

Into the red?

The state of the NHS' finances

An analysis of NHS expenditure between 2010 and 2014

Research report

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About this report

The unprecedented financial challenge facing the NHS, and the difficult decisions facing health and social care services in England, make it crucial to understand how the NHS spends money, and to identify areas of success and failure in financial performance.

Drawing on the accounts data of English NHS organisations, this Nuffield Trust research report provides detailed analysis of annual expenditure and financial performance across the NHS. It forms part of a research programme that aims to establish the Nuffield Trust as a centre of expertise in the analysis of spending and productivity.

Into the Red? The state of the NHS' finances examines current financial performance to update a previous study. It draws on the annual accounts of primary care trusts, NHS trusts and foundation trusts up to and including 2012/13; and on provisional accounts from regulatory bodies for 2013/14, which cover acute trusts and clinical commissioning groups. The report takes a comprehensive look at how the finances of the hospitals and commissioning groups that make up the NHS in England have held up under austerity between 2010 and 2014.

Programme supporter

This report forms part of a research programme that is supported by McKesson.

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Executive summary

The last three years have been a period of unprecedented financial pressure and organisational change for the English health care system. Understanding the financial performance of the National Health Service (NHS) during this period is increasingly important. In this report we assess the overall financial position of the NHS in England at the end of the 2013/14 financial year, drawing on provisional outturn data for that year and audited accounts for the previous two. Using the accounts data, we also update and develop the analysis published in a previous Nuffield Trust report, which examined financial performance between 2003/04 and 2011/12 (Jones and Charlesworth, 2013), looking in more detail at spending on primary care and community health, mental health and acute services, use of non-NHS providers¹ and acute trust finances. More detailed information for 2013/14 will only be available when the audited accounts for that year have been published and analysed.

Key points on the financial position of the NHS

- The NHS has risen to the challenge of living within its means since 2010 **but is increasingly poorly placed to manage the impact of austerity.**
- **The financial strength of trusts is weak and declining.** Provisional data for 2013/14 suggest that trusts will post a net overall deficit of just over £100 million, compared with an overall surplus of £383 million in 2012/13. In 2013/14, 66 NHS trusts are now in deficit, even after including over £360 million of national financial support from the Department of Health, compared with 45 in 2012/13 after stripping out financial support (the additional funding provided by the Department of Health for NHS organisations that face financial issues). Most of these are acute hospitals. Analysis of acute (hospital) trust income suggests that the level of financial support is greater than the £360 million provided nationally, as clinical commissioning groups help locally by funding care outside of tariff payments. Deficits are concentrated in the Midlands and London.
- **Commissioners found it harder to balance their budgets in 2013/14 than the previous financial year.** The main pressure was on the NHS England £12.7² billion budget for specialised services (such as chemotherapy and cystic fibrosis care), which overspent by £377 million.³ Clinical commissioning groups underspent their total allocation by £97 million⁴ with 19 incurring a deficit (primary care trust (PCT) figures for 2012/13 showed an underspend of £679 million, with one in deficit and a further

1. The accounts distinguish between payments to independent sector treatment centres, other private providers, voluntary providers and 'other', which includes local authorities and NHS bodies in Wales, Scotland and Northern Ireland. We have used these definitions in this report, except that we have combined payments to independent sector treatment centres and other private providers and refer to this group as 'independent sector providers'.

2. This is the equivalent of £12.5 billion in 2012/13 prices.

3. This is the equivalent of £370 million in 2012/13 prices.

4. This is the equivalent of £95 million in 2012/13 prices.

12 receiving financial support, but PCT budgets are not directly comparable with those of clinical commissioning groups). The total combined budget for NHS England and clinical commissioning groups was underspent by £256 million¹ in 2013/14 (0.3 per cent of net expenditure). In achieving this position, they drew on £394 million² of the accumulated surplus from previous years' underspends, which now stands at £790 million.³

- **The level of savings is falling and they are increasingly temporary or one-off.** Despite a requirement to achieve efficiency savings in the region of 4 per cent a year, commissioners reported savings of £1.72 billion⁴ in 2013/14 – just less than 2 per cent of their spending, with the largest shortfall (£235 million) against the 'transformational' heading. Monitor has provided a more detailed breakdown for foundation trusts, showing that they achieved savings of 3.0 per cent in 2013/14 compared with a plan of 3.9 per cent and achievement of 3.4 per cent in 2012/13. Moreover, the proportion of non-recurrent (one-off) savings continued to rise. Year-on-year sustainable savings of 4 per cent now look unachievable.
- **There is still an imbalance between hospital services and those outside of the hospital setting.** A key area of NHS England's transformation agenda has been to shift care from the hospital setting to primary and community services outside it. Finance and activity data show that this is proving elusive. Although spending on hospital services increased by 2.4 per cent in real terms, spending on community health services rose by just over £500 million (5.7 per cent) in 2012/13, while spending on general practitioner (GP) services decreased by £10 million (0.1 per cent). Provisional data on foundation trusts suggest that acute sector income increased by a similar amount in 2013/14. Emergency admissions increased by 1.8 per cent in 2012/13 and by a further 0.4 per cent in 2013/14. Outpatient attendances rose by 3.9 per cent in 2012/13 and by 7.5 per cent in 2013/14. There is no evidence to suggest that the Better Care Fund – a government initiative to pool existing health and social care spend to support the integration of health and social care – will reverse these trends, even though it relies on a substantial and rapid reduction in emergency admissions to work as intended.
- **Hospital staffing costs are rising.** In 2012/13, acute hospitals reduced their spending on permanent staff as they employed fewer permanent staff and pay grew very slowly: the numbers of full-time equivalent (FTE) employees reduced by 0.22 per cent and real pay rates increased by just 0.23 per cent per head. This has not proved sustainable and in 2013/14 employment rates rose, with more than 18,000 FTE staff employed between April 2013 and December 2013, a 1.6 per cent increase. (This may also be in response to the reports by Robert Francis QC and others.) This increase in staffing was most pronounced for hospital nursing staff. NHS providers employed an additional, 3,500 acute and elder care nurses between April 2013 and December 2013, a 2.0 per cent increase. Foundation trusts spent an extra £1.2 billion on staff in 2013/14 – some £660 million more than they had planned.

1. This is the equivalent of £251 million in 2012/13 prices.

2. This is the equivalent of £387 million in 2012/13 prices.

3. This is the equivalent of £776 million in 2012/13 prices.

4. This is the equivalent of £1.69 million in 2012/13 prices.

- **More is being spent on contract and agency staff, with associated risks to efficiency and quality.** Spending on contract and agency staff increased by 20 per cent in real terms in 2012/13 and, at least for foundation trusts, the trend continued into 2013/14, with spending on contract and agency staff rising by some £300 million (27 per cent). (Equivalent data for NHS trusts have not yet been publicly reported.)¹

Key points on expenditure trends

- Government-funded health spending in England fell in 2010/11 and 2011/12 but in 2012/13 it picked up slightly, growing by 2 per cent in real terms and reaching £102 billion.
- The government has made parity of esteem for physical and mental health services a policy priority (HM Government and Department of Health, 2011), but accounts data show that in 2012/13, **spending on mental health services grew more slowly than that on acute hospital care.** PCTs increased spending on mental health services by 1 per cent in real terms, compared with a 2.4 per cent increase in hospital spending. Provisional data from foundation trusts suggest that this disparity possibly sharpened in 2013/14.
- **Drug costs have been falling in primary care but rising sharply in hospitals.** In 2012/13, spending on drugs in primary care fell by 5 per cent as the NHS continued to benefit from the shift of common prescription medications from branded to generic alternatives. However, hospital spending on drugs increased by 10 per cent in real terms. In 2013/14, these pressures are not abating – foundation trusts reported that drug costs had risen by £344 million (12 per cent), over £200 million more than planned. The new Pharmaceutical Price Regulation Scheme (PPRS) should ease these pressures by freezing the total NHS spend for the next two years and only allowing it to grow slowly after that.
- **Increased spending on non-NHS providers of acute care has slowed.** Between 2010/11 and 2012/13, spending on acute care provided by independent sector providers (independent sector treatment centres and other private providers) increased by an annual average of 6.7 per cent, from £1.30 billion to £1.58 billion. In 2012/13, the growth in spending on NHS-funded care delivered by independent sector hospitals halted, with PCTs spending £14 million less in real terms compared with 2011/12.
- **But spending on community and mental health services has continued to rise.** The independent sector has become a more important provider of NHS community and mental health services. While expenditure by clinical commissioning groups in 2013/14 is not yet available, the 2012/13 data by PCT show that this upward trend in expenditure on the independent sector continued. Spending growth on non-NHS providers of community and mental health services outpaces spending increases for NHS trusts. These are now the major areas for non-NHS providers. Between 2010/11 and 2012/13, PCT expenditure on NHS-provided community services fell while spending on care provided by non-NHS providers increased rapidly. One pound in every five spent by PCTs on community health services in 2012/13 was spent on care provided by independent sector providers, an increase of 34 per cent in one year alone.

1. A small portion of the increase is due to NHS trusts becoming foundation trusts in 2013/14 and one acquisition. After removing the impact of these changes, spending on contract and agency staff rose by £247 million (23 per cent).

Similarly, funding for independent sector mental health service providers increased by 15 per cent in real terms between 2011/12 and 2012/13 alone, while funding for NHS-provided mental health services decreased by 1 per cent. Provisional data from foundation trusts suggest that funding of NHS-provided mental health services has again fallen slightly in real terms while that for community services has held steady.

Prospects for 2014/15 and 2015/16

- We expect NHS finances to deteriorate further in 2014/15 and 2015/16. Although acute hospitals are showing the clearest signs of financial strain, all providers and commissioners face financial challenges. There is no sign that demand is reducing, particularly for acute trusts. The financial year of 2015/16 is likely to be particularly difficult financially as the service seeks to meet the unpredictable demands of financing the Better Care Fund. NHS England estimates have suggested that this may require reductions of up to 15 per cent in emergency admissions, yet the health service will see £1 billion removed if reductions reach a threshold of just 3.5 per cent.
- Service transformation – which is much talked about and sought after as a way of meeting the twin challenges of austerity and rising demand through a combination of technological change, increasing the amount of care provided outside hospitals, reconfiguring the acute sector and focusing more on what patients can do for themselves – seems very distant. But hopes and plans have been pinned on such a change. In the absence of transformation and without a credible alternative plan, the NHS seems destined to experience a funding crisis this year or next.

1. Introduction

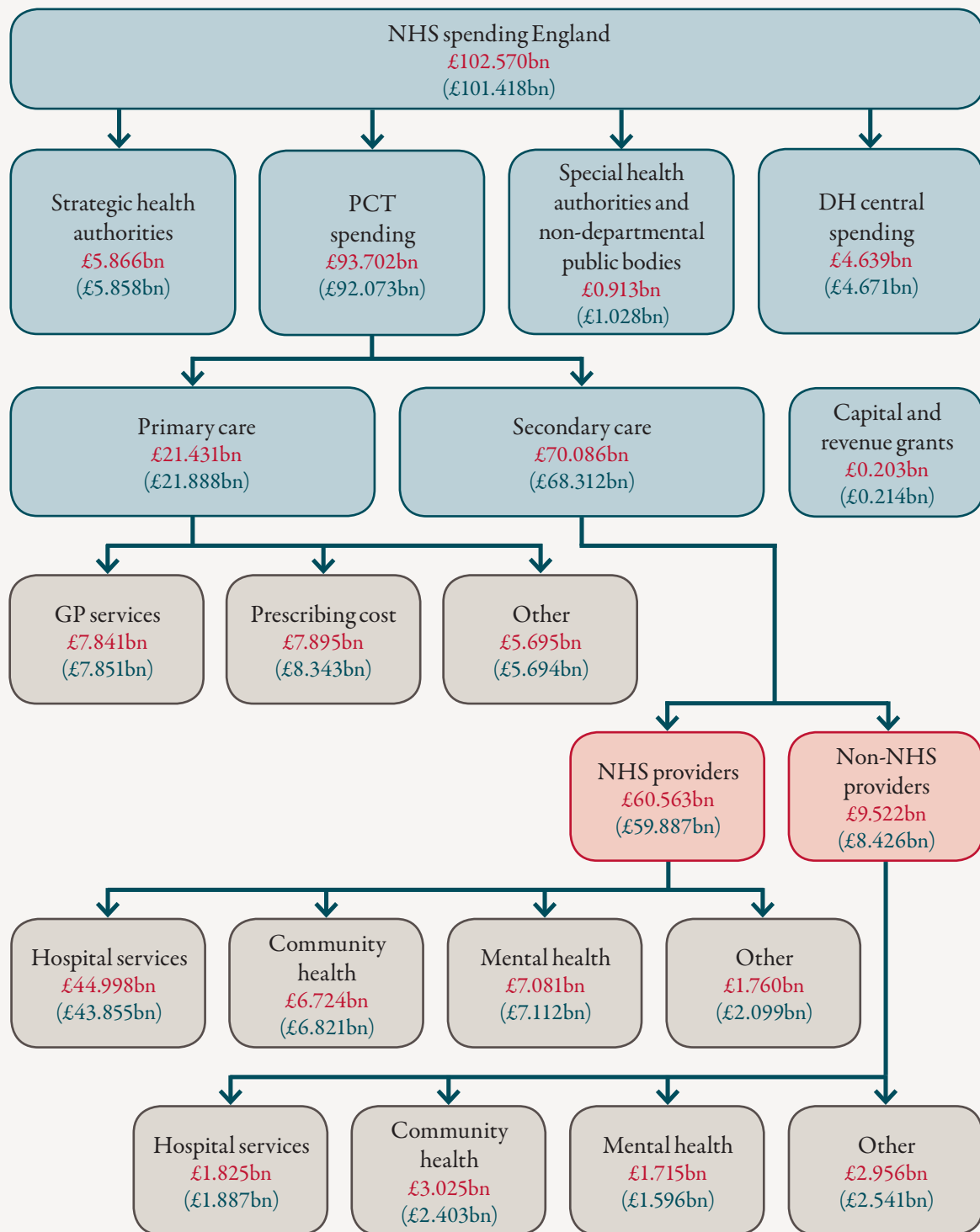
In recent years, NHS organisations in England have faced an unprecedented financial challenge. Since the formation of the NHS in 1948, health expenditure has increased by an average of 3.8 per cent in real terms (Crawford and Emmerson, 2012). However, over the three years 2010/11 to 2012/13, government expenditure on health increased at a much slower rate. After two consecutive years of a real-terms decrease in spending (HM Treasury, 2013a), government spending on health in 2012/13 in England rose by 1.6 per cent in real terms to £102.5 billion. The planned health expenditure for 2013/14 was £106.7 billion (£104.9 billion in 2012/13 prices, a 2.2 per cent increase in real terms) (HM Treasury, 2013b). As the tight financial situation continues, NHS organisations will find it harder to achieve the required savings.

In this report we take a close look at the financial performance of the NHS in England between 2010/11 and 2012/13 as the service prepared for the transition to a new health and social care system on 1 April 2013, brought about by the Health and Social Care Act 2012 (Department of Health (DH), 2013a). Where possible we update the picture by drawing on provisional outturn data for 2013/14.

Figure 1.1 shows how resource funding flowed through the English NHS in 2011/12 and 2012/13. In the financial year 2012/13, a wide range of trusts managed NHS health and social care in England. These trusts included: PCTs – local trusts that worked with local authorities and other agencies to commission and provide health and social care to local populations; and NHS and foundation trusts – trusts that deliver NHS services. Unlike NHS trusts, foundation trusts are independent legal entities that can raise capital from both the public and private sectors. With the new health and social care system, all NHS trusts are expected to become foundation trusts by this year (2014) and PCTs have been abolished and replaced by clinical commissioning groups and local area teams (NHS Choices, no date). Strategic health authorities have also been abolished.

With the abolition of PCTs and strategic health authorities, responsibilities have changed since April 2013. NHS England now has responsibility for commissioning primary and secondary care with a budget of £25.3 billion. There are 211 clinical commissioning groups, which are responsible for commissioning secondary care, including community and mental health services, with a total commissioning budget of £62.8 billion (NHS England, no date). Local authorities now have responsibility for some aspects of public health, with some £2.7 billion transferred to them from money mostly held by PCTs previously (DH, no date, a).

Figure 1.1: Resource spending in real terms in England, 2011/12 and 2012/13 (£ billion) (2012/13 prices)



Red figures indicate 2012/13 Teal figures (in brackets) indicate 2011/12

Notes: As primary and secondary care spending includes expenditure on patient treatment for the PCT's own patients only, the sum of these two spends is slightly lower than the value for PCT total spending. Hospital services include maternity care, accident and emergency and general and acute services. Other secondary care expenditure includes 'other contractual cost' and 'learning difficulties'.

About the rest of this report

Chapter 2 examines commissioners' income and expenditure. Chapter 3 then looks at the experience of NHS providers of secondary care (NHS and foundation trusts). Discussion of the state of the NHS' finances and conclusions drawn are considered in Chapters 4 and 5, respectively.

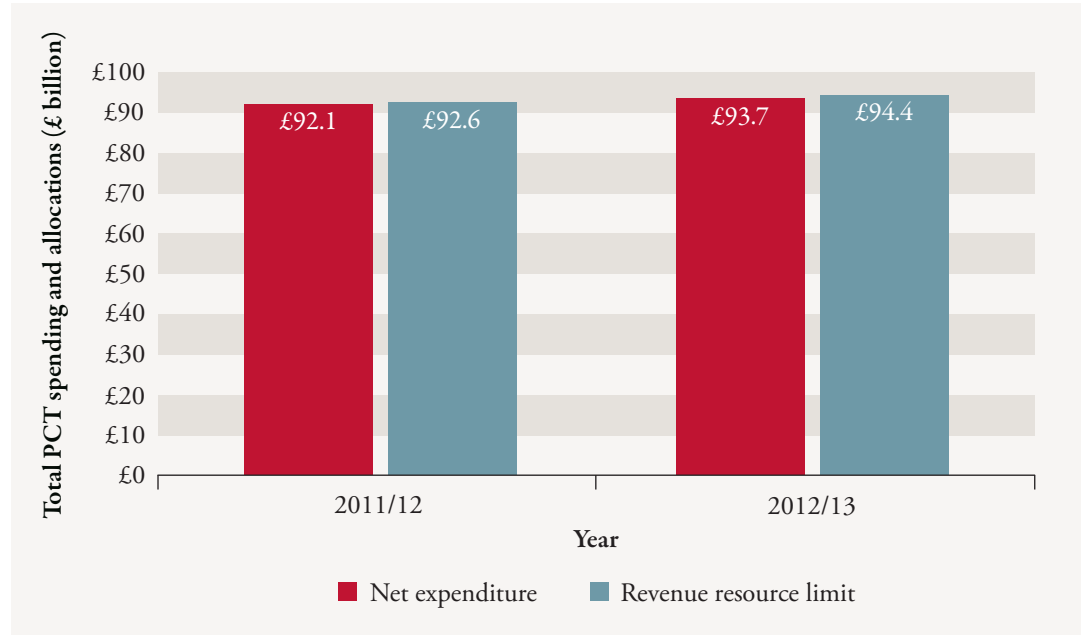
For this report, we have used the annual accounts of PCTs, NHS trusts and foundation trusts. We have adjusted all cash-terms figures to 2012/13 prices using HM Treasury's Gross Domestic Product (GDP) deflators – a measure of general inflation that allows the removal of the effects of changes in price from a time series – as at March 2014 (HM Treasury, 2014). We also include some information about 2013/14 based on the provisional outturn figures reported in the May board papers of NHS England, Monitor – the regulator that oversees foundation trusts – and the NHS Trust Development Authority, which oversees NHS trusts. The 2013/14 figures are in cash terms.

2. Commissioners' income and expenditure

Spending compared with allocations

Allocations to PCTs accounted for the vast majority (87 per cent) of the NHS' budget in 2012/13 (Figure 2.3). In the same financial year, PCTs spent £93.7 billion on commissioning services from both NHS providers, including their own provider arms, and independent sector providers, for the populations for which they were responsible. While PCT allocations increased by 1.9 per cent in real terms in 2012/13, PCT spending increased at a slightly slower rate of 1.8 per cent. As a result, the aggregate PCT underspend increased by nearly one third (28 per cent), from £532 million in 2011/12 to £679 million in 2012/13 (Figure 2.1).

Figure 2.1: PCTs' spending in real terms compared with their allocations, 2011/12 to 2012/13 (£ billion) (2012/13 prices)



Commissioners found it harder to balance their budgets in 2013/14 than between 2011/12 and 2012/13 (shown above). The main pressure was on the NHS England £12.7 billion¹ budget for specialised services, which overspent by £377 million.² Clinical commissioning groups underspent their total allocation by £97 million,³ with 19 incurring a deficit. The total combined budget for NHS England and clinical commissioning groups was underspent by £256 million⁴ (0.3 per cent of net expenditure).

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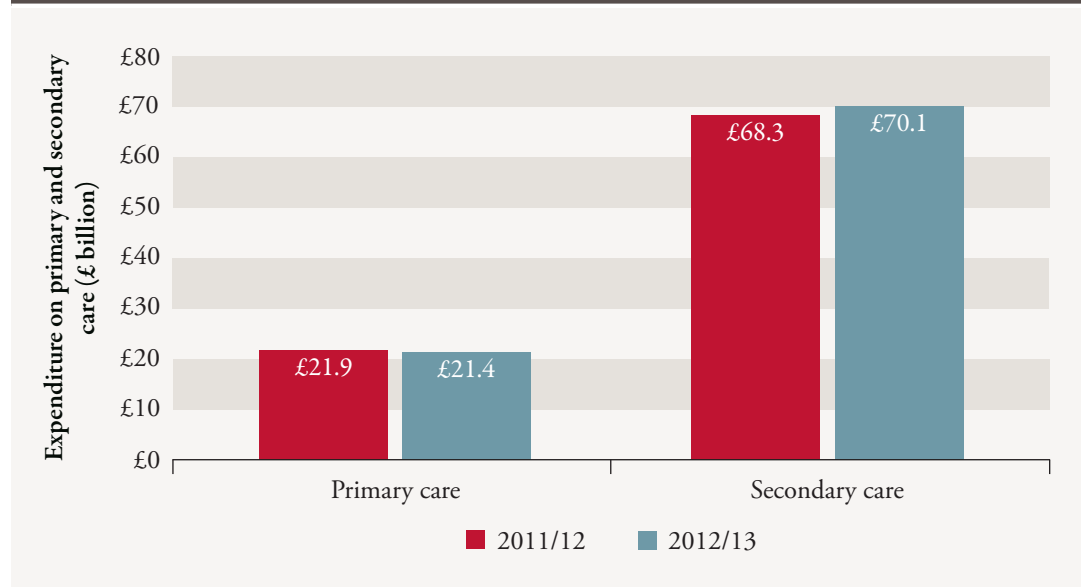
4. This is the equivalent of £251 million in 2012/13 prices.

In achieving this position, they drew on £394 million¹ of the accumulated surplus from previous years' underspends, which now stands at £790 million.²

Spending by service area

PCTs spent the majority of their allocations on secondary care. In 2012/13, secondary care accounted for over three quarters of total spending. Spending on primary care fell by 2.1 per cent in 2012/13, while spending on secondary care increased by 2.6 per cent (Figure 2.2).

Figure 2.2: PCT expenditure in real terms on primary and secondary care, 2011/12 to 2012/13 (£ billion) (2012/13 prices)



Primary care spending as a proportion of overall spending on NHS care by PCTs decreased from 24 per cent in 2011/12 to 23 per cent in 2012/13. The two main components of primary care spending are GP services and prescribing; for which expenditure has declined for both in real terms in 2012/13. Expenditure on GP services fell very slightly in real terms from £7.85 billion in 2011/12 to £7.84 billion in 2012/13 (Figure 2.3). Funding for GP services has continually decreased in real terms since 2010/11, although in 2012/13 it decreased at a slower rate of 0.1 per cent in real terms compared with 1.2 per cent in 2011/12 (Figure 2.4). The fall was partly the result of the government's pay policy, although investment in general practice continues to be low compared with hospital medical staffing – the number of full-time equivalent GPs increased by an average annual rate of only 0.7 per cent from 2010 to 2013 (Health & Social Care Information Centre (HSCIC), 2014a). Prescribing costs fell by 5.4 per cent in real terms in 2012/13 (Figure 2.4), from £8.34 billion in 2011/12 to £7.89 billion in 2012/13 (Figure 2.3), continuing the trend set in 2010/11. The fall was due to a lower unit cost per prescription, mainly as cheaper generics replaced branded drugs coming off-patent. The number of prescriptions dispensed continued to rise, by 2.9 per cent, topping one billion items. PCT expenditure on the remaining components of primary care remained relatively similar over the two years (Figure 2.3).

1. This is the equivalent of £387 million in 2012/13 prices.

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Figure 2.3: PCT spending in real terms on primary and secondary care, by service type, 2011/12 to 2012/13 (£ billion) (2012/13 prices)

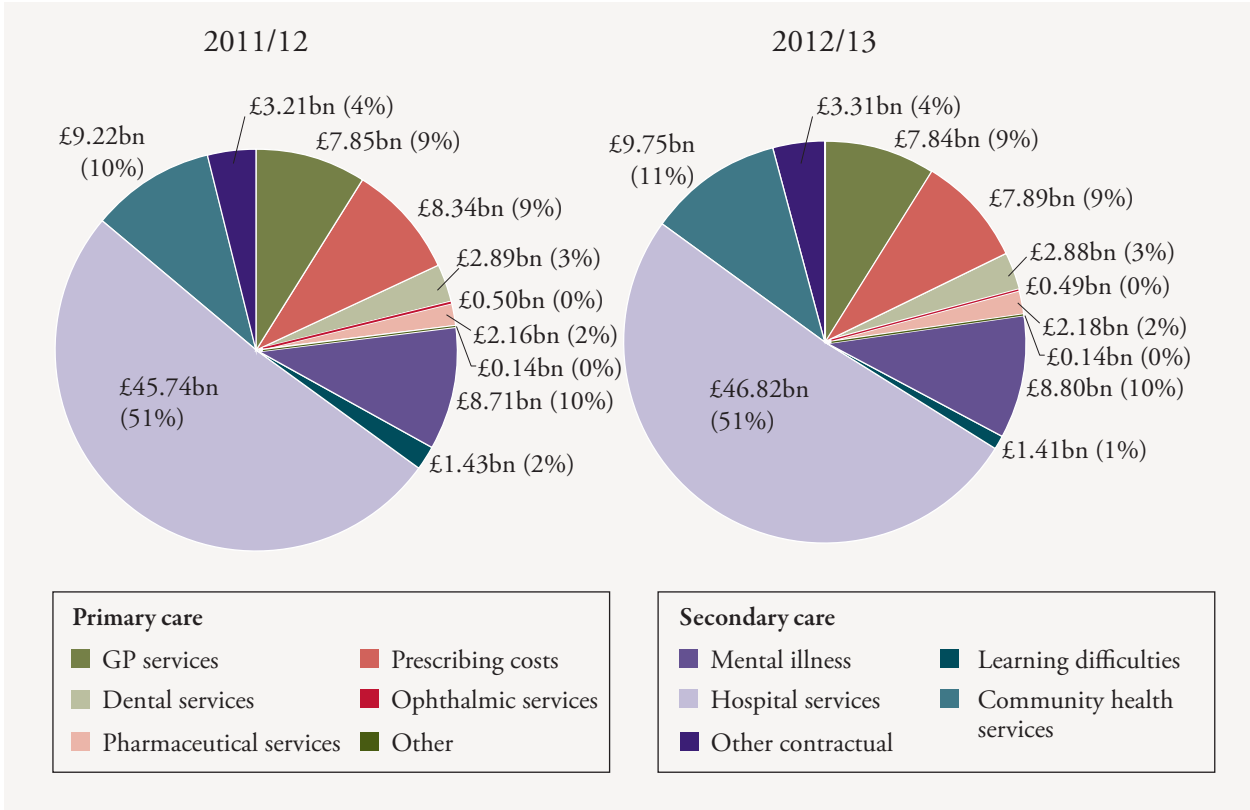
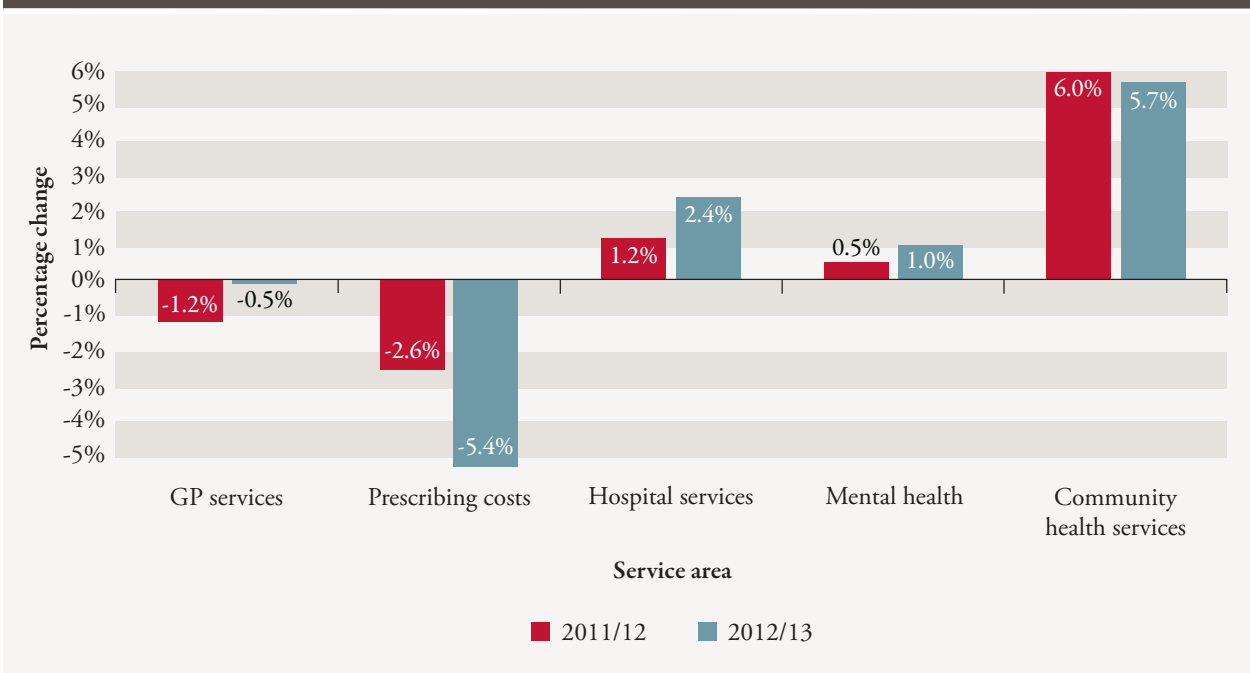


Figure 2.4: Percentage change from previous year in PCT spending in real terms, by service area, 2011/12 to 2012/13 (2012/13 prices)



Hospital services are the key component of secondary care, worth 67 per cent (£46.8 billion) of all secondary care spending.

In 2012/13, each of the main components of PCT spending on secondary care (hospital, community and mental health services) increased in real terms. The largest increase in secondary care expenditure was again for community health services. Despite the government's efforts to promote parity of esteem between mental and physical health to close the gap between the two sectors, funding for mental health providers increased at a much slower rate than that for hospital services (Figure 2.4).

PCT spending on NHS and non-NHS providers

Over the last decade, PCTs have purchased care from an increasingly wide range of providers. As a result, the independent sector now plays a much greater role in the provision of NHS-funded care. This section discusses changes in PCTs' spending on NHS, independent and voluntary sector providers of community health services, mental health care services and hospital services. The accounts distinguish between payments to independent sector treatment centres – centres that are privately run and commissioned by the English NHS to deliver services to NHS patients – other private providers, voluntary providers and 'other' which includes local authorities and NHS bodies in Wales, Scotland and Northern Ireland. We use these definitions in this report, except that we have combined payments to independent sector treatment centres and other private providers and refer to this group as 'independent sector providers'.

Spending on community health services

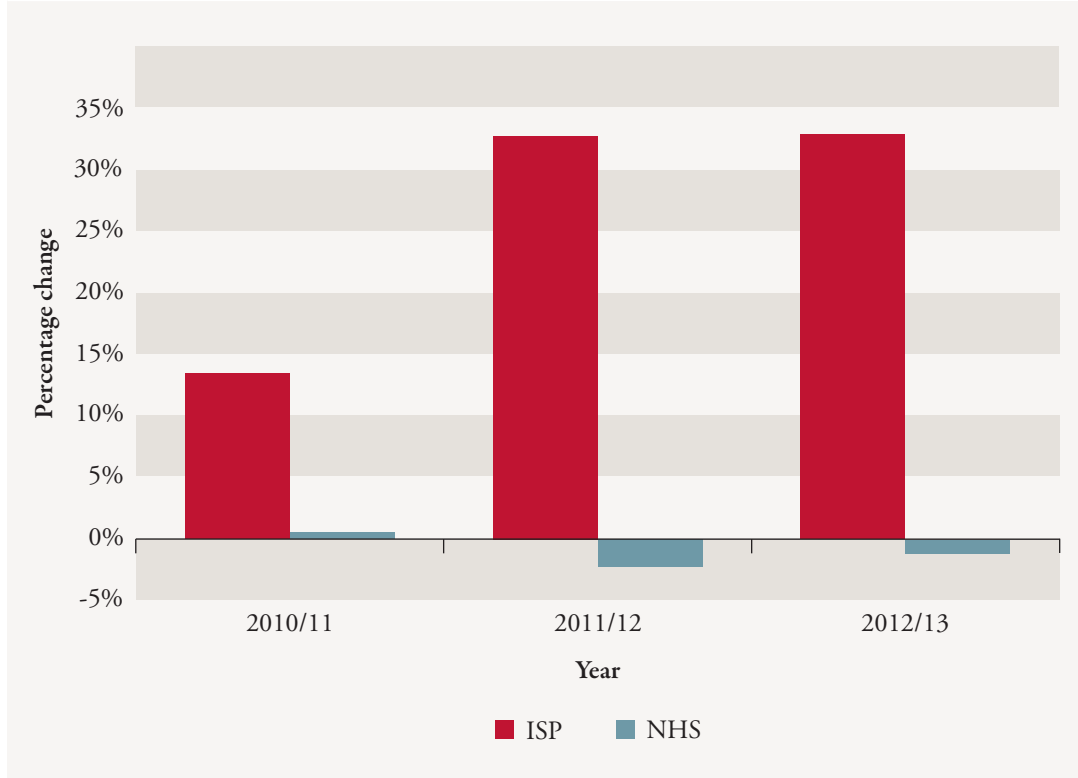
From 2010/11 to 2012/13, spending on community health services increased at an average rate of 5 per cent a year in real terms, from £8.7 billion to £9.7 billion. But within this total, PCT expenditure on NHS-provided community services fell while spending on care provided by non-NHS providers increased rapidly (Table 2.1 and Figure 2.5). Spending on non-NHS providers accounted for all the growth in community health services in 2011/12 and 2012/13. Nearly one third of NHS spending on community health services is now with non-NHS providers.

Table 2.1: PCT spending in real terms on community health services provided by NHS and non-NHS providers, 2010/11 to 2012/13 (£ billion) (2012/13 prices)

Year	PCT spending on ISPs (% total share)	PCT spending on NHS bodies (% total share)	PCT spending on voluntary and other service providers (% total share)	Total PCT spending on community health services
2010/11	£1.001 (12%)	£6.982 (80%)	£0.715 (8%)	£8.698
2011/12	£1.329 (14%)	£6.820 (74%)	£1.073 (12%)	£9.224
2012/13	£1.765 (18%)	£6.724 (69%)	£1.259 (13%)	£9.749

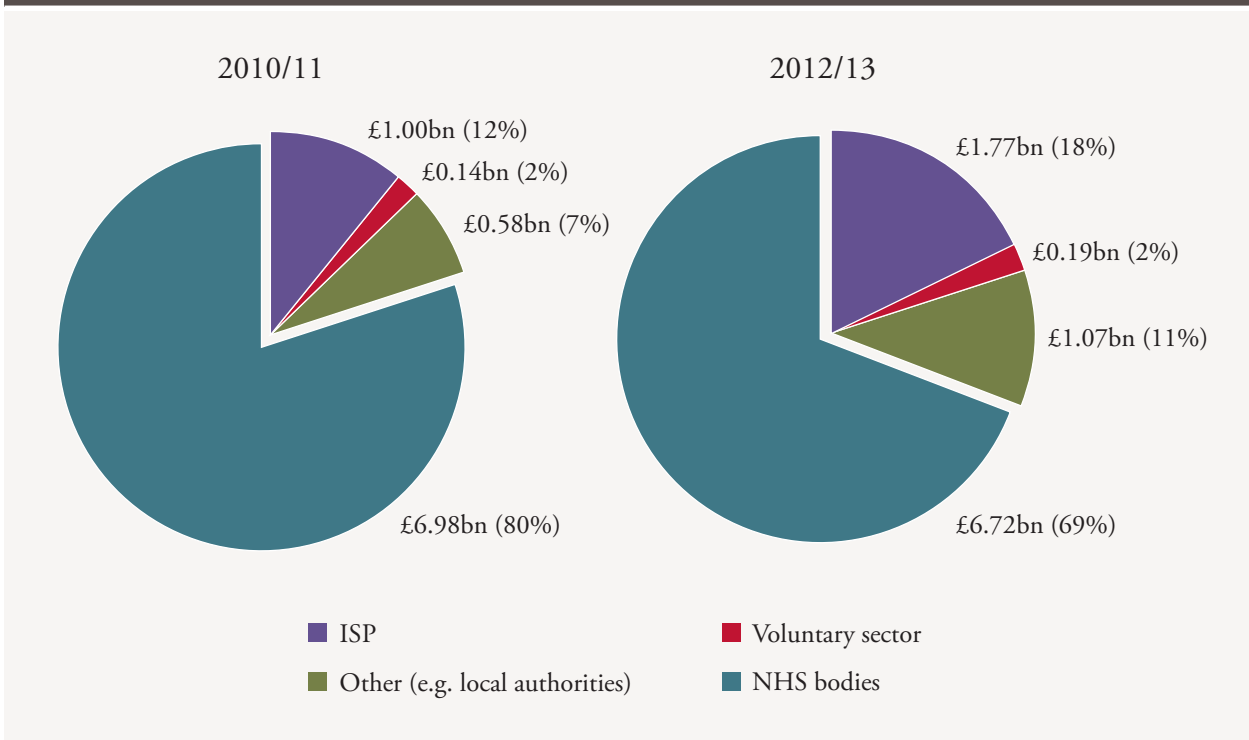
Note: ISP = independent sector provider.

Figure 2.5: Annual change in PCT spending on independent sector providers (ISPs) and NHS providers of community health services, real terms, 2010/11 to 2012/13 (2012/13 prices)



The proportion (by value) of community health services provided by the independent sector increased from 12 per cent in 2010/11 to 18 per cent in 2012/13 (Figure 2.6). The total amount spent on independent sector providers was greater than that in the acute sector. The proportion of expenditure with voluntary and other sector providers also increased significantly, almost certainly as the Transforming Community Services programme led to new employee-owned organisations being established (DH, no date, b) (Figure 2.6). Policy and service priorities may also have led to the increase, for example investment in reablement services, which are normally supplied by non-NHS providers. Provisional data from foundation trusts in 2013/14 suggest that spending on NHS providers of community services held more or less steady in real terms.

Figure 2.6: Expenditure on community health care by service providers, 2010/11 to 2012/13 (£ billion) (2012/13 prices)



Spending on mental health care services

Non-NHS providers accounted for almost £1 in every £5 of NHS-funded mental health care in England in 2012/13, but this has been relatively stable for the last few years (Table 2.2).

Table 2.2: PCT spending in real terms on mental health care services, by service provider, 2010/11 to 2012/13 (£ billion) (2012/13 prices)

Year	PCT spending on ISPs (% total share)	PCT spending on NHS bodies (% total share)	PCT spending on voluntary and other service providers (% total share)	Total PCT spending for mental health care services
2010/11	£1.05 (12%)	£7.26 (82%)	£0.56 (6%)	£8.86
2011/12	£1.01 (12%)	£7.11 (82%)	£0.58 (7%)	£8.71
2012/13	£1.17 (13%)	£7.08 (81%)	£0.54 (6%)	£8.80

However, over this period, PCT spending on NHS providers of mental health services fell by 2.5 per cent in real terms (£17 million), with funding for independent sector providers rising by 12 per cent (£126 million), but from a much lower base. Funding for voluntary sector and local authority providers also fell slightly. All the growth in mental health

spending in 2012/13 was in non-NHS providers. Figure 2.7 shows the annual change in spending by provider type in each of the three years from 2010/11 to 2012/13 and Figure 2.8 shows the proportion spent in each type of provider in 2010/11 and 2012/13. Provisional data from foundation trusts suggest that funding for NHS-provided mental health services fell slightly in real terms in 2013/14.

Figure 2.7: Annual change in PCT spending in real terms for ISP and NHS-provided mental health care, 2010/11 to 2012/13 (2012/13 prices)

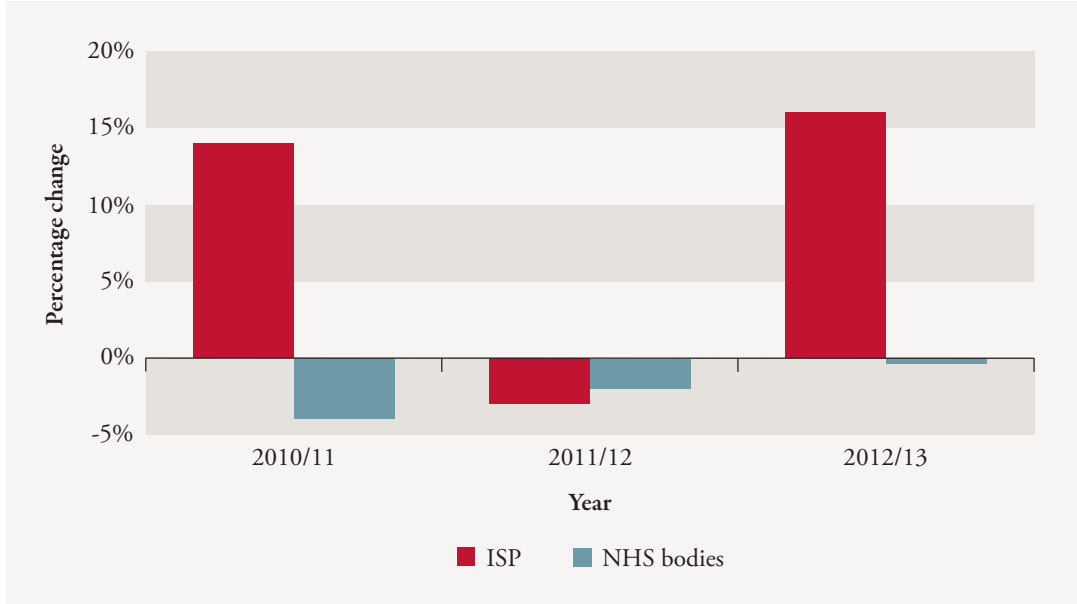
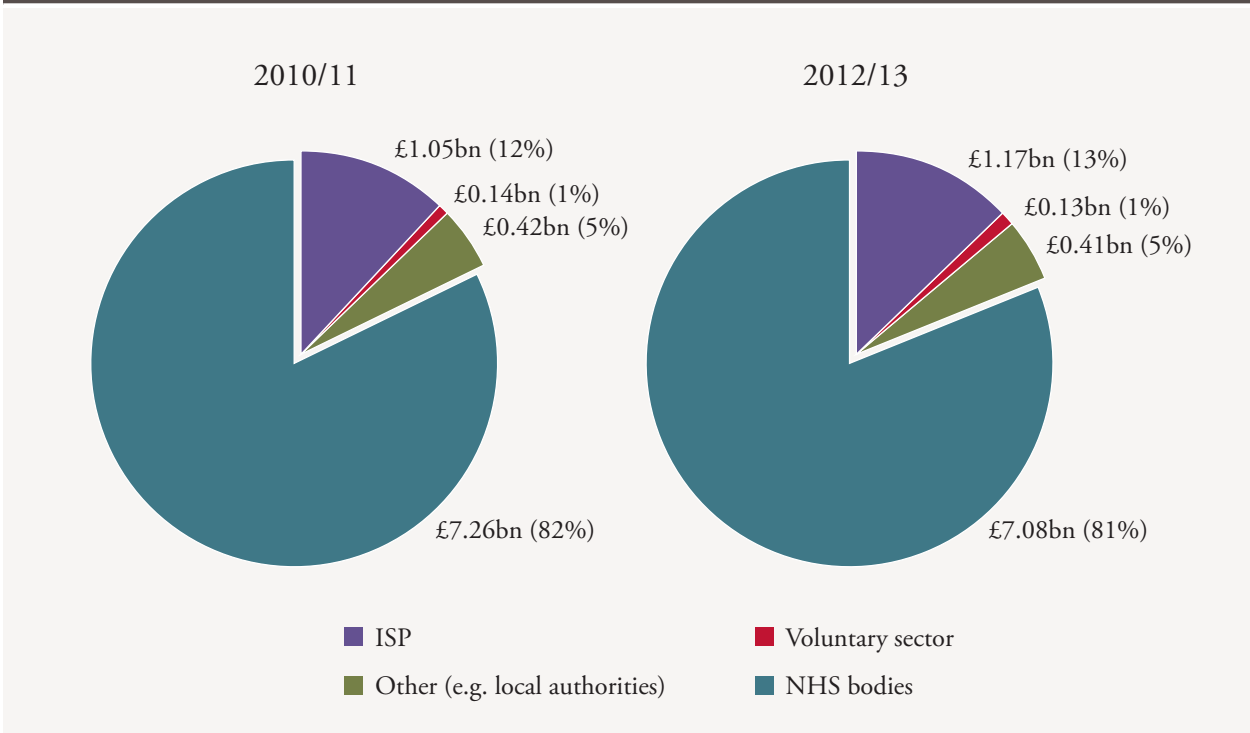


Figure 2.8: PCT expenditure on mental health care by service providers, 2010/11 to 2012/13 (£ billion) (2012/13 prices)



Spending on hospital services

Contrary to community and mental health services, hospital services are much more concentrated in NHS providers. Spending on hospital services increased by 4.0 per cent in real terms, from £42.5 billion in 2010/11 to 44.2 billion in 2012/13, at an annual average rate of 1.3 per cent (Table 2.3).

Table 2.3: PCT spending in real terms on hospital services, by service provider, 2010/11 to 2012/13 (£ billion) (2012/13 prices)

Year	PCT spending on ISPs (% total share)	PCT spending on NHS bodies (% total share)	PCT spending on voluntary and other service providers (% total share)	Total PCT spending on hospital services
2010/11	£1.346 (3.2%)	£40.962 (96.3%)	£0.243 (0.57%)	£42.552
2011/12	£1.596 (3.7%)	£41.262 (95.8%)	£0.231 (0.54%)	£42.601
2012/13	£1.582 (3.6%)	£42.424 (95.9%)	£0.234 (0.53%)	£44.241

In 2010/11 and 2011/12, PCT funding for independent sector providers of hospital services grew at a much faster rate than funding for NHS providers, but from a much lower base. However, in 2012/13, PCT expenditure on care provided by independent sector providers fell by £13 million (-0.86 per cent) compared with that of the previous year, while funding for NHS bodies increased by nearly £1.2 billion (2.7 per cent) (Figures 2.9 and 2.10).

Figure 2.9: Annual change in expenditure with NHS and ISP providers of hospital services, 2010/11 to 2012/13 (2012/13 prices)

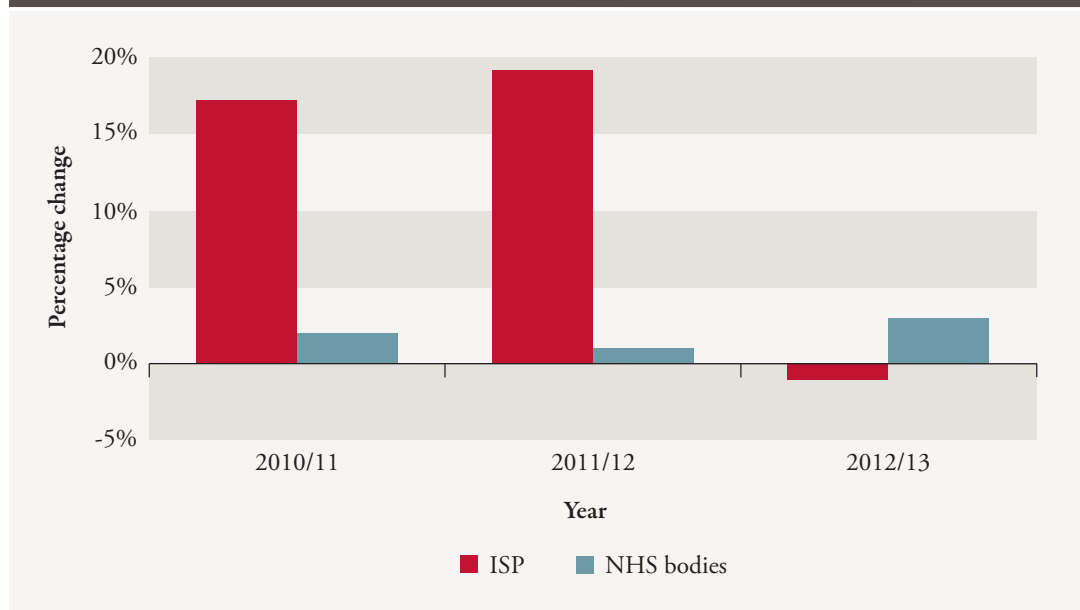
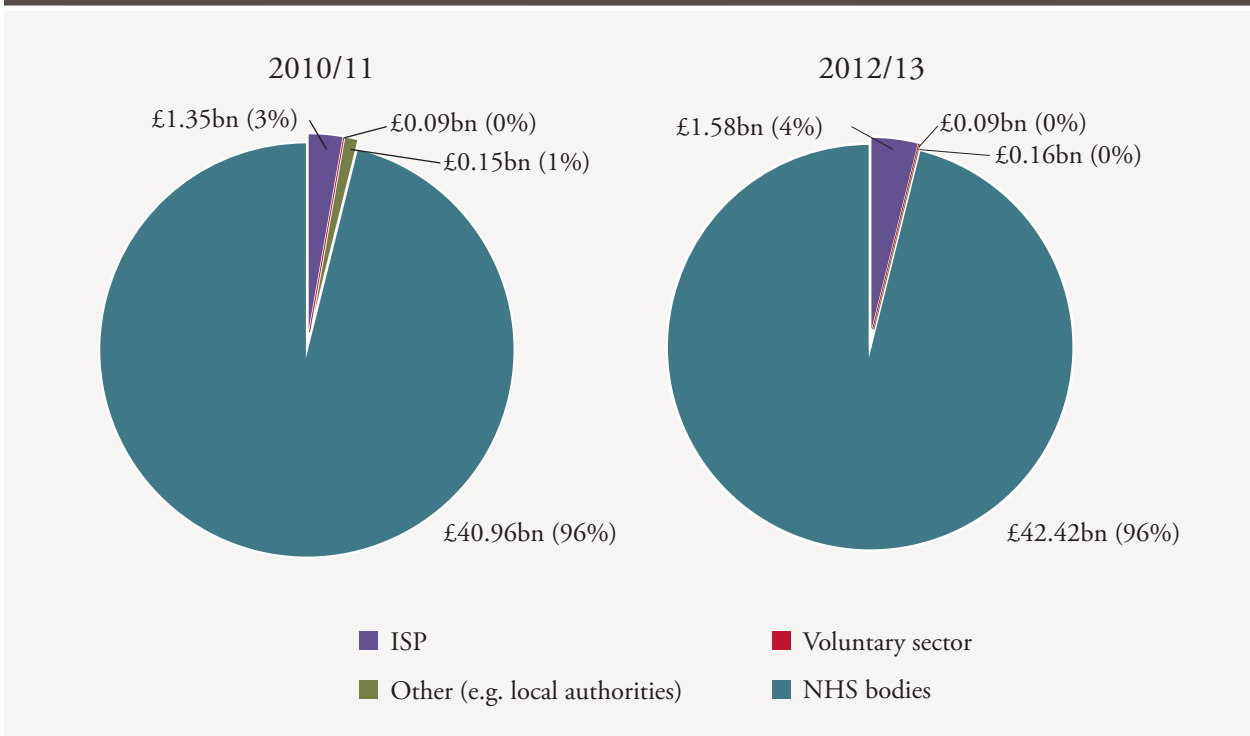


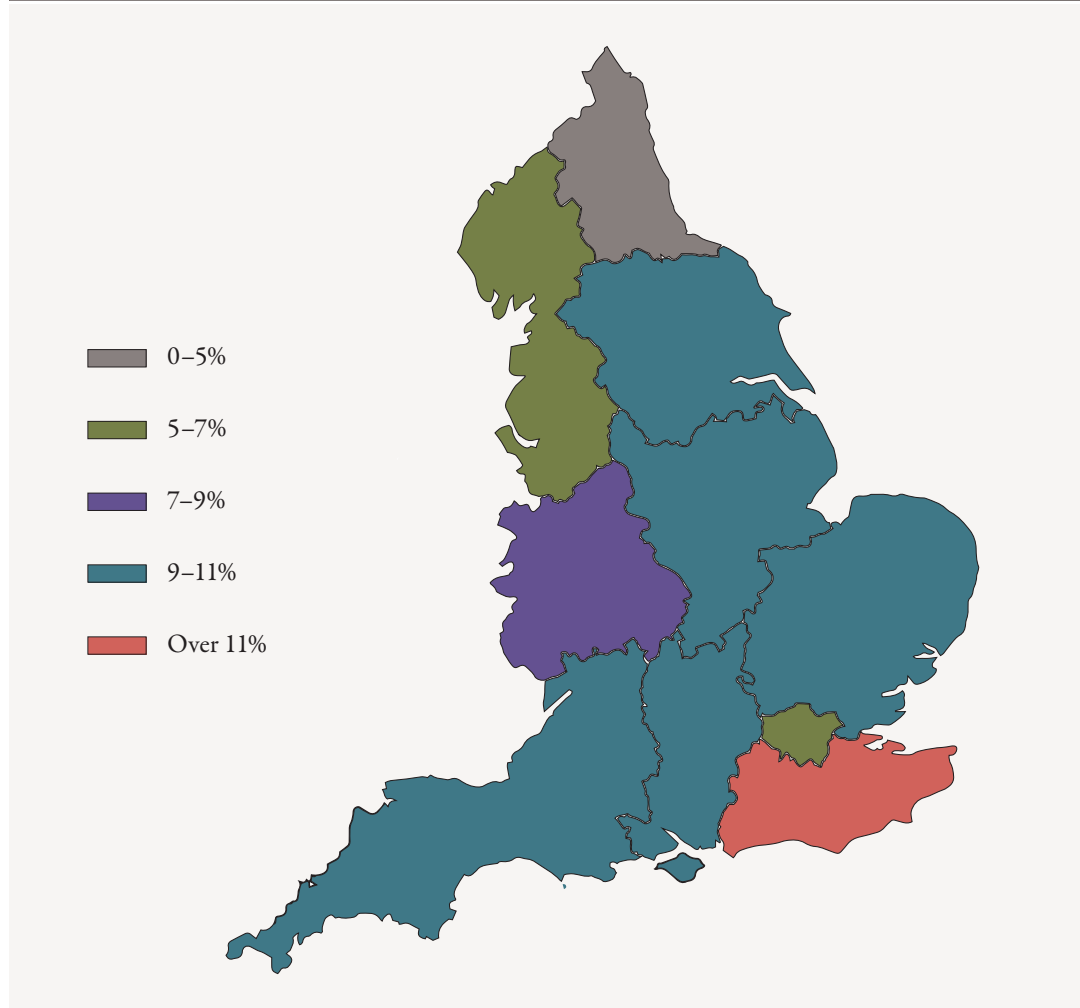
Figure 2.10: PCT expenditure on hospital care by service providers, 2010/11 to 2012/13 (£ billion) (2012/13 prices)



Regional variation in service providers

The provision of secondary care services by independent sector providers varies across England by region. In 2012/13, 9 per cent of secondary care funding was spent with independent sector providers. The proportion was highest in South East England (12 per cent), and lowest in London (6 per cent) and the North East (5 per cent) (Figure 2.11).

Figure 2.11: Proportion of secondary care funding spent on independent providers, 2012/13



3. NHS trusts' and foundation trusts' income and expenditure

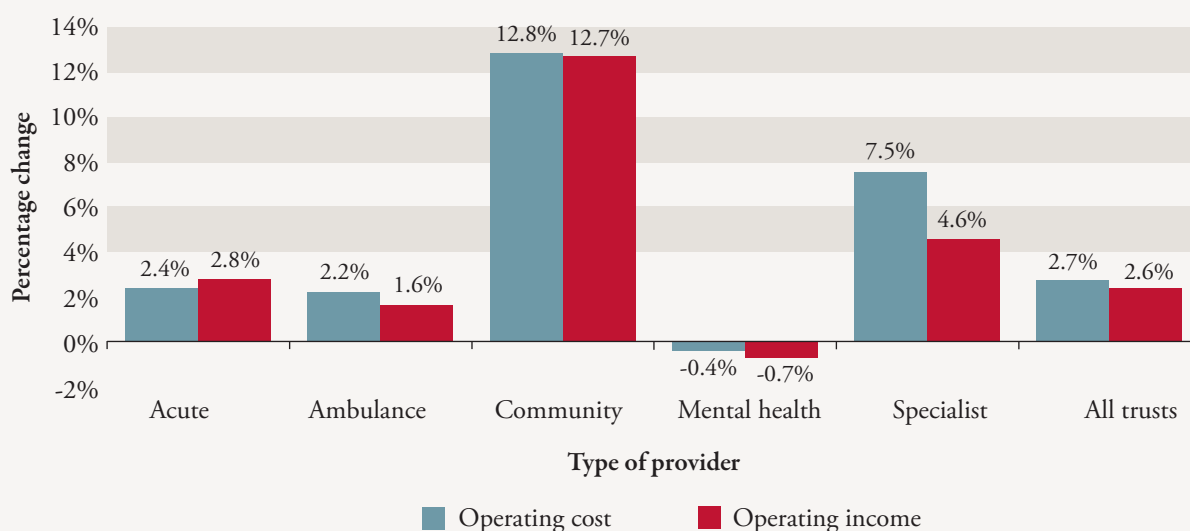
In 2012/13, there were 104 NHS trusts (including NHS Direct) and 145 foundation trusts. Of the 249 trusts in total, 56 per cent (142) are acute hospitals (Table 3.1). The number of NHS providers achieving foundation trust status remains very low. In 2012/13, just two NHS trusts became foundation trusts, and in 2013/14 two more – itself a further sign of financial stress.

Table 3.1: Number of NHS and foundation trusts, 2011/12 to 2012/13

	2011/12	2012/13
Acute	144	142
Ambulance	11	11
Community	16	17
Mental health	58	58
Specialist	20	20
NHS Direct	1	1
Total	250	249

NHS provider income grew in real terms in 2012/13 (by 2.6 per cent). Their operating costs increased at a slightly faster rate (by 2.7 per cent). But, even so, the total adjusted net surplus (without taking into account central financial support of NHS providers) rose from £362 million in 2011/12 to £383 million in 2012/13 (Figure 3.1).

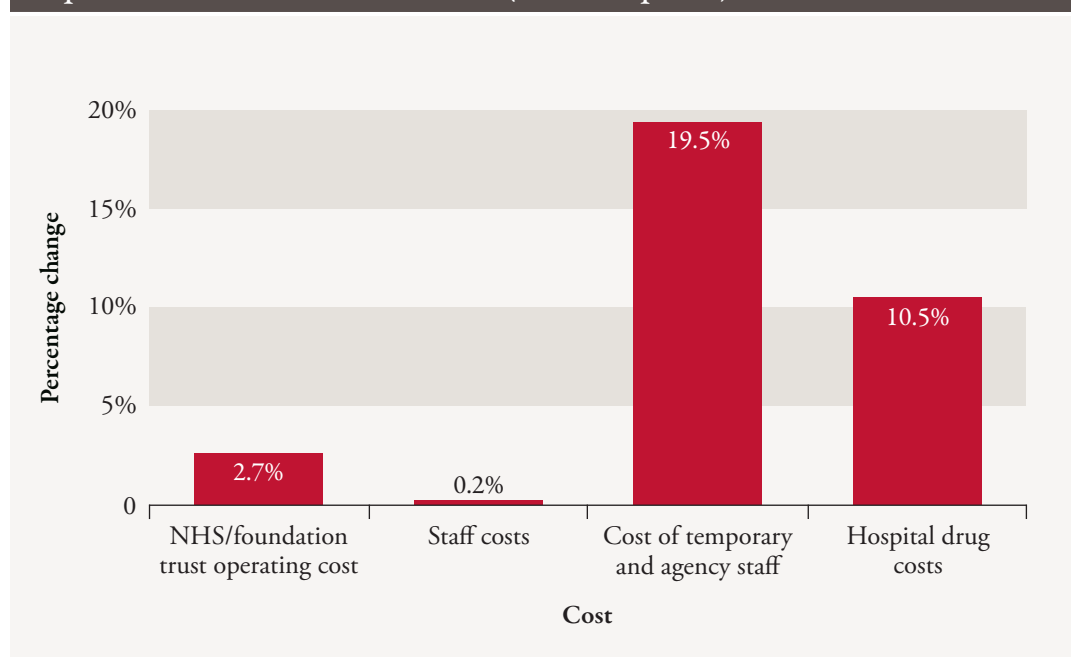
Figure 3.1: Percentage change in providers' operating income and cost, by type of provider, 2011/12 to 2012/13 (2012/13 prices)



Note: The total net surplus figure excludes NHS Direct. In 2012/13, NHS Direct produced a net deficit of £0.05 billion.

The financial position of NHS providers varies depending on the services they provide; deficits are concentrated in acute hospitals with a few mental health trusts experiencing financial problems. Community health services providers and ambulance services have tended to have fewer financial problems. In 2012/13, specialist hospitals experienced a sharp increase in operating costs, outpacing income growth. This may reflect a very different pattern of cost pressures for different types of inputs to care. In 2012/13, NHS providers saw modest growth in their total staff costs but large increases in drugs costs (Figure 3.2).

Figure 3.2: Percentage change in NHS trusts' and foundation trusts' expenditure, 2011/12 to 2012/13 (2012/13 prices)



The financial performance of NHS providers varied across the country as well as by service area. Deficits were concentrated in London with 10 out of 40 trusts in London reporting a deficit in 2012/13 (nine of which were acute hospitals). In 2012/13, the position of providers in the East Midlands deteriorated noticeably with a 54 per cent reduction in their net surplus compared with the previous year. Within London there were substantial differences in the financial performance of trusts. As a region, London contained the trust with one of the largest surpluses and the trust with the largest deficit. Overall, acute trusts in inner London fared better financially than those in outer London.

Figures 3.3 and 3.4 show the adjusted reported financial performance without central support. In 2012/13, only London and the East of England retained a net deficit while all the other regions of England produced a net surplus. With support, London produced a net surplus of £58 million but without support it showed a net deficit of £35 million. With financial support only six London trusts were in deficit and without financial support an additional four trusts were in deficit. In the East of England, the number of trusts reporting a deficit increased to six rather than three after stripping out financial support.

Figure 3.3: Adjusted reported financial performance of NHS providers in England without support, 2012/13

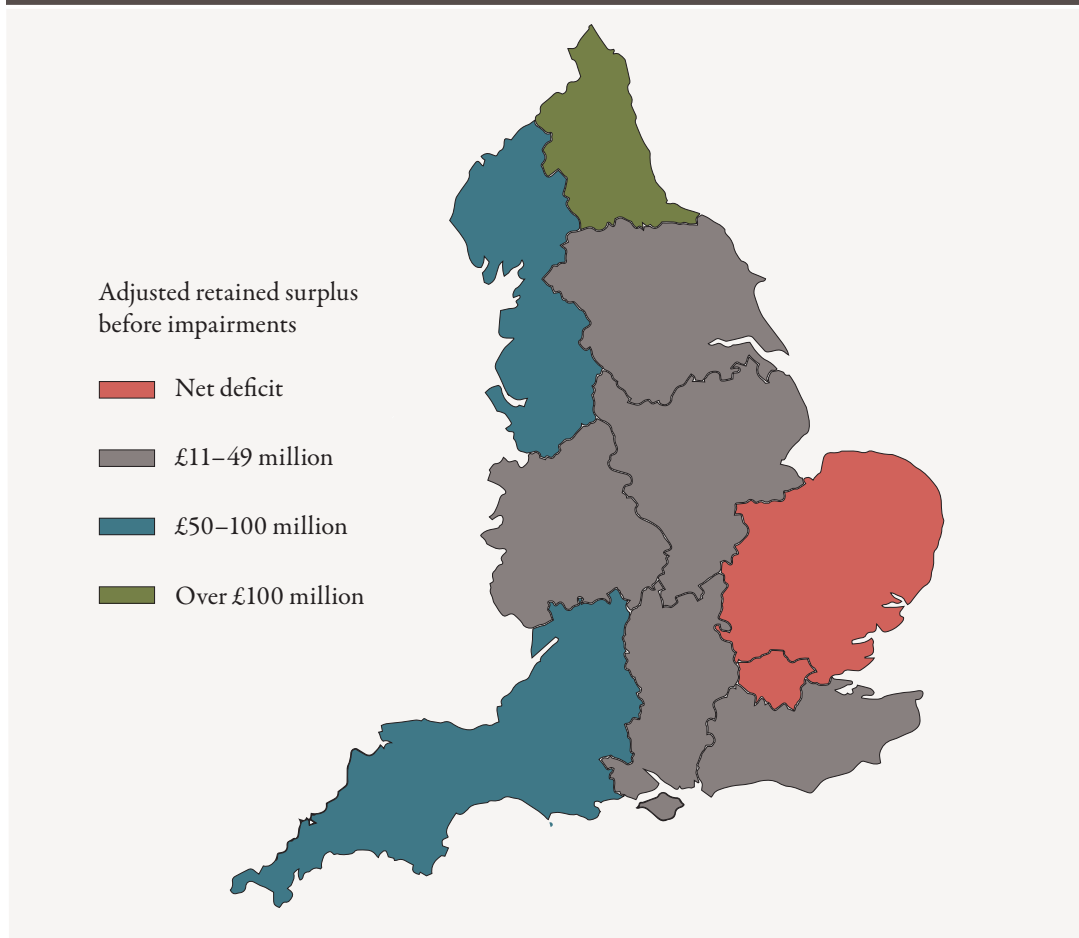
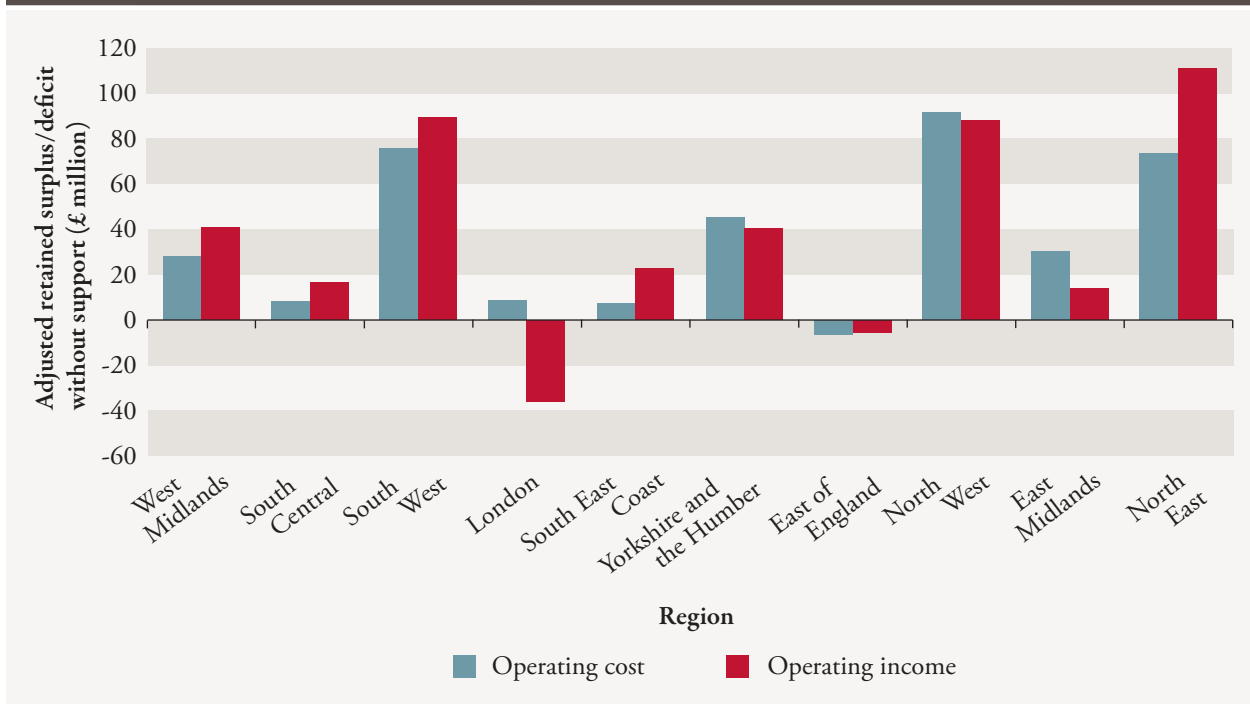
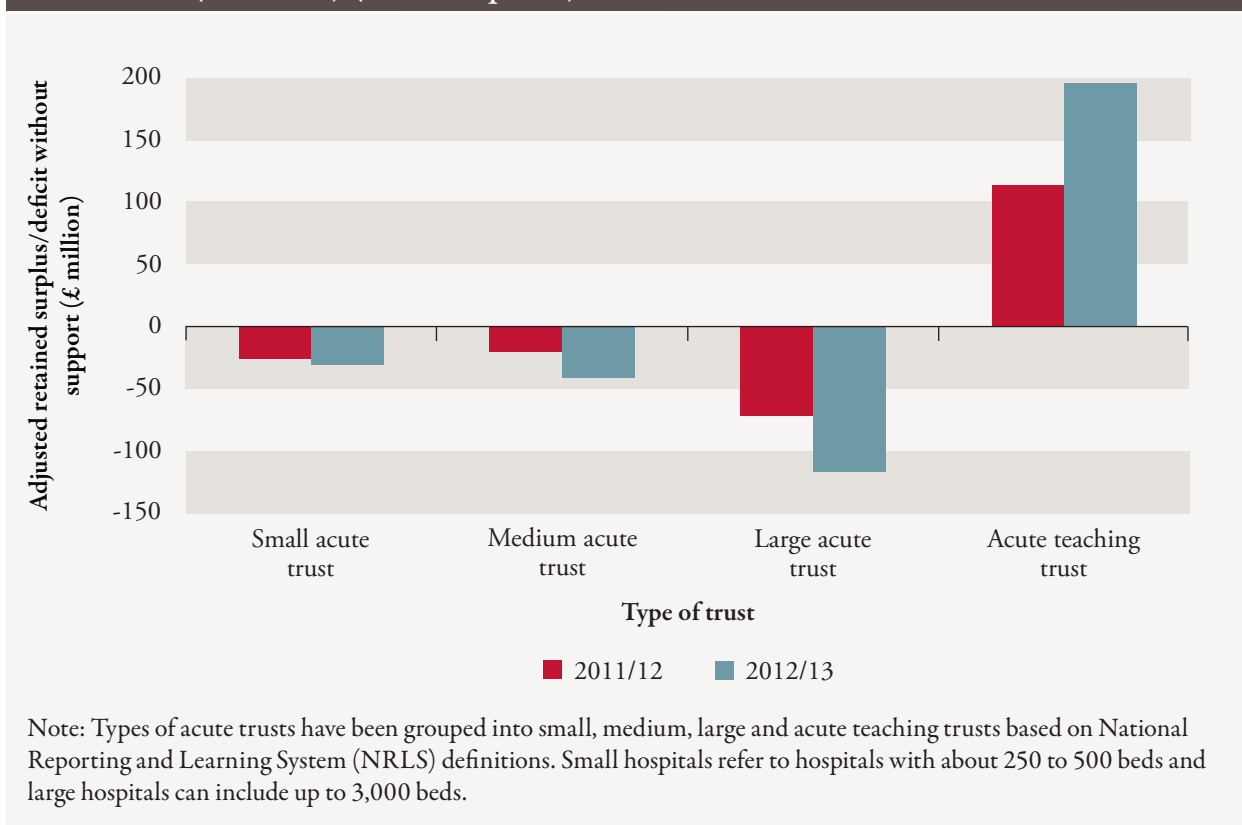


Figure 3.4: Adjusted reported financial performance of NHS providers in England without support, by region, 2012/13 (£ million) (2012/13 prices)



Among acute hospitals, there were marked differences between general acute hospitals and those with teaching status. General acute hospitals of all sizes were in net overall deficit in both 2011/12 and 2012/13, while acute teaching hospitals reported a net surplus (Figure 3.5).

Figure 3.5: Variation in adjusted reported surplus/deficit across trusts, by type, 2011/12 to 2012/13 (£ million) (2012/13 prices)



Source: NHS England (2014)

Financial performance in 2013/14

The year 2013/14 has seen a marked deterioration in the finances of NHS providers. Sixty-six trusts reported a deficit on their draft accounts. Most were in the acute sector. NHS and foundation trusts combined reported a provisional net deficit of just over £100 million, even with £369 million of financial support for 20 NHS trusts. Monitor (2014) also reported declining margins across all foundation trusts – the main factor in reducing the surplus in that sector. Deficits were concentrated in the Midlands (27 out of 48 trusts) and London (11 out of 30 trusts).

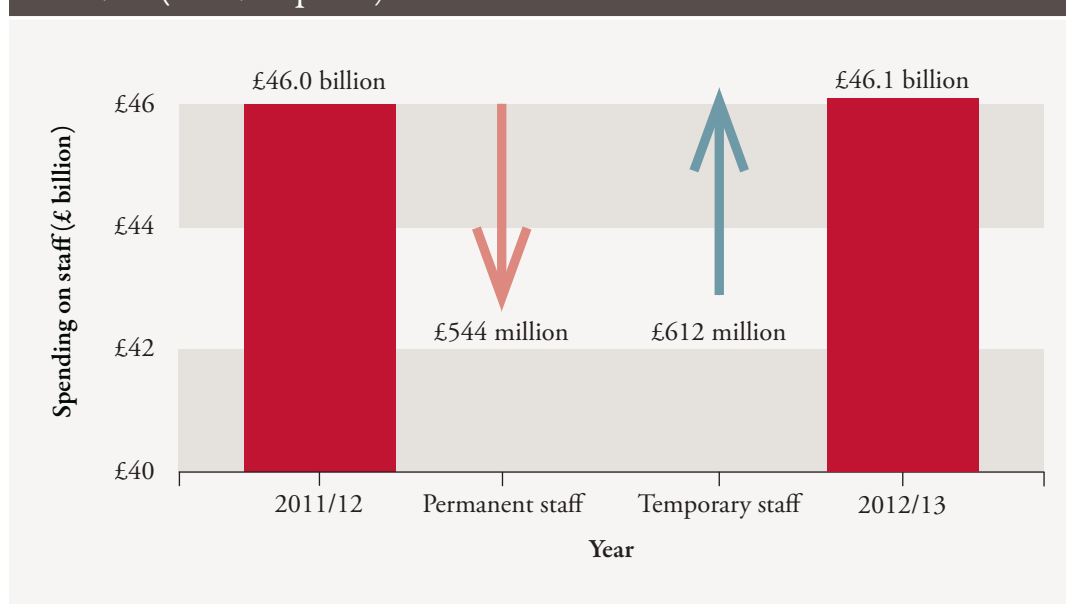
Spending on staff

Spending on staff accounted for about half of PCT net expenditure in 2012/13 (49 per cent) and two thirds (63 per cent) of NHS and foundation trusts' operating expenses. In our analysis of spending on staff, we included spending by PCTs as well as NHS and foundation trusts. This was in order to remove the impact of staff moving between PCTs and providers, which has happened particularly in recent years with the Transforming Community Services programme, a programme launched by the government in 2008

to shift care out of hospitals and closer to people's home (DH, 2009). Our analysis also includes the cost of temporary and agency staff. However, we have not been able to take account of staff moving to new organisations such as social enterprises as these are not part of the NHS staff data collection. The reported number of NHS staff now significantly underestimates the number of professionals providing NHS services, particularly in community health services. As the number of non-NHS providers and investment in them increases, the gap will get larger, so making it increasingly difficult to make judgements about trends in the 'NHS' workforce.

Overall spending on staff rose slightly in 2012/13 by 0.15 per cent in real terms. However, this increase hides a fall in the cost of permanent staff and an increased reliance on temporary staff. The cost of the permanent NHS workforce fell by 1.3 per cent, while the cost of temporary agency staff increased by 20 per cent (Figure 3.6). It also hides a small fall in the average number of FTE staff, which decreased by 0.22 per cent (2,317 FTE staff) over the same period (HSCIC, 2014b). Some of this change may be due to staff transferring to non-NHS providers as PCTs, and now clinical commissioning groups, award new contracts for services.

Figure 3.6: Changes in spending in real terms on staff, 2011/12 to 2012/13 (2012/13 prices)



Source: The figures on temporary staff come from the Department of Health accounts and the figures on permanent staff are drawn directly from the annual financial accounts.

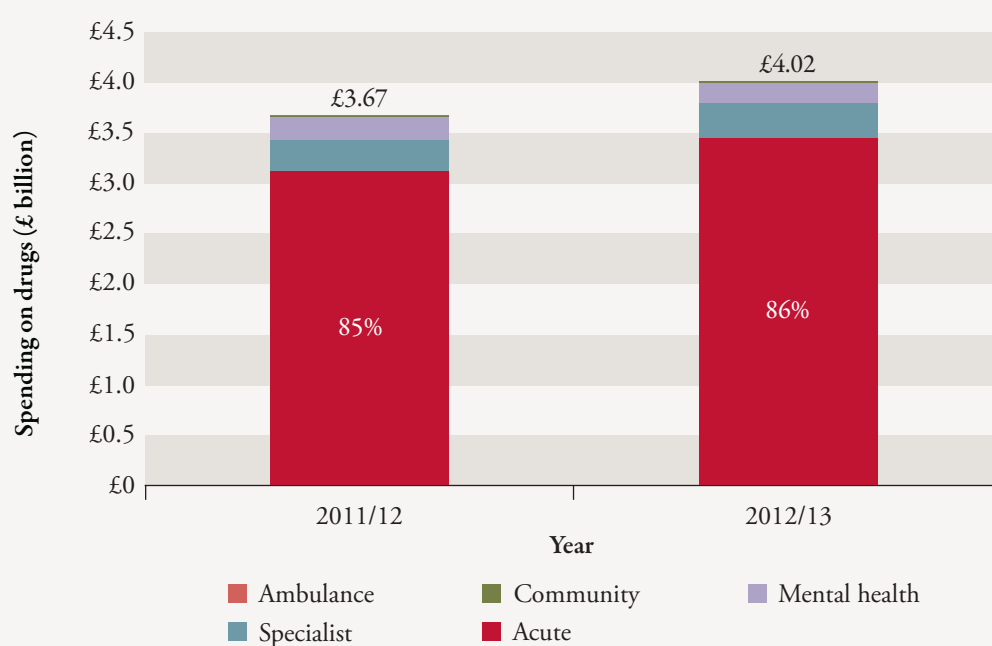
The low rate of growth in spending on the NHS workforce is partly explained by the government's public sector pay policy under which NHS employees with earnings above the £21,250 threshold received no increase in their headline pay in 2012/13. This is equivalent to a real-terms cut in pay of 1.1 per cent. Despite this, overall pay per employee increased slightly in real terms, with the average cost per head of staff increasing by 0.23 per cent in real terms, suggesting that a combination of incremental progression and possibly higher grading offset some of the pay policy. However, this increase is still significantly lower than the average 2 per cent annual real-terms rise in pay for hospital and community health service staff in the UK over 35 years to 2009/10 (authors' calculations, based on DH, 2011).

Holding down the number of NHS staff has not proved sustainable. Numbers and costs rose in 2013/14 as trusts responded to the Francis Report (Francis, 2013), inspections by the Care Quality Commission and reviews of the quality of services in several trusts by Sir Bruce Keogh (Keogh, 2013). These changes are discussed in more detail in Chapter 4.

Spending on drugs

The second largest area of cost for NHS providers is spending on drugs. We have analysed reported spending on drugs for 199 foundation and NHS trusts (those providers that had consistent data in 2011/12 and 2012/13). NHS providers' total spend on drugs increased by 9 per cent in real terms between 2011/12 and 2012/13, from £3.68 billion to £4.02 billion. Most drug costs are incurred by acute hospitals (Figure 3.7). Compared with 2011/2012, the total spending on drugs in 2012/13 increased in real terms by 10 per cent in the acute sector and by 11 per cent for specialist trusts.

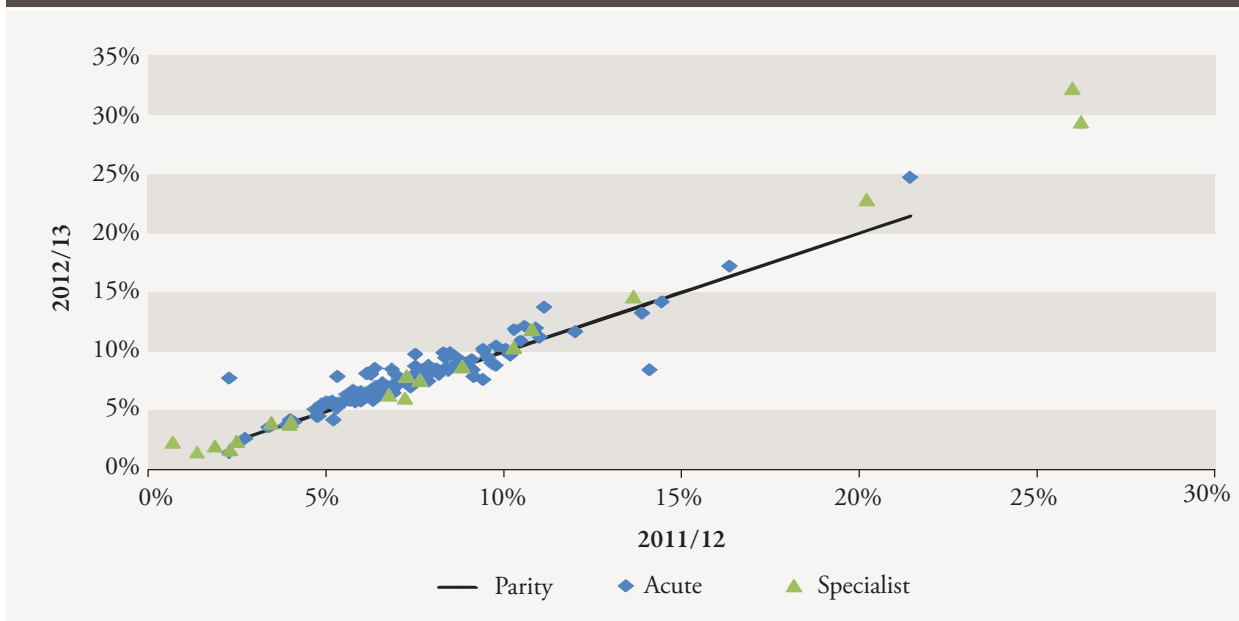
Figure 3.7: Total drug spending in real terms, 2011/12 to 2012/13 (£ billion) (2012/13 prices)



Note: In order to ensure comparability, we have included 200 trusts in this analysis for which the data were available for both 2011/12 and 2012/13.

As a result, on average, trusts spent a higher proportion of their total operating cost in 2012/13 on drugs than in the previous year. In 2011/12, the drug cost in the acute sector accounted on average for 7.4 per cent of the acute trusts' total operating cost compared with 7.8 per cent in 2012/13. Most trusts spend between 5 and 10 per cent of their total expenditure on drugs. However, in 2012/13, fewer trusts spent between 0 and 5 per cent of their operating cost on drugs and three of the four trusts that spent more than 20 per cent of their operating income on drugs in 2011/12 spent an even higher proportion of their operating income on drugs in 2012/13 (Figure 3.8). The national schedule of reference costs shows that the unit cost of high-cost drugs for hospitals increased by 6 per cent in real terms between 2011/12 and 2012/13 (DH, 2013b). This suggests that

Figure 3.8: Drug costs as a proportion of operating costs, 2011/12 to 2012/13
(2012/13 prices)



the rise in drugs spending is driven not only by an increase in the cost of high-cost drugs but also by additional volumes.

The cost of hospital drugs rose by a further 12 per cent in 2013/14, based on data from foundation trust accounts.

Acute trust income

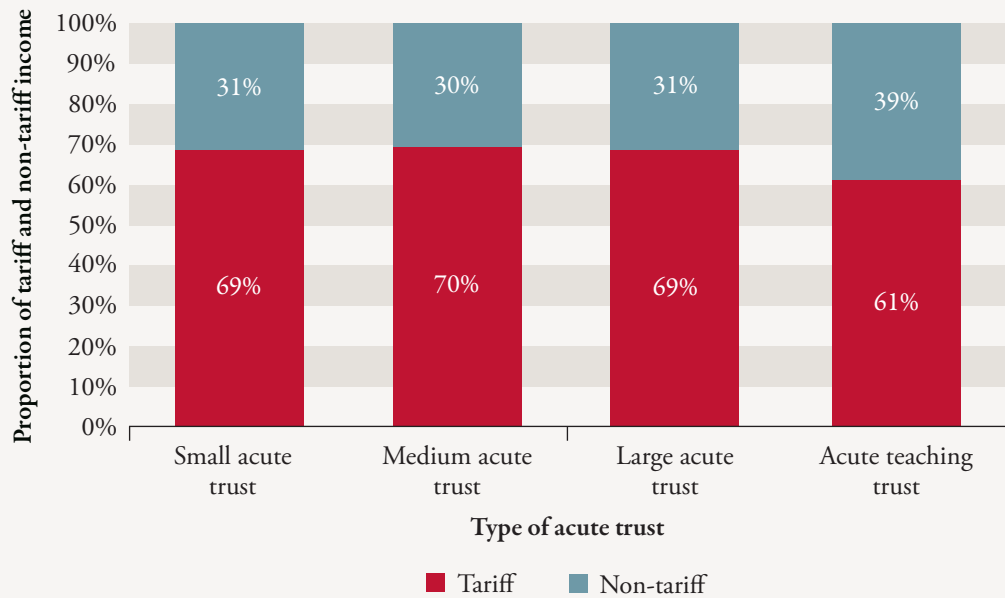
NHS and foundation trusts are paid for the care they provide for NHS patients under a mix of Payment by Results (PbR) (tariff income) and locally negotiated payments (non-tariff income). In 2012/13, the PbR system reduced the headline tariff prices by 1.8 per cent, following a decrease of 1.5 per cent in 2011/12 (Marshall and others, 2014). This reduction was intended to ensure that the NHS meets its annual 4 per cent efficiency target in each year from 2011/12 to 2015/16 under the Quality, Innovation, Productivity and Prevention (QIPP) programme. In 2011/12, the 1.5 per cent cut to the tariff accounted for half of the cash savings under QIPP (Audit Commission, 2012).

The PbR tariff covers the majority of acute services provided in hospitals, but its coverage is falling. The total amount spent on services through the PbR tariff was £28.7 billion in 2012/13, down from £29.3 billion in 2011/12 (in 2012/13 prices) – a fall of 2.1 per cent. In 2012/13, it covered 58 per cent of acute hospitals' income compared with 60 per cent in 2011/12 in real terms. We have compared 139 acute trusts where data were available for both tariff and non-tariff income for 2011/12 and 2012/13.

Acute teaching trusts received a higher proportion of their income from non-tariff income compared with general acute providers. But there was no systematic difference in the share of tariff payments by size of trust (Figure 3.9).

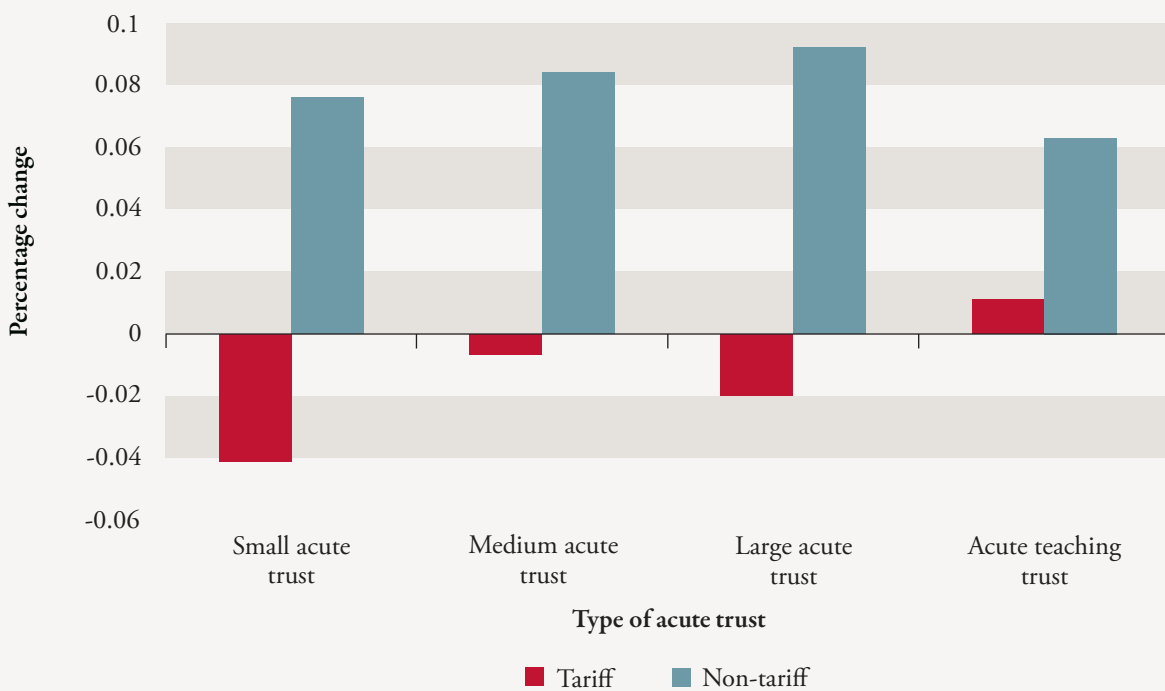
In 2012/13, all acute trusts experienced growth in non-tariff income and all acute trusts experienced a decline in tariff revenue, except acute teaching trusts where it increased by 1 per cent (Figure 3.10). Growth in non-tariff income has again outstripped that from tariff income in 2013/14, based on a preliminary analysis of foundation trust draft accounts.

Figure 3.9: Proportion of 139 acute trusts' tariff and non-tariff income, by acute trust type, 2012/13



Note: We grouped acute trusts into small, medium, large and acute teaching trusts based on National Reporting and Learning System (NRLS) definitions.

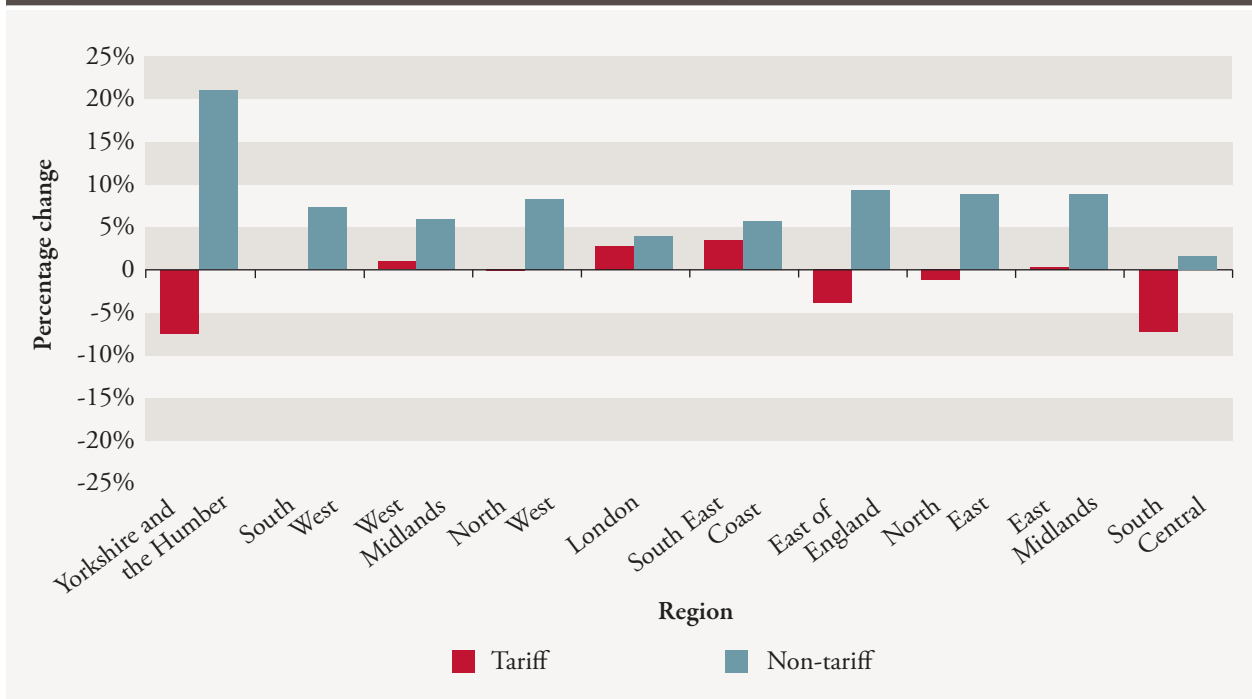
Figure 3.10: Percentage change in 139 acute trusts' tariff and non-tariff income, by acute trust type, 2011/12 to 2012/13 (2012/13 prices)



As Monitor (2014) notes, non-tariff income is a prime way of local commissioners providing financial support to trusts. National figures include financial support provided to trusts and therefore understate the true financial position.

In 2012/13, there was a significant increase in non-tariff income for providers in Yorkshire and the Humber, perhaps reflecting increasing financial pressures in providers in this strategic health authority (Figure 3.11).

Figure 3.11: Percentage change in 139 acute trusts' tariff and non-tariff income, by region, 2011/12 to 2012/13 (2012/13 prices)



4. Discussion

The year 2012/13 was a period of comparative stability for NHS finances, with modest growth in funding and cost. However, data for 2013/14 suggest that this has not been sustained and the prolonged period of austerity is starting to have a broad impact on the resilience of NHS providers, particularly NHS hospitals.

This analysis suggests that the NHS is increasingly poorly placed to manage the impact of austerity. There are five key trends in the financial position of the NHS, which suggest that the system will find it increasingly difficult to manage within a budget that is broadly constant in real terms:

- weak and declining financial strength in hospitals, with little prospect of improvement
- an increasing reliance on one-off or temporary savings to make ends meet
- continuing rising demand for hospital services and further reductions in spending on primary care
- significant underlying cost pressures on staffing and hospital drugs
- a shift from NHS to independent and voluntary sector provision in a number of services potentially leaving NHS providers with flat or declining income and potentially sunk costs.

Weak and declining hospital financial strength

Both Monitor and the NHS Trust Development Authority (TDA) have recently reported a further decline in the financial strength of trusts, driven mainly by the acute sector (Monitor, 2014; NHS TDA, 2014). Provisional data for 2013/14 suggest that trusts will post a net overall deficit of just over £100 million, compared with an overall surplus of £383 million in 2012/13. There are now 66 trusts in deficit, even after including over £360 million of financial support, compared with 45 in 2012/13 after stripping out financial support. Most are acute hospitals. Monitor also reports declining revenue margins. These developments continue a trend. There seems every reason for this decline to continue at an increasing pace, given the four factors described below. Commissioners are also finding it much harder to balance their budgets in 2013/14, limiting the scope for easing some of the financial pressures on trusts.

Temporary and short-term savings

Spending figures reported in the 2012/13 NHS accounts suggested that the NHS struggled to deliver on the transformative change envisaged in the QIPP agenda. Research by The King's Fund looking in depth at how six NHS organisations have been managing with austerity found that there has been a mixture of salami-slicing of budgets, recruitment freezes and income generation. But, there was evidence of innovative ways of working and delivery of more cost-effective care (Appleby and others, 2014). However, across the NHS the issue is one of balance when sustainable savings totalling 4 per cent a year need to be achieved. Commissioners reported savings of £1.722 billion in 2013/14 – just less than 2 per cent of their spend, with the largest shortfall (£235 million) against

NHS England's 'transformational' heading. Monitor (2014) has provided a more detailed breakdown for foundation trusts, showing that trusts achieved savings of 3.0 per cent in 2013/14 compared with a plan of 3.9 per cent and achievement of 3.4 per cent in 2012/13. Moreover, the proportion of non-recurrent savings continued to rise. Recurrent savings are becoming harder and harder to achieve. Non-pay costs in foundation trusts rose faster than inflation in 2013/14 and there are particular pressures on staffing, as set out below. Year-on-year sustainable savings of 4 per cent now look unachievable.

Rising demand for hospital services

One key area of the transformation agenda has been the desire to shift care from hospital settings to primary and community services. Finance and activity data suggest that this is proving elusive. Although investment in community health services has continued to grow, that on primary care has fallen, whereas that on acute care has steadily risen.

The rising spending on acute hospitals reflects to a large extent rising demand and activity. Hospital episode statistics (HSCIC, 2013) show that between 2011/12 and 2012/13:

- emergency admissions increased by 1.8 per cent (from 5,243,000 to 5,336,000 admissions)
- outpatient attendances increased by 3.9 per cent (from 72,620,000 to 75,756,000 attendances)
- day case episodes increased by 2.3 per cent (from 5,924,000 to 6,062,000 episodes).

All increased further in 2013/14.

There is research to suggest that at least some of this activity could be avoided through more appropriate out-of-hospital care (Blunt, 2013). The government's proposals for the Better Care Fund seek to address this by focusing health and social care funding on provision to reduce avoidable admissions. The initial plans for a £3.8 billion fund in 2015/16 would be financially sustainable for the NHS if 15 per cent of emergency admissions were avoided and the full costs associated with these admissions could be released by hospitals (Bennett and Humphries, 2014). However, to achieve both of these would be very challenging.

In recognition of the risks this creates, the government has now introduced provisions which will return Better Care Fund money to the NHS where targets for savings from better joined-up care are not met. However, the target will generally be set at a 3.5 per cent reduction in emergency admissions. This is much lower than previous estimates of what would be required for the NHS to break even.

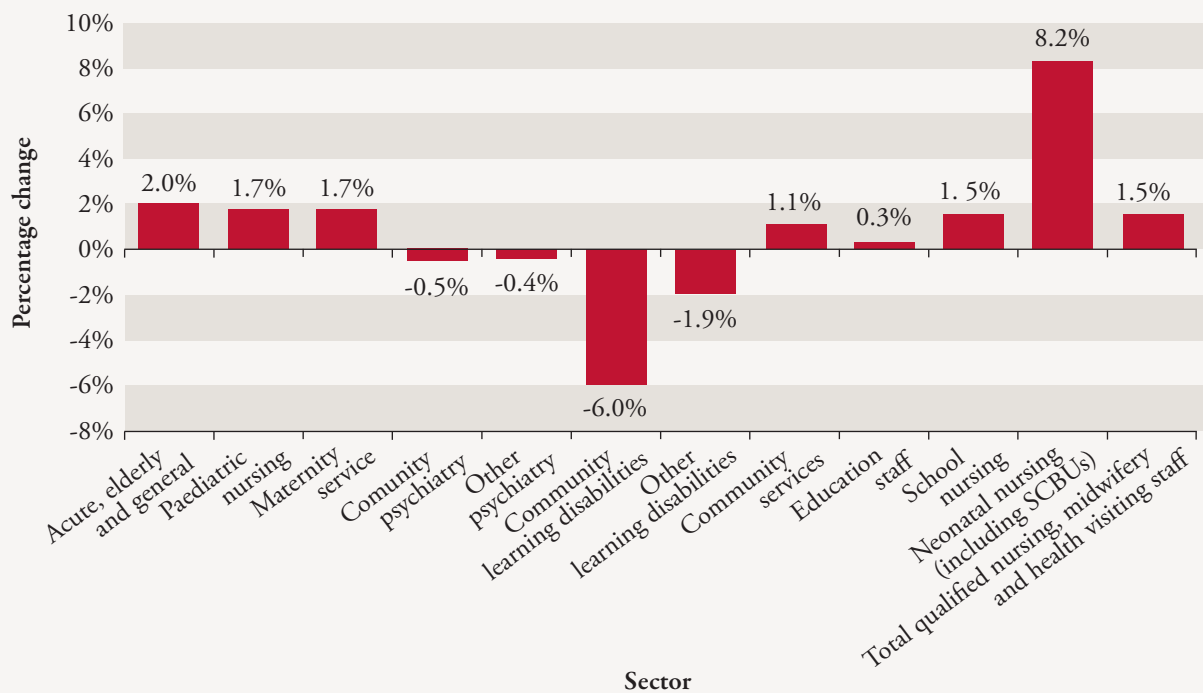
Research examining 38 integration schemes across eight countries indicates that achieving even a 3.5 per cent reduction in emergency admissions would be very difficult (Mason and others, 2014). In 2012/13, emergency admissions continued to rise. Research also suggests that hospital costs have significant elements of fixed (buildings and large equipment) and semi-fixed (skilled staff) costs (DH and NHS Confederation, 2010). Releasing the staff costs will be very challenging – not only does it mean NHS boards and management teams having real confidence that admissions will reduce so that they reduce staff numbers, but also ensuring that hospitals have the right mix of skills in teams and can support the quality imperative for seven-day working. Furthermore, senior staff presence may be hard in smaller units that are doing less emergency work.

Increasing cost pressures in hospitals

In 2012/13, the NHS held down the cost of the workforce – in part through the pay restraint imposed by the government's public sector pay policy, but also by reducing the permanent workforce. It also carried hidden costs as this was accompanied by a substantial rise in the use of temporary and agency staff, which have high costs per employee and raise concerns about quality and continuity of care. Acute hospitals experienced significant spending pressures from rising agency costs, with the cost of non-permanent staff increasing (20 per cent) while the cost of permanent staff decreased (1.3 per cent).

The reduction in permanent staffing also proved unsustainable, with workforce numbers rising sharply in 2013/14. The total number of NHS staff increased by less than 1 per cent in 2012/13, but the total number of FTE staff in the NHS rose by 1.6 per cent (18,000 FTE staff) between April 2013 and December 2013, with the number of nurses in the acute and elderly care sectors increasing more rapidly than in other sectors – at a rate of 2.0 per cent (Figure 4.1).

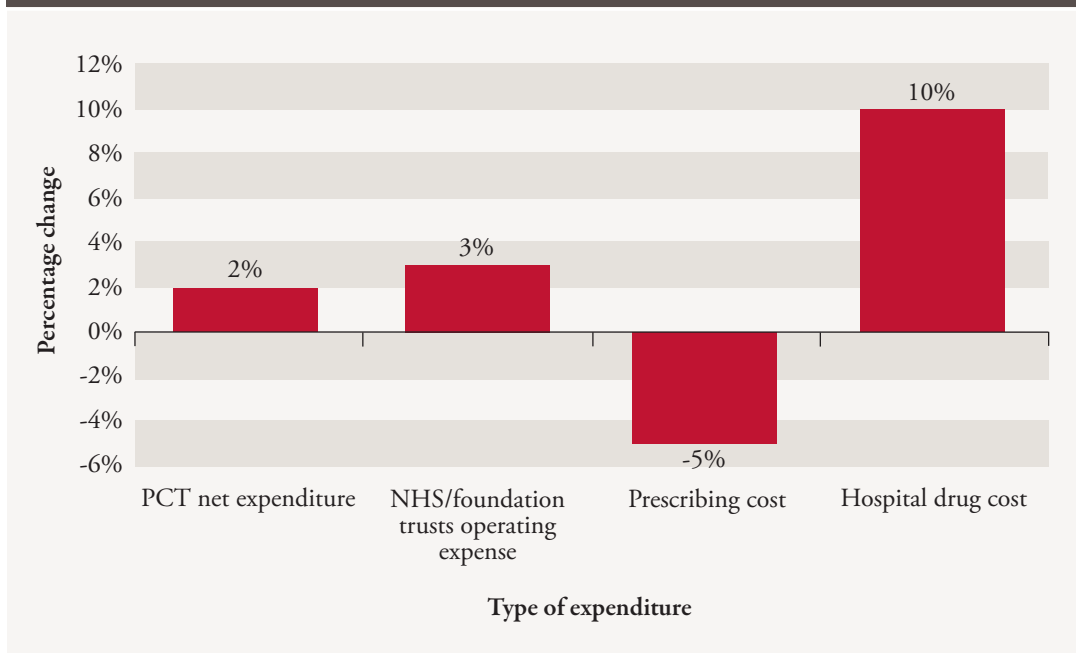
Figure 4.1: Percentage change in the number of nurses, by sector, April 2013 to December 2013



Note: SCBU = special care baby unit.

Source: Health & Social Information Centre (2014)

Figure 4.2: Real-terms percentage change in types of expenditure, 2011/12 to 2012/13 (2012/13 prices)



Hospitals planned to increase their staffing in 2013/14. But, on the basis of data from foundation trusts,¹ they were expecting to do this by increasing spend on permanent staff and reducing spend on contract and agency staff. In the event, spending on permanent staff increased by £1.37 billion to £24.87 billion but that on contract and agency staff increased by £295 million (a 27 per cent increase in cash terms compared with 2012/13) to £1.37 billion despite a planned fall to £523 million.

Although spending on drugs in primary care fell between 2011/12 and 2012/13 as branded drugs came off patent and cheaper generic ones became available, acute and specialist trusts' spend on drugs increased rapidly (10 per cent in real terms) (Figure 4.2).

These pressures continued in 2013/14 – foundation trusts reported that spend on drugs increased by 12 per cent compared with 2012/13. The new Pharmaceutical Price Regulation Scheme (PPRS), which covers branded medicines, provides assurance that overall spending (primary and secondary care) on branded medicines will stay flat over the next two years and will then grow slowly after that two-year period (DH, 2013c), which should give some relief from rising spend in hospitals.

The use of non-NHS providers

Our analysis of services by provider shows that there are changes in the mix of funding by type of service provider in the primary and secondary care sector. Funding for NHS-provided mental health care and community health services both saw a fall in funding in real terms. By contrast, funding for the provision of those services by the independent sector experienced a rapid increase. Our analysis focuses on the three

1. A small portion of the increase is due to NHS trusts becoming foundation trusts in 2013/14 and one acquisition. After removing the impact of these changes, the revised figures for permanent staff are an increase of £900 million to £24.4 billion, and for agency staff an increase of £247 million (23 per cent) to £1.33 billion. The planned fall to £523 million for agency staff is unchanged.

financial years to 2012/13 but these trends started before 2010/11. Indeed, the share of the independent sector as a proportion of total spend on community health services nearly tripled from 2006/07, from 7 to 18 per cent. The share of spending on voluntary sector and other providers rose from 8 to 13 per cent, meaning that nearly a third of community health services were supplied by non-NHS providers. The share of the independent sector as a proportion of total spend on mental health services increased by 4 percentage points between 2008/09 and 2012/13, while the share of NHS bodies decreased by the same amount (4 percentage points).

This rapid growth is partly explained by the Transforming Community Services programme, a two-year programme that ended in March 2011, which has led to some community health services becoming stand-alone social enterprises (DH, no date, b). Other service priorities, such as the growth in reablement services, may also have played a part. But it clearly goes beyond this. There is very little information on the number or nature of the contracts that commissioners are tendering or agreeing with non-NHS bodies. However, some research has tracked invitations to tender and contract awards in the 2013/14 financial year (Davies, 2014). This found that clinical commissioning groups awarded 80 contracts during 2014. Two thirds of these contracts were awarded to non-NHS providers and they covered a diverse range of clinical services, with diagnostics, mental health and pharmacy featuring prominently.

In the hospital setting, non-NHS providers compete for NHS work under the fixed national tariff – this limits the scope for price competition. In community health services and mental health there is no system of national pricing and so local commissioners determine both the quality and price parameters of any contracting. However, it is almost impossible to judge what impact this shift from NHS to non-NHS providers has had on access to care and the efficiency of provision as there is little data available nationally. Beyond concerns about efficiency, such a rapid change over a short period of time raises questions about the impact on NHS community and mental health services that are left with a declining revenue base.

5. Conclusion

The last three years have been a period of unprecedented financial challenge and organisational change for the English health care system. Our analysis shows that the NHS has risen to and met this challenge and overall lived within a much tighter budget. The NHS has also been increasing its productivity (Bojke and others, 2014). However, as the accounts and latest provisional data confirm, the NHS has relied heavily on one-off or temporary savings and is experiencing rising cost pressures that it is struggling to contain. Seeking to deliver year after year of productivity improvements significantly above the estimates of the whole economy's trend rate of productivity is a very demanding, if not, unrealistic goal. Much of the strategy in future is predicated on reducing costs and activity in hospitals but acute hospitals look in a particularly vulnerable position financially. Moreover, while there is evidence that some hospital admissions could be avoided and there is scope to further reduce average length of stay, research suggests that realising savings from these changes is difficult and international comparisons show that the NHS does not have a large hospital sector and admission rates are not particularly high compared with other developed countries (OECD, 2013).

We expect NHS finances to deteriorate further in 2014/15 and 2015/16. Although acute hospitals are showing the clearest signs of financial strain, all providers and commissioners face financial challenges. There is no sign that demand is reducing, particularly for acute trusts. The financial year of 2015/16 is likely to be particularly difficult financially as the service seeks to meet the unpredictable demands of financing the Better Care Fund. NHS England estimates have suggested that this may require reductions of up to 15 per cent in emergency admissions, yet the health service will see £1 billion removed if reductions reach a threshold of just 3.5 per cent.

Service transformation – which is much talked about and sought after as a way of meeting the twin challenges of austerity and rising demand through a combination of technological change, increasing the amount of care provided outside hospitals, reconfiguring the acute sector and focusing more on what patients can do for themselves – seems very distant. But hopes and plans have been pinned on such a change. In the absence of transformation and without a credible alternative plan, the NHS seems destined to experience a funding crisis this year or next.

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Sarah Lafond joined the Nuffield Trust in December 2013 from the Health Analytical Services of the Scottish Government where she worked on a number of health and social care projects and publications such as the integration of health and social care and the new social care survey. Sarah's current projects at the Trust include financial analysis of NHS funding and projection of future health care costs.

Sarah has a Master's degree in ecological economics from the University of Edinburgh. Her MSc dissertation was on the government cost of occupational cancer in Great Britain where she conducted a cost and benefit analysis of implementing a health intervention to reduce exposure to asbestos.

She graduated from McGill University in Canada in 2010 with a degree in international development and environmental studies, focusing on the ecological determinants of health in society.

Sandeepa Arora

Sandeepa Arora has a Master's degree in economics with an emphasis on health economics from the University of Edinburgh. Her MSc dissertation was on the intergenerational effect of alcohol consumption, where she conducted research using the HILDA (Household, Income and Labour Dynamic in Australia) survey.

During her time as an undergraduate student, Sandeepa interned at the Health Economics Research Unit (HERU) in Aberdeen, where she developed an interest in the field of applied health economics research and how it can be applied to health policy.

Before joining the Nuffield Trust, Sandeepa assisted in a research project at Healthcare Management Group, Imperial College London, on understanding people's willingness to pay for health care. The work involved estimating the trend in people's willingness to pay for health care and looked at people's attitudes towards risky behaviours.

Sandeepa is particularly interested in exploring the field of applied econometrics in relation to health policy-based research.

Anita Charlesworth

Anita Charlesworth is Chief Economist at the Health Foundation. She leads a team responsible for the foundation's work in economics.

Anita joined the Health Foundation from the Nuffield Trust where she led on analysis of financing and market reforms in health care. Prior to this she had been Chief Analyst and Chief Scientific Advisor at the Department for Culture, Media & Sport. Previously, Anita was Director of Public Spending at the Treasury, where she led the team working with the late Sir Derek Wanless on his reform of NHS funding. Anita has a Master's degree in health economics from York University and has worked as an Economic Advisor in the Department of Health, and for SmithKline Beecham pharmaceuticals in the UK and USA. She is also a non-executive director at Whittington Health NHS Trust.

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Andy McKeon is Senior Policy Fellow at the Nuffield Trust, after being interim Chief Executive of the Nuffield Trust from September 2013 to April 2014. Previously Andy had been a trustee for five years. He is also Adjunct Professor at the Centre for Health Policy in the Institute of Global Health Innovation at Imperial College London.

Formerly a career civil servant at the Department of Health, Andy led on several major White Papers reshaping the NHS. He also had responsibility for primary care and all pharmaceutical matters.

He joined the Audit Commission in 2003, where he was responsible for all the commission's work in the NHS and on wider health matters. During his time at the commission, he undertook a review for the Secretary of State on the NHS' financial management and accounting regime, and produced a number of major studies on the NHS and public health issues more generally.

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