CHPI Centre for Health and the Public Interest

The 2016/17 Sustainability and Transformation Fund

Why it is not enough and what are its implications for the provider sector?

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About the author

This report was produced by the CHPI research team.

The Centre for Health and the Public Interest (CHPI) is an independent think tank committed to health and social care policies based on accountability and the public interest. The Centre seeks to frame the policy debate in a way that is evidence-based and open and accessible to citizens.

Introduction

In the time since this analysis paper was prepared Britain has voted to leave the European Union. The referendum result creates enormous uncertainties for the future of the NHS, not least because it will likely mean that existing assumptions about the future financial settlement of the NHS will need to be revised. However, while the context has changed, the challenges facing the NHS have not abated. The circumstances of political and economic uncertainty make rigorous analysis of the financial plans for the future of the NHS even more important.

1. In April this year the CHPI called attention to the five-year Sustainability and Transformation Plan (STP) programme with which all parts of the NHS in England are currently being required to comply.[1] It is now clear that barring a political upheaval this centrally-driven process, aimed at implementing the changes outlined in Simon Stevens' *Five Year Forward View*, is going to be the decisive force shaping the NHS for years to come. At the heart of it is an attempt to close the shortfall in NHS funding entailed by the government's austerity programme. This makes it very important that the financial elements in the programme are well understood.

2. Central to the programme is the hospital sector, which accounts for around 78% (approximately £86bn) of the £115bn NHS budget (in 2014/15).[2] In the past year the provider sector as a whole ran up a deficit officially totalling £2.45bn – or more like £3.2bn if non-recurrent savings are disregarded – amounting to some 3.2% of operating income and this shows every sign of getting bigger.[3] The STP programme is above all about closing this escalating black hole.

3. The prime cause of the deficit is escalating demand coupled with a severe shortage of adult social care funding. This has led to delays in moving medically fit but frail elderly patients from hospital beds onwards to social care creating bed shortages for new hospital patients being admitted. In 2015-16 A&E departments had a record-breaking 20.7 million attendances. They struggled to meet this demand, with March 2016 becoming the worst month on record against the 4-hour maximum waiting time standard, and the number of patients left waiting on trolleys for a bed for over 4 hours jumped by over a quarter to 387,809. The median waiting time for planned operations also increased by over a week to 6.4 weeks, and almost a thousand patients were left waiting for over a year. The vital cancer standard of having to wait no more than 62 days for treatment was failed in every quarter of the year. In face of this unprecedented surge in demand many hospitals felt obliged to overspend in order to try safety standards. For example an extra £1.4 billion above plan was spent on agency staff.[3]

4. To halt this surging overspend £2.1bn has been made available from a Sustainability and Transformation Fund (STF) which is intended to eliminate the provider sector's deficit in 2016/17.[4] This is a challenging goal and the Chief Executive

of NHS Improvement, the hospital regulator, has already concluded that it will not be achieved.[5]

5. Yet if this extra £2.1bn of STF funding does not bring hospitals to break-even by the end of 2016/17 (March 2017) the consequences will be serious. Firstly it will threaten the independence of hospitals and the wider NHS by justifying an increasingly tight control by the Treasury. Secondly there will be collateral damage to patient care, with much-needed capital expenditure delayed (e.g. equipment not upgraded), and further pressure to reduce costs on non-emergency operations, with increased waits likely.

6. This analysis will focus on two key questions:

1. **Why is the STF not sufficient to eliminate the providers' deficit in 2016/17?**
2. **What are the implications for providers who accept the funding, and for the NHS in general?**

7. To answer these questions a brief overview of the Sustainability and Transformation Fund (STF) is required.

The Sustainability and Transformation Fund

8. In the November 2015 Spending Review the Chancellor announced a £10bn real terms increase in NHS funding over the course of the parliament to support the NHS Five Year Forward view, published in 2014.[6] Of this increase £3.8bn will be available ('front-loaded') in 2016/17, including £2.1bn earmarked for a Sustainability and Transformation fund (STF).[4] In 2016/17 the focus of the STF is primarily on sustainability, by helping acute and specialist providers to eliminate their deficits and bring the sector to break-even by the end of the year. It also aims to provide funds to help transform services to achieve the NHS Five Year Forward View.

9. The bulk of the funding is only available for providers of emergency care, i.e. the acute and specialist sectors. The acute sector requires the most funding; over 85% of providers were in deficit by Q4 of 2015/16 and contributing to over 90% of the overall provider deficit.[3]

10. The funding is divided into three parts:

- £1.6bn – a general fund to be distributed to all providers of emergency care, based on allocations by NHS Improvement; and two targeted funds:
- £0.2bn – available for all providers who can deliver additional efficiencies and improvements.
- £0.3bn – available for funding transformations in the way services are delivered.

11. Access to the £1.6bn is conditional on providers meeting a series of strict conditions. These include agreeing a recovery plan, meeting their assigned financial target for 2016/17 (which can be a surplus or a deficit, called their 'control total'); having plans to implement the productivity savings prescribed in Lord Carter's review; reducing their spend on agency staff; achieving core operational standards; and setting out a credible plan to provide 7-day services by 2020. The £0.2bn targeted element of the STF for delivering extra efficiencies is only available for providers who accept their control total and the conditions of the STF. If all the conditions for accessing the funding are not met then the provider will receive no STF funding and the amount will be transferred to the two targeted elements of the fund.[7]

Why is the size of the STF not sufficient to eliminate the providers' deficit in 2016/17?

The 2015/16 deficit – worse than planned for

12. The STF was premised on the assumption that the combined provider deficit in 2015/16 would be no greater than £1.8bn.[7] By the end of 2015/16, however, the provider sector had generated a net deficit of £2.45bn, £461m worse than assumed in the plan, even after an additional £724m of non-recurrent 'financial improvement' measures were implemented after January 2016.[3] Without these improvement measures the deficit would have been closer to £3.2bn.

13. The main drivers of this deterioration in financial performance are the failure to deliver planned cost improvement schemes, the on-going high-level use of agency staff, delayed transfers of care, and pension contribution changes. These drivers are unlikely to abate in 2016/17 posing problems for the goal of the sector breaking even with the STF. We consider each of these in turn.

Cost improvement programmes (CIPs) – unlikely scale of efficiencies required

14. Given that the provider sector finished 2015/16 with a deficit of £2.45bn, after the £1.8bn of STF funding (£1.6bn plus the £0.2bn available for providers who find additional efficiencies) there would still be a shortfall of £650m to break even. To close this gap would require providers to achieve a 1% reduction in their expenditure

costs (i.e. additional efficiency saving) on top of the 2% annual efficiency improvements already assumed in the 2016/17 tariff. Over 65% of operating expenses comes from pay costs which provide little scope for reduction. This means that cost cutting will need to be focused on the remaining 35% of non-pay costs which include clinical supplies, drugs, buildings, and administration.[3]

15. In 2014/15 NHS foundation trusts managed cost improvements of 2.7% against a planned target of 4.0%, and by Q2 2015/16 the actual efficiency savings were 2.5% against a planned target of 3.5%.[8] Moreover only 78% of these efficiency savings were recurrent, against a planned target of 92%. If this trend continues then whilst providers may be able to achieve the 2% cost improvements assumed by the 2016/17 tariff, the likelihood of them sustainably achieving the necessary additional efficiencies to close the £650m overspend from the previous year is low.

Agency costs – making NHS working conditions more attractive

16. In the 11 years to September 2015 the proportion of the pay bill spent by foundation trusts on agency staff for has grown from 3.5% to 7.2%.[9] For 2015/16 the agency staff spend was £3.6bn, more than a billion over plan.[3] This overspend is a significant contributor to the providers' deficit.

17. To address this, in September 2015 Monitor and the Trust Development Authority implemented limits on the total spend allowed on agency staff, and then in November price caps on agency staff pay. The aim was to empower providers to reduce their agency costs and "remove £1bn from agency spending bills over three years".[10]

18. However the price caps do not appear to be working as planned, with, for example, an average of 30,000 shifts reported as exceeding the price cap from the weeks commencing 23 November to 28 December 2015.[11] Why are they not as effective as hoped?

19. Recent analysis conducted for the Health Service Journal (HSJ) suggests that the agency problem is driven by an excess of demand for staff over supply at current NHS pay rates and working conditions.[9] Capping the pay offered to agency staff does not solve the problem of staff shortages, especially as there is evidence that poor working conditions are driving NHS staff to move to agency work.

20. Over 55% of trusts surveyed had used agencies outside the agreed NHS frameworks in the three months before November 2014. For 63% of these trusts national shortages were one of the top two drivers of their need for agency staff;

40% cited safe staffing requirements, and 21% cited staff sickness. Each of these three issues is considered below.

21. Most of the shifts where the price cap was broken were nursing shifts. The Royal College of Nursing in their Labour Market Review 2015 cite the main issues driving nurses to choose agency employment.[12] For qualified nursing staff working in the NHS median annual earnings since 2011 have been reduced by between 6.3 – 10.5% in real terms. Many nurses are choosing agencies to increase their earnings and also to gain flexible working hours, a reason cited by 14% of nurses who left the NHS from October – December 2014.

22. Safe staffing requirements that were adopted following the Francis Report on the Mid Staffordshire hospital scandal have also increased the likelihood that staffing gaps will be filled whereas before gaps may have been left unfilled.[9]

23. Finally, NHS staff sickness absence is 27% higher than in any other public sector organisation, with higher sickness rates at lower bands (predominantly nurses). For Band 5 (a common band for registered nurses) the rate was 4.7%.[13] In the NHS Staff Survey 2014 39% of staff reported being unwell from work related stress.

24. It is clear that there will need to be improvements in pay and the flexibility of working conditions to attract more workers away from agency employment. Trusts are beginning to recognise these issues but there is an obvious contradiction between finding the funds to make these changes whilst achieving the necessary efficiency savings to meet ambitious control totals in 2016/17.

Delayed transfers of care – the impact of social care budget freezes

25. It was estimated that delayed discharges from hospital cost providers £145m in 2015/16.[3] Often these delays were due to a lack of adequate adult social care provision for patients who were ready for discharge (i.e. to leave the hospital).

26. Despite the announcement in the spending review that councils can raise council tax by 2% to offset cuts to social care, research by the Kings Fund shows that real terms spending on social care is expected to fall over the next three years.[14]

27. Even if all councils used this new power (an unlikely scenario) the £329m raised would not close the £700m estimated funding gap for adult social care. Furthermore the poorest areas with the lowest council tax base also tend to have the greatest social care needs. This puts these areas at a double disadvantage and makes it likely that delayed discharges will be a persisting problem there.

28. Even with increased funding from the Better Care Fund, established in 2013 to support integration between NHS and local authority care, and assuming that all councils raise the additional tax, the proportion of GDP spent on social care will still fall from its 2009 level of 1.2% to 0.9% by 2020.

29. Against this backdrop the tension between universal NHS care, free at the point of use, and means-tested social care budgets, will worsen, potentially leading to more, rather than fewer, delayed transfers of care. This will add to provider deficits throughout 2016/17 and beyond.

Pension funding changes – inescapable cost increases

30. In the 2016 budget a new state pension was announced, and NHS employers will lose access to a 3.4% rebate on their national insurance contributions. This additional cost (estimated at £800m a year) has been reflected in the new tariff with a 1.8% cost uplift.

31. However the discount rate for the public service pension scheme[1]will be reduced in 2019/20 from 3% above CPI inflation to 2.8%. This will require extra contributions from NHS employers, estimated, by the NHS Confederation, to be a further £600m a year.[15]

32. It is very unlikely that providers will be able to cut their pay bill to compensate for these additional expenses. If this increased cost is not matched by a funding increase then it will become a real funding cut at a time when providers will be faced with planned real income growth of only 0.2% in 2018/19, and even less in the following year.

What are the implications for providers who accept the funding and the NHS in general?

The discount rate is a pension plan's expected risk-free return in the future. When the discount rate falls a pension plan needs to purchase more assets today in order to ensure that it can generate sufficient investment returns to pay the expected pension benefits promised in future

Increased control from HM Treasury

33. The nature and conditions attached to this funding are different and may reflect a change in the general approach for future increases in NHS funding. Unusually the extra £1.8bn of sustainability funding has not been transmitted to providers by means of an increase in the tariff. Instead the Financial Directions to NHS England emphasise that the £1.8bn for sustainability is part of a separate pot from NHS money and "allocations…must be agreed in advance with HM Treasury and DH".[16] This also applies to the £10bn real terms increase announced in the Spending Review.

Reduced independence for Foundation Trusts

34. Foundation Trusts (FT) have been asked to agree to capital expenditure and revenue controls as part of the STF conditions. The freedom to spend and invest as they see fit was one of the key privileges of FT status. Their independence was meant to help drive greater efficiencies in the provider sector. The erosion of these freedoms indicates central government's lack of faith in the FT model.

Increased pressure on providers has led to governance concerns

35. Already providers have been under increased pressure from regulators to "manipulate figures" and reduce headcount in order to bring their 2015/16 deficit closer to the £1.8bn target. In January the Finance Director of one FT expressed some serious concerns about this to the Commons Public Accounts Committee.[17] This is a worrying development as it may lead to boards and finance directors feeling compelled to sign off on inaccurate or misleading accounts and mask the true extent of the NHS' current predicament.

Reduced independence for Commission-ers too

36. However it is not just providers who are facing tighter control of their spending. New guidance for commissioners states that they must not commit to spending the 1% of their budget which under national rules has to be reserved for non-recurrent one-off spending. Instead any requests to spend this reserve will now require approval from HM Treasury. [18] Furthermore, commissioners may not fine providers

that are in receipt of STF funding for failure to meet key performance targets. This is to avoid a 'double jeopardy' situation where providers facing both a withdrawal of STF funding and commissioner penalties. Local sanctions can only be applied following agreement from both the commissioner and provider with no local sanctions being the default position.[7]

37. This is already having an impact on commissioner finances, since the increase in the tariff, while less than the full increase in providers' costs, is still an increase, so that commissioners are faced with paying more out whilst still holding back 1% of their budget to offset overspending by providers. Deadlines for operational plans for 2016/17 had to be pushed back by a week in April 2016 because few providers and commissioners were able to sign and agree a contract under such tight funding controls on both sides.[19]

Conclusion

A tough year even with the extra funding

38. 2016/17 will be a tough year for providers given the increased costs they can expect to incur due to long term problems such as delayed transfers of care and agency staff. The STF will help alleviate some of the financial distress but it seems unlikely that even coupled with provider efficiencies the funding will be sufficient to eliminate the deficit in 2016/17.

The beginning of the end for the market reforms?

39. Aside from the increased control over spending from HM Treasury the planning guidance for 2016/17 represents a shift away from the current model of NHS organisation. Remarkably enough NHS England itself now states "For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve".[20]

40. As noted in a previous CHPI analysis ('Can Simon Stevens' Sustainability and Transformation Plans Save the NHS?), for 2016/17 and beyond the focus has shifted back to achieving savings and improved delivery systems by means of plans produced by local health systems, grouped in 44 'footprints' across England, under tight central direction and control.[1] The 1% non-recurrent funding which Commissioners cannot commit to spending (approximately £800m) may now be used to "provide financial stability within each transformation footprint".[18]

41. This is a radical departure from the vision of the Health and Social Care Act 2012 according to which autonomous commissioners and providers would compete amongst themselves and in the process deliver efficiencies. It is clear that the costs and burdens of these market reforms, detailed in a prescient CHPI 2014 report by Calum Paton, are now beginning to be fully felt.[21]

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