The Reporting of NHS Finances

1. Introduction

This short paper sets out to provide a context for the reporting of NHS finances that will help people understand the figures presented to them and the issues underlying them.

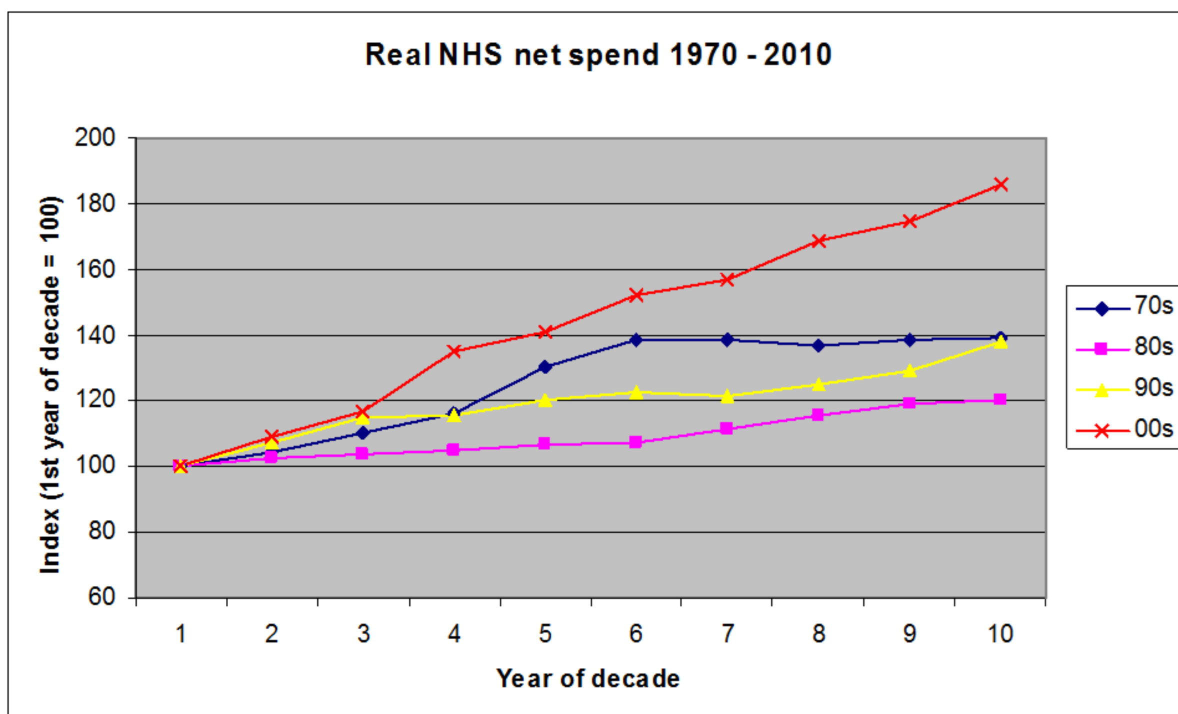
2. What is the NHS?

The NHS is no longer a unitary body. It consists s of strategic bodies (, the Department of Health itself , NHS England and 14 other Arm's Length agencies including Monitor, The Trust Development agency , NHS Litigation Authority etc), local commissioning bodies (CCGs), NHS trusts reporting to the Trust Development Authority, and Foundation Trusts reporting to Monitor. In addition the boundaries of the organisation are affected by moves both to sub-contract services to the private sector and to work in partnership with local authorities in the provision of social care (integrated care).

The implications of this are that the health of the overall body cannot be gauged from taking the temperature of one part of it. A more holistic view is required. This means that in interpreting the reported deficits of NHS trusts the financial picture of the other parts of the NHS system and its close partners must also be considered.

3. What is the Financial Context?

Historically NHS expenditure has grown steadily with funding increasing year on year by up to 4%. Since 1976 however a cash limits system has applied whereby the NHS has been allocated a cash budget and has been statutorily obliged in law to live within these constraints, subject to minor flexibility. There have been periods of strict government control at times of financial national economic distress (late seventies, early eighties, mid-nineties, post 2010) when real time increases to funding have been much reduced.



Nb Growth in 2010-2015 has been 0%,0.6%,0.5%,2.7% and 1.1% respectively or 5% cumulatively (Source DH annual report p40.)

Thus although there has been a general upward drift in funding over the years there have also been significant periods where growth has been constrained.

What is the current position? The following is an extract from Annex B of the Department of Health Annual Report and Accounts 2014/15.

Table 1 Department of Health financial outturn, 2014/15

	original plan	revised plan	Outturn	under(overspend)
	£'000	£'000	£'000	£'000
Resource DEL	109,650,145	110,555,553	110,554,300	1,253
Capital DEL	4,653,667	4,013,667	3,950,694	62,973
Resource AME	6,006,000	6,606,000	3,418,733	3,187,267
Capital AME	10,000	15,000	4,938	10,062
TOTAL	120,319,812	121,190,220	117,928,665	3,261,555
increase in planned expenditure		870,408		

Annex B, Core Table 2, DH Annual Report and Accounts 2014/15 (DH, 2015)

NB the most significant area of underspending was against the Resources AME (annual managed expenditure) target. This is defined as an “A technical control for items that HM Treasury have deemed to be demand-led or exceptionally volatile or that have no real impact on the fiscal framework, requiring no taxes be raised to cover”. It covers litigation costs, NHS provider impairments and the costs of legacy departmental guarantees. I would expect this back door method of avoiding normal expenditure controls to be much used in future years if litigation increases as quality reduces, assets are disposed of at lesser values than recorded on the public balance sheet and guarantees for unsuccessful private finance deals are invoked.

This shows that against all the aggregate spending targets used in controlling NHS spending the NHS was underspent in 2014/15 despite providers having a deficit of £790m. Commissioners had a total surplus of £456m and the DH admin budget a surplus of £556m See pages 46-54 of the annual report for a full discussion.

Throughout the last few years there have been reports of the NHS in trouble with huge deficits predicted but as can be seen at the end of the financial year the NHS has been underspent.

The following table extracted from the DH annual report 2014/15 further illustrates the point.

Table 2 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%

Is this likely to be different in the current financial year?

4. NHS providers are in deficit

So how are we to interpret news that NHS providers continue to be in deficit in the early months of 2015/16?

Headlines designed to shock have appeared in newspapers and journals saying that NHS providers are £930m in deficit. For example, the Guardian (9 October 2015) *NHS facing £2bn Deficit and 'worst financial crisis in a generation'*; BBC News (9 October 2015) *NHS Deficits hit 'massive' £930m*. But if we examine the detail of what is being reported we find that the whole situation is not as bad as is claimed.

NHS Trusts and other providers had **planned** to be in deficit by almost £800m at this point after the first three months of the financial year. The deficit is greater than planned but not drastically so. The most recent published information showed this for the FTs and non-FT providers respectively:

Table 3: NHS provider performance, Q1, 2015-16

		Budget	Actual	Variance	Planned Variance	Variance from plan
		£m	£m	£m	£m	£m
FT's		11246	11247(!)	-450	-363	-87
Non-FT		not available		-485	-412	-73
			Total	-935	-775	-160

Sources
1.Monitor Performance of The Foundation Trust sector for the three month period ending 30th June 2015
2. NTDA http://www.ntda.nhs.uk/blog/2015/10/09/nhs-trusts-financial-position-for-q1-of-201516/

This shows that although the reported deficit is £935m the planned deficit was £775m meaning that the deterioration according to plan was only £160m. This is small relative to an overall Departmental budget of some £110bn.

What has not been considered in these reports is the position of commissioners and centrally held reserves and budgets. As Table 2 earlier illustrates, for all the talk of financial crises in the NHS in recent years, actual financial performance overall is characterised by underspends and good overall control. Capital and central budget surpluses covered provider deficits in 2014/15.

In addition the Government promised £8b would be provided to the NHS over the term of the new government ie up to 2020. There is some debate as to what this means and whether the £22bn of efficiency savings promised by the new Chief Executive of the NHS can be delivered or are pre-conditions for the extra money but at time of writing it is understood that negotiations are still taking place on the timing and the extent of extra funding with announcements due only in November 2015 alongside the results of the Comprehensive Spending Review (CSR). Any significant extra funding would erode the reported deficits and it is understood that the £8bn is being pushed up to £12bn in negotiations.

In 2014/15 extra monies were allocated mid year to the NHS (see Table 1 and the net revisions to plan of £870m). Perhaps this was to win an election and George Osborne would not want it to be seen as a habit. Nonetheless it shows that there can be flexibility in managing the total NHS budget.

The Department of Health Annual Report and Accounts for 2014/15 shows that income has risen by 1% less in real terms than costs (expenditure) in the last two financial years, so it is no surprise that deficits are emerging.

Table 4 NHS Provider Income and expenditure growth

	2012-13	2013-14	2014-15
	%	%	%
Nominal Growth-Income (%)	3.8	3.2	3.0
Nominal Growth-Expenditure (%)	3.7	4.2	4.0
Real Terms Growth-Income (%)	2.2	1.2	1.3
Real Terms Growth-Expenditure(%)	2.0	2.1	2.3

There could be several reasons for deficits but spending too much is only one. Not providing enough income to providers is more likely to be the case.

5. Better management of NHS finances

While this paper suggests that the deficit problem in the NHS suffers from much exaggeration, there are a number of ways in which NHS finances might be managed better. These include:

1. Look at gross expenditure not just net expenditure. The NHS spends about £9bn more than is declared as this amount is met by income drawn from various sources (education and training, private patient charges, patient fees , charges to local authorities and land sales). For example it is surprising that the NHS only derives £500m income from allowing its staff and premises to support private practice.

2. Reconsider the speed and implications of transferring NHS services to private and charitable providers. Over £10bn is now spent and this increased by over £900m in 2014/15. This inevitably draws on resources that could have been directed to NHS providers (see p47 of 2014/15 Annual report).

3. Review central and commissioner reserves and funds earmarked for initiatives. Commissioners top-slice 2.5% of funds to use for speculative and unproven 'transformation' projects; large funds are also set aside by NHS England and the DH. These initiatives have all too often been very poor value for money and squandered on high fees for management consultants (£605m see p204 DH annual report 2014/15).

4. Reappraise the fiscal impact of increasing health expenditure compared to other avenues of public expenditure. Independent appraisals[i] have shown that spending on healthcare has a high multiplier effect benefiting the wider economy. Spending more on healthcare is not a waste of money but has economic and social benefits as well as health benefits.

5. Better diagnosis of financial problems alongside improved intervention. It is well known that expensive PFI projects have been at the heart of financial problems in e.g. South London, East London and Peterborough. Palmer [ii]has shown that simple adjustments to funding mechanisms to address the excess costs of some PFI deals would solve much of these problems. It is inexcusable that health economies have been left out to dry, suffering from the pressures of intractable deficits but without the action taken to resolve those deficits.

6. Respond more quickly to problems as they emerge. The adverse effect of a move to less strategic management and more localism is that the response once local difficulties emerge can be delayed and ineffective. There have not been appropriate national responses to shortages in key staff either by increasing training budgets and training places or by planning for the appropriate numbers of skilled staff. The difficulties in A&E and the belated response is a case in point.

7. Properly consider the impact of withdrawal of state funding from social care. The massive reductions to local authority social care budgets [iii] have had the effect of increasing pressures on health services just as the ambition has been to transfer more services to local authorities. In effect a double whammy. The UK spends less on health and social care in aggregate than most other developed countries[iv]; it makes little sense to pretend that integration alone will solve this issue.

6. Conclusions and recommendations

Caution should be used in approaching reports of NHS deficits. The overall context is one of good overall financial control and persistent underspends not deficits.

Alarmist reports may be spin applied by forces looking to lobby for extra resources in advance of the forthcoming Spending Review; or, forces looking to tar the reputation of the NHS so as to increase the pace of privatisation, 'transformation' initiatives and the downsizing of the acute hospital sector in favour of community-based services led by GPs or by independent providers.

Nonetheless there remain issues that must be addressed but this should be in a calm and rational manner and not in panicked response to what in retrospect are well sign-posted problems. The biggest problem seems to be that emerging problems are being inadequately strategically managed in the new style NHS in which ministers are detached and hide behind regulators.

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18.10.2015

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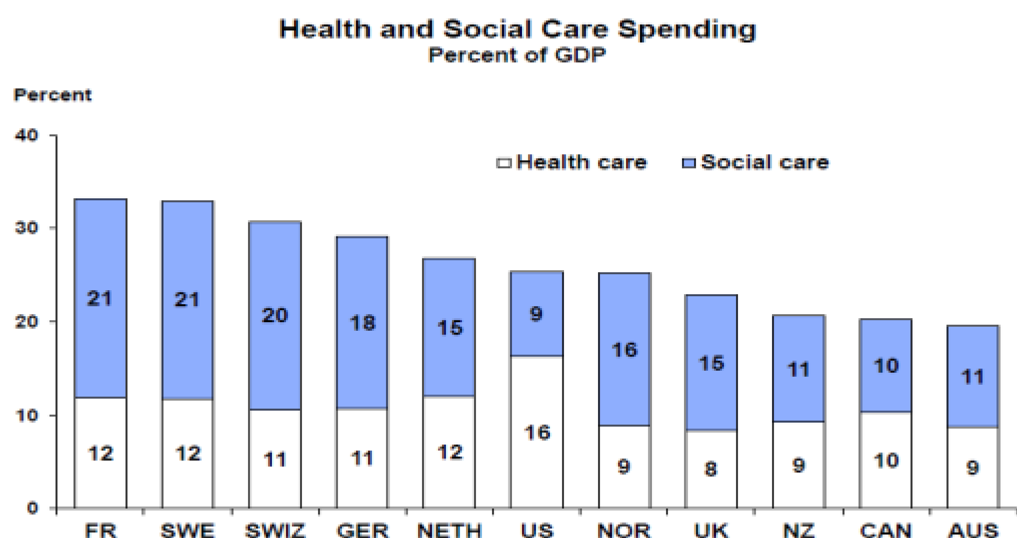
[i] Reeves et al. Globalization and Health 2013, http://www.globalizationandhealth.com/content/9/1/43

[ii] Reconfiguring Hospital services: Lessons from South East London by Keith Palmer Kings Fund 2011

[iii] "There have been 5 years of funding reductions totalling £4.6 billion and representing 31% of real terms net budgets" –ADASS 2015 https://www.adass.org.uk/uploadedFiles/adass_content/policy_networks/resources/Key_documents/Key%20Messages%20FINAL.pdf



[iv] Source: E. H. Bradley, L. A. Taylor, and H. V. Fineberg, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.