the whole of the Department of Health's budget, rather than NHS England's budget

Figure 4 Annual trends in hospital activity and overall NHS funding, 2009/10 to 2015/16



Source: NHS England 2016d

Rising staff costs

Staff costs account for just under half of total NHS spending and approximately 70 per cent of a typical hospital's total costs (Appleby *et al* 2014). These costs have grown as a proportion of overall spend over time. For example, the National Audit Office found that between 2011/12 and 2014/15 the share of income spent by acute trusts on staff costs rose by 8.1 per cent (National Audit Office 2015). One reason for this rise is the need for more staff to respond to rising demand. However, this has not been the only factor.

In response to serious concerns about the quality of care following the Francis Report on Mid Staffordshire NHS Foundation Trust, providers were encouraged to focus on clinical staffing levels (particularly of nurses), resulting in a growth in the number of nurses employed (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013) and an improvement in the nurse–patient ratio, which had been falling (NHS Improvement 2016c). At the same time, however, the NHS was struggling to recruit and retain permanent staff – in 2014, there was a shortfall of 5.9 per cent (equating to around 50,000) between the number of staff that providers said they needed and

the number in post, with particular gaps in nursing, midwifery and health visitors (National Audit Office 2016b). To fill these gaps, trusts have had to employ more costly temporary staff, pushing up staff costs overall. This represents a failure of workforce planning, as has been highlighted by both the National Audit Office and the Public Accounts Committee (National Audit Office 2016b; Public Accounts Committee 2016).

Diminishing cost savings

Since 2010 the NHS has been set two efficiency targets, both seeking to match rising costs and demand with a set of offsetting savings. The first, dubbed 'the Nicholson Challenge', tasked the NHS with delivering £20 billion of productivity improvements over the four years to 2014/15. The second, outlined in the *NHS five year forward view* (Forward View), challenges the NHS to deliver an additional £22 billion by 2020/21 (NHS England *et al* 2014). This translates at a national level into savings of 2–3 per cent a year – a considerable increase on its long-run efficiency performance, which has been estimated at around 1 per cent per year over the past 35 years (Alderwick *et al* 2015). At a local level, however, organisations are tasked with much more demanding efficiencies, with the average CIP target for trusts in 2016/17 set at 4.2 per cent and the average QIPP target for CCGs set at 3.4 per cent (Appleby *et al* 2016).

The NHS responded well to these challenges until 2014/15 when substantial deficits first began to emerge. However, the two key national strategies for improving productivity, which accounted for a majority of the savings in the last parliament – freezing pay and reducing the prices paid to hospitals for services (by cutting tariff prices in real terms) – now look unsustainable. Locally, providers are finding it increasingly difficult to release savings. In the most recent findings from our own quarterly monitoring report, 38 per cent of all NHS trust finance directors expressed concern about achieving their savings plans this year; this is the most pessimistic finance directors have been at this time of year since our survey began. In addition, also for the first time since the survey began, CCG finance leads were more pessimistic than their trust counterparts about their savings programmes. Just under two-thirds (61 per cent) of all CCG finance leads expressed concern about achieving their plans this year (Appleby *et al* 2016).

While focusing on better value offers many opportunities to improve productivity, we do not believe that this can be achieved at the pace or on the scale needed to deliver £22 billion in productivity improvements by 2020/21.

Cuts to social care and public health

Cuts to other budgets such as social care and public health can impact on the demand for and cost of health care provided by the NHS. Despite transfers from the NHS budget to social care (reaching £1 billion in 2014/15), social care spending fell by an average of 2.2 per cent a year over the course of the last parliament. As well as leading to reductions in services (resulting in an estimated 400,000 people being denied access to the care they need over the past five years), this has a knock-on effect on the NHS.

This can be observed most clearly in the increase in delayed transfers of care, which official data suggests rose by 28 per cent between 2013 and 2015. Waits for social care arrangements to be put in place was the biggest cause of this sharp rise, although it should be noted that, overall, the majority of delayed transfers are due to delays within the NHS (62 per cent in 2015/16) (**NHS England 2016h**). The National Audit Office estimates the gross annual cost to the NHS of delayed transfers for older people to be in the region of £820 million (**National Audit Office 2016a**).

Although the 2015 Spending Review provided some recognition of the pressures facing social care, with new powers for councils to raise council tax to pay for social care and an increase in the funding provided through the Better Care Fund, spending is likely to be broadly flat in real terms over the parliament. This will not be enough to meet projected cost pressures of 4 per cent a year (**Wittenberg and Hu 2015**) and will result in a funding gap of somewhere between £2.8 billion and £3.5 billion by the end of the parliament.

In addition, local authority public health budgets will be cut by an average of 3.9 per cent a year in real terms until 2020/21, on top of £200 million already cut from the budget in 2015/16. This will affect a wide range of services, including health visiting, sexual health and vaccinations, and will have a significant knock-on effect on the NHS.

Actions taken to tackle deficits

> *In reality, the deficit is not what causes the problem. The problem comes when you try and tackle it…* (Nicholson 2015)

At a high level, many of the strategies to tackle the current deficits involve either giving providers more money, often with strings attached, or trying to find ways to tackle the underlying causes.

Immediate action

Non-recurrent measures and accounting adjustments

In an effort to contain the 2015/16 provider deficit to £1.8 billion, all providers were asked to consider and report on a number of 'opportunities' including 'technical or one-off measures'. This list covered (among other things) managing the carry-over of annual leave and short-term non-medical staff sick leave, and '[removing] prudence' from their handling of bad debts, deferred income and a range of other balance sheet items (Monitor and NHS Trust Development Authority 2016b). Towards the end of the 2015/16 financial year, the *HSJ* reported that the Department of Health had also sent teams of accountants into 20 NHS organisations to review their accounts (Dunhill 2016a).

One-off measures like this do not tackle the underlying financial position of the sector (as they only reduce the in-year deficit), thought to be around £3 billion in 2015/16 (Dowler 2016).

Switching capital into revenue

There has been a growing tendency in recent years to redirect capital spending to shore up revenue budgets and support day-to-day running costs, with £640 million switched from capital to revenue in 2014/15 and £950 million in 2015/16.

This has been achieved via slippage on planned capital programmes and underspends in central and NHS trusts' capital spending. This means that the NHS is spending less on building and maintaining hospitals and buying equipment, storing up problems for the future.

Turnaround teams

In early 2016, NHS Improvement launched a new 'financial improvement programme', offering support to selected providers delivered by centrally procured teams of experts (Clover 2016c). Sixteen trusts and partner consultancies were selected from 80 applicants in May 2016 (Clover 2016d), with a second wave of providers due to join later in the year. This expert support will be funded from trusts' own budgets – 'likely to cost around £25 million' – and 'could find around £50 million of savings in its first year' (NHS Improvement 2016d).

Sustainability funding and the introduction of control totals

In 2016/17, £1.8 billion of sustainability funding (from the £2.1 billion sustainability and transformation fund) will be distributed to providers with the aim of eliminating the net provider deficit. The 'general element' of the fund – £1.6 billion – will go to providers of acute emergency care, where deficits are most widespread. Allocations from this general element were set by NHS Improvement and NHS England and offered to trusts, conditional on them agreeing to – alongside other stipulations – financial control totals for 2016/17 (*see* below).

The remaining £0.2 billion of sustainability funding – the 'targeted element' – is available to all providers, including mental health and community trusts, and will be allocated on a case-by-case basis to generate additional efficiencies.

As part of NHS Improvement's new financial oversight regime for 2016/17, all providers – whether in deficit or surplus – were asked to agree to a financial control total to try to ensure the sector achieves aggregate financial balance. In some cases, these financial control totals were for a deficit, ie, not all providers were expected to break even this year. Concern has been expressed that 'external pressure' is being placed on NHS finance directors to sign up to the totals, which have been described as 'fundamentally unsustainable' (Lintern 2016). At the time of writing, around 20 NHS trusts still did not have an agreed control total in place (Dowler 2016).

These twin strategies were intended to clear the provider-side deficit in 2016/17. However, our most recent quarterly monitoring report found that half of trusts are forecasting an end-of-year deficit in 2016/17 (*see* Figure 5). The 87 organisations we surveyed also gave end-of-year forecasts; scaling these estimates up for each type of provider suggests a net overall provider deficit across the NHS by the end of 2016/17

of around £1.4 billion. Although around 60 per cent of CCGs in the survey forecast a surplus for 2016/17, nearly 20 per cent said they were expecting to overspend – the highest proportion since the survey began in 2013 (*see* Figure 6).

National NHS leaders have recently announced they will no longer be able to fulfill the requirement to return the provider sector to financial balance in 2016/17, with the Chair and Chief Executive of NHS Improvement saying in June 2016 that the planned provider deficit for this year now stands at around £500 million (Dowler 2016).

Figure 5 Trusts' forecast end-of-year financial situation, as reported in the quarterly monitoring report, 2010/11 to 2016/17

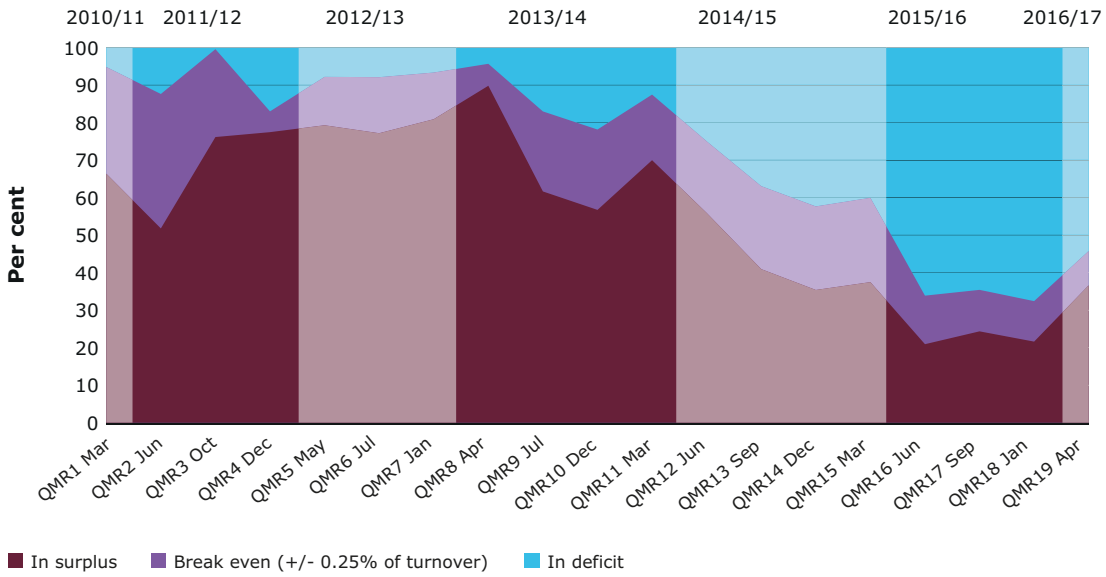
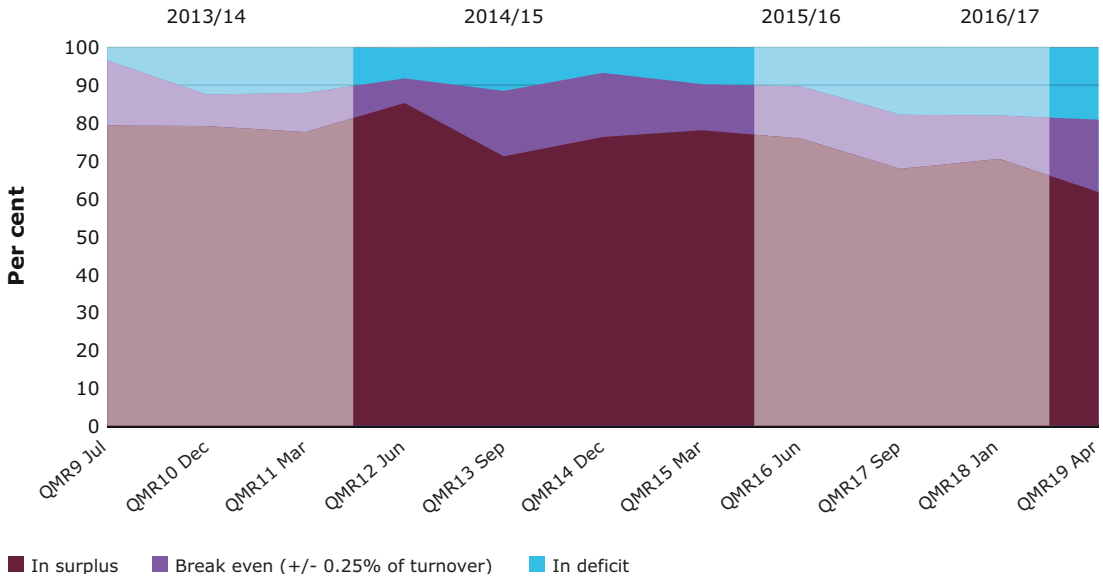


Figure 6 CCGs' forecast end-of-year financial situation, as reported in the quarterly monitoring report, 2013 to 2016



Creating a 'risk reserve' among commissioners

HM Treasury has stipulated that in 2016/17 all commissioning organisations (bar those commissioning specialised and public health services) must ensure that the 1 per cent non-recurrent spend required by this year's business rules are fully uncommitted at the start of the year, creating 'c. £800m of additional headroom to mitigate financial risk' (NHS England 2016b). This money is intended to be used 'for non-recurrent health economy priorities, not to bail out providers' (NHS England 2016a). NHS England and NHS Improvement will review in-year financial positions to decide whether an area needs to continue to hold the 1 per cent or if it can be released (which also requires approval from HM Treasury).

Action on pay-related costs

Collectively known as the 'agency rules', NHS Improvement (Monitor and NHS Trust Development Authority) have introduced a number of requirements for NHS providers, including (NHS Improvement 2016b):

- complying with a ceiling for total agency expenditure in 2016/17 (an extension of the previous requirement setting a ceiling on agency nursing staff only)

- procuring all agency staff at or below a set of hourly price caps – from April 2016 this was ratcheted down to 55 per cent above basic pay rates
- using only approved frameworks to procure agency staff.

When these rules were first announced, the Department of Health estimated that £1 billion could be saved over three years (Department of Health 2015a). Six months in, NHS Improvement reported that £300 million had been saved since the measures were introduced (NHS Improvement 2016a), However, there is concern that if caps are enforced and shortages of permanent staff are not tackled, providers will not be able to get the staff they need (Appleby *et al* 2016).

Other measures relating to pay include the following.

- A £50,000 cap on management consultancy contracts came into effect last June (Department of Health and The Rt Hon Jeremy Hunt MP 2015). Although NHS Improvement reports that in 2015/16 'overall consultancy spend saw a £86 million reduction compared to a year ago' (NHS Improvement 2016e), consultancy spend makes up a very small proportion of expenditure by providers and so this cap will have only a marginal impact on finances (NHS Providers 2016).
- Also introduced in June 2015, measures to control the pay of 'very senior managers' mean that ministerial approval is required for any board appointments with a salary higher than £142,000 and limits the rate paid to off-payroll interims. To our knowledge, no national data has been released on the impact of this measure.
- The 2015 Budget announced that public sector pay rises will be capped at 1 per cent each year of the parliament. There are concerns that this may make it more difficult to recruit and retain NHS staff (Lafond *et al* 2016).
- A letter sent by Monitor and the NHS Trust Development Authority in January 2016 suggested that it may be necessary to reduce headcount in order to bring down deficits in the most financially challenged providers (Monitor and NHS Trust Development Authority 2016b).

NHS England direct commissioning and central budgets

NHS England has taken measures to control its central budgets and programme costs, and although board papers state that any recurrent elements have been reflected in 2016/17 budget levels, it seems likely that there will be a continued squeeze on these central budgets in future years.

'For the first time in recent history', specialised commissioning (excluding the Cancer Drugs Fund) was slightly underspent (by 0.1 per cent) in 2015/16; managing the growth in specialised commissioning will almost certainly be a continued focus for NHS England. A new approach to prioritisation and management of drugs within the Cancer Drugs Fund (which has overspent its allocated budget each year since 2013/14) is due to be implemented in July 2016 in an effort to ensure that it remains within budget (**NHS England 2016c**). While spending on general practice has been held down in recent years, adding to significant pressures on GPs, the recent commitment to invest much-needed additional funding in the sector should mean that this budget will grow as a proportion of overall NHS funding, although this will add further pressure to other areas of spend.

Further action in 2016/17

As this briefing was going to press, further action aiming to bring the projected 2016/17 deficit down from £500 million to £250 million was announced by NHS Improvement. In an unpublished letter to trust leaders, Chief Executive and Chair Jim Mackey and Ed Smith set out three areas where further action will be taken:

- action on pay cost growth among providers that are out of step with the rest of the sector, to be carried out in collaboration with the Care Quality Commission to ensure that any adjustments are in line with NHS Improvement's commitment to patient safety
- consolidation of back office and pathology services
- identifying unsustainable planned care services – eg those heavily reliant on locums – that could be either consolidated, changed or transferred to a neighbouring provider (with Jim Mackey quoted in *HSJ* as saying that this was not referring to 'A&E and obstetrics and all the contentious stuff' (Dowler 2016)).

The latter two actions will be implemented at sustainability and transformation plan (STP) level, and all three are to be either proposed by areas or agreed by the end of July 2016.

Long-term strategy

A number of the measures outlined in this briefing feature in NHS England's (2016g) 'technical briefing', a high-level plan for finding the £22 billion efficiency savings by 2020/21 identified in the Forward View. While it is welcome to have this breakdown, we note that a fairly large proportion of the required efficiencies are planned from sources that have not consistently delivered in the past – for example work to reduce activity and delivering higher secondary provider productivity.

Implementing the Carter report

Lord Carter's final report on productivity in English non-specialist acute hospitals came out in February 2016. This gave a detailed account of the variation that exists across all of the main resource areas, estimating that if this variation was reduced, £5 billion of the £55.6 billion spent annually by acute hospitals could be saved by 2020. The areas covered were: the clinical workforce, hospital pharmacy and medicines optimisation, diagnostics, procurement, estates and facilities, and back office costs (Lord Carter of Coles 2016).

A core part of this is the work being led by Professors Tim Briggs and Tim Evans (National Director for Clinical Quality and Efficiency and National Director for Clinical Productivity, Department of Health, respectively) focusing on the opportunities to get better value from the NHS budget by improving clinical care and reducing variation in clinical practice.

Many of the 15 recommendations require significant further work by both trusts and NHS Improvement, with a lot of the savings coming towards the end of the period. In the context of current financial pressures, while this may be part of the answer to improving efficiency in acute hospitals, it is not the answer for balancing the books over the next few years (though we note that savings are expected this year: '£1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on continuing healthcare spending' is included in the government's mandate (Department of Health 2015c)).

Concerns have also been expressed about how the programme is progressing (McLellan 2016) and whether the estimated saving is realistic given the accuracy of the reference cost data used to calculate it.

The Carter report identified potential savings by improving management of the NHS estate. NHS estate is also being disposed of: in 2015/16, NHS trusts in England sold land worth more than £250 million (Clover 2016b), and David Williams (Director General of Finance at the Department of Health) has said the Department of Health is looking to generate around £2 billion of capital receipts this parliament through disposals, 'partly to free up money for investment in transformation and partly to play our part in supporting public sector land sales for the homes target' (Williams 2016).

Transforming care: integration, devolution, new models of care, and sustainability and transformation plans

In recognition of the fact that fundamental changes are required to the way in which care is delivered, there are a number of transformation programmes under way within the NHS. Often these initiatives aim to reduce costs by delivering more care in the community and in people's homes, as opposed to more expensive acute settings, and/or by reducing demand for health and care services. Other initiatives take a place-based approach, recognising that longer-term sustainability requires all players to work together in local systems of care.

Key elements of transformation include:

- implementation of a range of new care models (eg, integrated primary and acute care systems; multispecialty community providers), building on those outlined in the Forward View (NHS England 2016e)
- the requirement to build on Better Care Fund arrangements and other initiatives to achieve 'full integration of health and social care' by 2017 (HM Treasury 2015)
- devolution of health and social care budgets to regions such as Greater Manchester (McKenna and Dunn 2015)
- the requirement for NHS organisations to start working as place-based systems of care (Ham and Alderwick 2015) through the new sustainability and transformation plans (NHS England *et al* 2015).

While programmes to develop new care models and transform services offer significant opportunities to improve care, they are unlikely to deliver substantial financial payback during the term of this parliament. If they are to succeed, it is important that they receive the funding and support needed to extend progress to date, and to share and spread learning to other areas. Most importantly, they will also need to be given the time to demonstrate results. Although it is clear that the focus must be on stabilising and ultimately improving performance, 'this should not be at the expense of a continuing commitment to support work… to transform care' (**Ham 2016**).

What next?

In an attempt to limit the 2015/16 deficit – which still far exceeded the £1.8 billion limit imposed – national bodies have implemented a series of measures to release resources and improve balance sheets. The problem is that many of these measures can only be deployed once, so although they helped to improve the position in 2015/16, they cannot be repeated this year. It also means that the underlying deficit is significantly worse than the aggregate figure reported and that 2016/17 will be even more challenging.

The Chief Executive of NHS England, Simon Stevens, has stated that there is unlikely to be additional funding beyond that already announced and that 2016/17 should be 'the reset moment to get our finances, our performance, back in a place where we can pivot off to the rest of what this five year settlement looks like' (**Stevens 2016**). Notwithstanding this ambition, NHS Improvement leaders have confirmed that deficits will not be eliminated this year, despite all the levers used by NHS England and NHS Improvement. These include implementing Lord Carter's recommendations and delivering better value by improving clinical practice. They also include work to transform services through sustainability and transformation plans and the new care models programme which is testing innovative ways of integrating care in 50 areas of the country.

These initiatives offer significant opportunities to improve services for patients but will not deliver major financial benefits in the short term. There is also a growing risk that work to transform care is crowded out by day-to-day firefighting and the focus on operational and financial pressures. This is exemplified by the bulk of additional funding provided through the Sustainability and Transformation Fund in 2016/17 being used to tackle deficits in the acute sector rather than supporting ambitions to move more care into the community and achieve parity of esteem between mental and physical health.

How this circle will be squared is uncertain but if restoring financial balance is the government's highest priority, it is inevitable that staffing levels will need to be reduced. This presents a clear and present danger that patient safety and quality of care will be compromised and staff morale damaged further. It would also contrast starkly with the period leading up to the 2015 general election, when the priority was to ensure safe staffing and the government in effect turned a blind eye to

overspending. Pressures to restrict access to care, which we are currently analysing (Robertson 2016), are also certain to increase and lead to more explicit rationing of services, particularly from 2018/19 onwards when growth in NHS funding effectively comes to an end.

The political and economic instability following the UK's vote to leave the EU adds to these risks. A prolonged fall in the value of sterling could lead to higher costs and increase financial pressures, while there are significant concerns about the impact of the Brexit vote on the ability of the NHS to recruit and retain staff from EU countries. The Chancellor has already been forced to abandon the government's commitment to deliver a budget surplus by 2020. If warnings about a major economic shock prove to be correct, this could have significant implications. Any reduction in health or social care funding as a result of cuts in public spending would pose a serious risk to patient care.

Regardless of the impact of Brexit, the government must review its priorities for the NHS to ensure that they can be delivered within available resources. Specifically, new commitments such as implementing seven-day services may not be feasible until additional funding becomes available. Existing commitments may also need to be reviewed; for example, the aim of treating 95 per cent of patients in A&E departments within four hours, which has not been achieved across England for the past nine months, and other waiting times targets may need to be relaxed. To be clear, we are not advocating that standards and targets should be relaxed, but rather highlighting that there may be no other option if restoring financial balance is the overriding priority. The fact that Simon Stevens praised the NHS in a recent speech for treating nine out of ten patients within four hours suggests that national leaders may already be thinking in this way.

There needs to be realism about what the NHS can achieve with the funding allocated to it for the rest of this parliament. With the share of GDP spent on health care set to continue to fall regardless of the impact of the UK's vote to leave the EU, it is not credible to argue that the NHS can continue to meet increasing demand for services, deliver current standards of care and stay within budget. This is widely understood within the NHS and now needs to be debated with the public. Of course, the government has a duty as well as a right to decide how much funding should be allocated to the NHS given the state of the economy and the public finances. However, it also has a responsibility to be honest with the public about the consequences for the NHS 'offer', particularly in view of its manifesto commitment

to 'protect and improve' the NHS. There are no easy choices, but the worst of all worlds would be to adopt a mindset that fails to acknowledge the serious state of the NHS in England today. We are drawing attention to these issues now while there is still time to have an informed and honest debate about the best way of sustaining and transforming care.

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