The reporting of NHS Deficits – these are not what they seem

1. Introduction

It is little over six months since NHSManagers.net published my short article on the subject of NHS Deficits. It was prompted by lurid headlines of NHS finances spiralling out of control and dire threats of the consequences. But it turns out that early outturn figures for 2015/16 show the NHS as a whole had a £600m surplus after all.

As Captain Renault might have retorted "shocked" but that doesn't really sum it up.

I discuss below what may be going on and make some recommendations.

2. The figures for 2015/16

We have been commissioned to look at the STP planning process in North West London and I was trawling through board reports to try to piece together what the overall financial position was in 2015/16. We have all seen the headlines of huge deficits at Imperial and North West London Hospitals but it turns out that it is not as straightforward as that.

In North West London you have to examine eight separate sets of CCG board papers to find the other side of the coin. What you discover is that local commissioners were sitting on a cumulative £72m of surpluses at year end (it may be slightly different to this in the final analysis as I could only find Month10 figures for two CCGs).

But that is not the end of it. Searching for the NHS London position I found:

https://www.england.nhs.uk/wp-content/uploads/2016/05/item7-26-05-16.pdf

for Paul Bauman's report to the Board of NHS England on 26th May 2016.

This is what it presents : (see over)

Summary of Year to Date and Forecast Expenditure by Area of Commissioning

Year ended 31 March 2016 Net Expenditure	Outturn Net Expenditure			
	Plan £m	Actual £m	Var £m	Var %
Local Net Expenditure				
North	22,208.0	22,200.9	7.1	0.0 %
Midlands & East	21,411.5	21,448.3	(36.8)	(0.2%)
London	11,393.7	11,367.2	26.5	0.2 %
South	17,521.7	17,547.6	(25.9)	(0.1%)
Quality Premium [2]	13.1	0.0	13.1	0.0 %
Total Local Net Expenditure	**72,548.0**	**72,564.0**	**(16.0)**	**0.0 %**
Direct Commissioning				
Specialised Commissioning excluding Cancer Drugs Fund	14,308.2	14,294.4	13.8	0.1 %
Cancer Drugs Fund	340.0	465.7	(125.7)	(37.0%)
Armed Forces	54.1	54.1	0.0	0.0 %
Health & Justice	492.0	483.0	9.0	1.8 %
Primary Care & Secondary Dental	10,395.0	10,232.3	162.7	1.6 %
Public Health	1,216.9	1,194.3	22.6	1.9 %
Total Direct Commissioning Expenditure	**26,806.2**	**26,723.8**	**82.4**	**0.3 %**
Other (excluding Technical)				
NHS England Running Costs	485.9	485.2	0.7	0.1 %
CSUs	0.0	5.0	(5.0)	100.0 %
NHS England Central Programme Costs	1,047.5	806.1	241.4	23.0 %
Other Central Costs	233.0	13.8	219.2	94.1 %
Total Other (excluding Technical)	**1,766.4**	**1,310.1**	**456.3**	**25.8 %**
Total before Technical Adjustments	**101,120.6**	**100,597.9**	**522.7**	**0.5 %**
Remove AME/Technical items	(72.2)	(226.2)	154.0	
Total RDEL under/(over) spend	**101,048.4**	**100,371.7**	**676.7**	**0.7%**
Remove ringfenced under/(over) spend	(166.0)	(88.7)	(77.3)	
Total non-ringfenced RDEL under/(over) spend	**100,882.4**	**100,283.0**	**599.4**	**0.6%**

[2] Quality Premium is added to the planned expenditure (and income) of CCGs in the lines above w hen earned. This line show s the element of annual Quality

It turns out London overall was in surplus by £ 26.5m and the NHS as a whole in surplus to the tune of £600m (or thereabouts).

This may be of some relief to Simon Stevens and nervous senior executives but I don't think it washes very well with many in NHS Trusts forced through the tumult of hitting ever higher QIPP targets and clamours for plans demonstrating how the NHS is to be transformed by October.

What's going on?

3. STPs – the new game in town

Local authorities pricked up their ears when they heard about the plans of Simon Stevens to give delegated authority to hand-picked representative executive boards supporting the Leads of the Sustainability and Transformation Planning (STP) processes. His intention seems to be to oversee the implementation of transformation plans in October without any requirement for the usual processes of consultation with stakeholders, overview and scrutiny and express consent from local authorities; nor even the presentation of a compelling business case ahead of implementation.

We became aware of the significance of this following the publicity given by the HSJ (25 May 2016) when an interview with Simon Stevens revealed to the professional press his intentions and an editorial appeared in the HSJ endorsing this. Apparently the idea is to abolish the "veto powers" of local organisations, boards and local authorities and to empower executives given "safe haven" status to put the foot down on implementing transformation.

Here an interest has to be declared as for the past ten years we have been advising local authorities on the plans presented by the NHS for ambitious reconfiguration based on implementing new models of care and rationalising acute care. We haven't been impressed: business plans have been non-existent or lacking, costs hopelessly underestimated, the new care models still unproven after all these years and wildly optimistic projections made about the reductions to admissions and demand that could be achieved, enabling rationalisation in acute care without unacceptable risks.

It has been a convenient excuse for managers to bemoan the cumbersome processes for presenting plans, achieving consent and applying for very large sums of capital requiring Treasury approval. The truth is often that a rational case cannot be achieved.

Giving "carte blanche" to managers in these circumstances is an accident waiting to happen. In normal circumstances the very idea would have been shot down before it left the seminar room – which is where NHS Deficits come in.

4. The Meaning of NHS Deficits

The rhetoric of reconfiguration is well known by now and rehearsed in many a case for change document around the country. It goes like this.

The NHS is about to be submerged in a tsunami of debt. The NHS is unaffordable in its present guise. Everyone agrees, especially doctors, that the solution is to cut the numbers of doctors, nurses and accident and emergency departments to bring about a rationalisation of acute care made possible through the introduction of new care models and preventative medicine. The only obstacles to modernising the NHS are bureaucratic delay and luddites defending vested interests. You know the story…

It sounds convincing until you examine the details.

The NHS is not in debt. It is under control despite the lowest level of funding increases and highest increases in demographic pressures since its inception.

In fact I had summarised performance in the previous three years as follows:

Table DH Performance 2010-2015

Revenue Departmental Expenditure Limit						
		2010-11	2011-12	2012-13	2013-14	2014-15
		£m	£m	£m	£m	£m
Budget		98,567	101,092	104,097	106,801	110,556
Outturn		97,469	100,266	102,570	106,495	110,554
Underspend (£m)		1098	826	1527	305	1
Underspend (%)		1.114%	0.817%	1.467%	0.286%	0.001%

The unaudited figures for 2015/16 will show the NHS as £600m underspent; although it may be even greater when the audited figures are revealed (I suspect there may be some more cash lying around in unspent capital and departmental budgets).

The NHS is under pressure but it is under control; too much control.

It suits many however to overdramatise and provide a context for eradicating checks and balances, democracy and the tedious requirement to win informed consent to plans in advance of implementation. The rest of the standard case for change is equally shaky but chapter and verse can wait for another day.

5. Recommendations

- The NHS should stop presenting a partial picture on NHS Deficits. The reality is that deficits in some organisations are exceeded by underspends/surpluses in others.

- Boards and chief executives should not provide delegated authority to the STP executives about to be appointed.

- All stakeholders including staff, patients and community representatives need to find out what is going on in their locality on STPs and make their opinions felt.

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