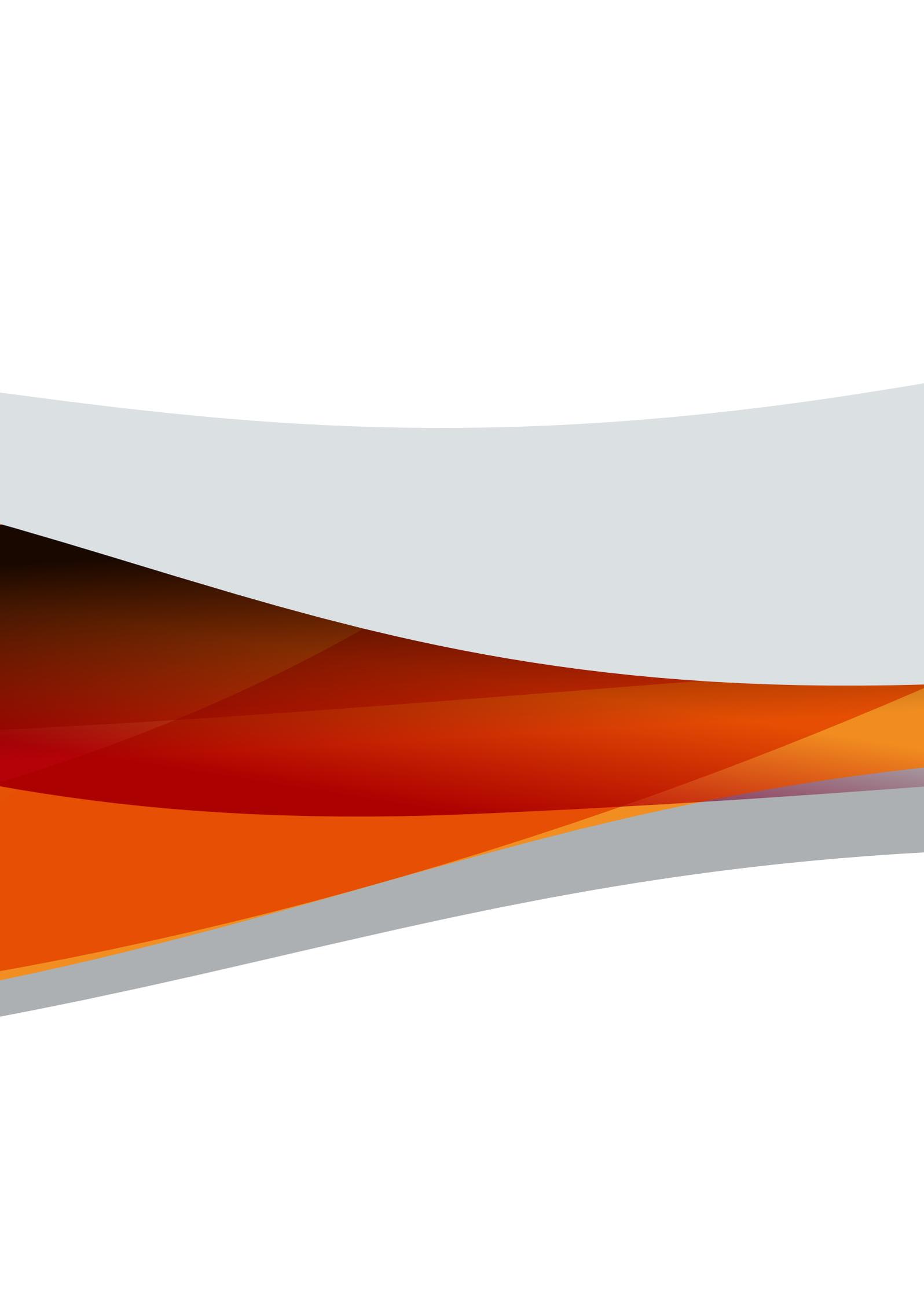


RECOVERING PROVIDER DEFICITS

**Has it worked
and at what cost?**



KEY POINTS

- In response to the rapid deterioration in provider finances in 2015/16, a new financial framework was introduced in an attempt to recover deficits and re-establish financial discipline within the sector. Each provider, irrespective of their financial position, was asked to sign up to a control total – a financial target – setting a minimum surplus or maximum deficit they had to meet. In exchange for meeting financial control totals and performance targets, providers would receive their share of a new £1.8bn in sustainability and transformation funding (STF).
- There is widespread acceptance that a temporary mechanism was required following 2015/16, and that the regime has been broadly effective at reducing the aggregate provider sector deficit. However, the level of savings required has led many providers to rely on unsustainable and non-recurrent approaches to meeting control totals. Therefore, the financial framework is in danger of masking the underlying financial deficit and challenges facing the sector, and it is important that we continue to be transparent about the impact of these measures on longer-term sustainability.
- There are clear benefits of a direct allocation being made to providers, and we have seen an almost pound for pound benefit from the £1.8bn investment. This would not have been guaranteed if the funding had been routed through more mainstream mechanisms, such as clinical commissioning group allocations or the national tariff.
- The £1.8bn STF has now become an integral part of provider finances, and provider deficits would balloon once again if the funding was removed in 2019/20. Although it may be appealing to the national level to maintain a high degree of control over individual providers, the current framework is incompatible with the principles of delegation and autonomy which should sit at the heart of the NHS. Providers now need an opportunity to earn back their autonomy based on the improvements they have made, while ensuring a crucial element of provider funding continues to flow to the sector.

INTRODUCTION

Over the past two years, we have seen a fundamental shift in how provider finances have been managed at the national level.

In 2015/16, the provider sector ended with a record £2.45bn deficit and 157 providers (65% of the sector) were in deficit. A measure of financial health – EBITDA¹, which is effectively income minus current operating costs – was 1.6%², well below the 5% Monitor* used as a guide to test whether an NHS trust was financially strong enough to be licensed as a foundation trust. In effect, the financial survival of the NHS provider sector was in question and provider deficits were in free fall.

In response to this rapid deterioration in provider finances, at both the aggregate and institutional level, a new financial framework was introduced in an attempt to reduce provider deficits and support a return to greater financial discipline over the sector. Each provider, irrespective of their financial position, was asked to sign up to a control total – a financial target – setting a minimum surplus or maximum deficit they had to meet.

This was an approach many NHS trusts, overseen by the Trust Development Authority, would have been used to but was new territory for many well performing foundation trusts, which had traditionally been free to set a surplus, breakeven or deficit position. Although provider finances had already started to come under greater scrutiny in previous years, the universality of the approach was a new development.

In exchange for meeting financial control totals and performance improvements, providers would each receive their share of a new £1.8bn in sustainability and transformation funding (STF) (see *Key features of the current financial framework – control totals and STF* on pages 6-7). Making this sustainability funding contingent on hitting financial and performance targets was seen by the Treasury, the Department of Health and the national bodies as means of ensuring the investment they were making in the provider sector in 2016/17 delivered genuine financial improvement.

This framework was introduced as a short-term, temporary approach to support the sector back to a sustainable financial footing.

On paper, it has had some notable successes. As a result of a substantial amount of hard work across the NHS, the provider sector deficit was reduced to £791m this year, a £1.7bn improvement since 2015/16.

However, the administration of the system has had many challenges and it has exercised provider boards up and down the country.

As we enter the second half of 2017/18, early work is now required to identify what a future financial framework looks like for 2019/20. It is clear that the current arrangements cannot continue in perpetuity, not least because the STF has not yet been confirmed in 2019/20,

* Monitor and the Trust Development Authority have come together as NHS Improvement

but also because the sector now needs the opportunity to earn back its autonomy based on the improvements they have made to date.

Even the chief executive of NHS Improvement has recognised that “none of us should think that this is sustainable for ever...I want to see more movement in this next phase back to earned autonomy to get local systems into a place where they have a better chance to build their own agendas...”³

In this briefing, we start to look at future options, setting out provider perspectives on how the STF and control totals have operated to date and considerations for how the regime should develop in future.

We build on trust feedback from:

- The results of a new survey, conducted in July 2017, which received responses from 109 trusts, 47% of the sector. This builds on earlier surveys we carried out in August 2016⁴ and February 2017.⁵
- An NHS Providers roundtable on control totals and STF in August 2017, with 25 members of the provider sector, NHS Improvement chief executive Jim Mackey and finance director Elizabeth O’Mahony.

Key features of the current financial framework – control totals and STF

Providers are not required to sign up to control totals but failure to do so forfeits access to a share of the £1.8bn and other financial incentives

Although the vast majority of providers have tended to sign up to a control total – 97% did last year, and 88% had by quarter 1 this year – there are very legitimate reasons why some boards are unable to. Trusts often cite the level of savings being asked of them as a key reason for not signing up – for example, those that had not yet signed up to a control total by March 2017 were asked to deliver a 6.4% average cost improvement plan (CIP), well above what the evidence suggest it is realistic to achieve. In our latest survey, one trust highlighted that the gap between their plan and the control total requirement was £100m. Although failure to sign up means a provider loses access to their share of £1.8bn, as well as other financial benefits such as a suspension of contractual fines, the scale of the ask required might still mean it makes more financial sense to opt out.

If a provider does not meet their financial control total and performance trajectory on a quarterly basis, they do not receive their full STF allocation

In the first year of operation (2016/17), 217 out of 228 trusts accepting a control total benefitted from the £1.8bn STF.⁶ Not all providers would have received their full amount, as performance is assessed on a quarterly basis but it does mean the majority of the sector received a share of the £1.8bn. Helpfully, an element of judgment is also made when deciding whether providers have met their financial and performance targets, rather than a strict pass/fail application.

The STF payment is a direct payment to providers from NHS Improvement

This has created a significant income stream for providers, separate to the national tariff and commissioner/provider contracts. Whereas direct allocations have traditionally been routed through commissioners (such as recent winter resilience funding), the explicit transaction between NHS Improvement and providers demonstrates the level of national oversight exercised over the process and payment.

The £1.8bn STF was used to support the national balance sheet

The STF was not allocated to the provider sector with the aim of increasing expenditure, but instead was targeted with the specific aim of improving the bottom line. This means that gross surplus positions had to be used to offset the gross deficit run up by other providers. According to analysis from the Nuffield Trust, this means that £715m of the £1.8bn allocated in 2016/17 “now sits as unspent surplus in provider bank accounts”⁷

While the funding cannot be spent on revenue in 2017/18 as it would run the risk of breaching current control totals, there are opportunities for trusts to use their surplus to support capital investment programmes.

All but £4m of the £1.8bn remained within the provider sector in 2016/17

£480m of the £1.8bn was unallocated from providers not signing up to a control total or from those missing financial and performance targets. This led to the introduction of a 'pound for pound' incentive payment for those who exceeded their control total and an additional year-end bonus to those that delivered or exceeded their control total. At the end of 2016/17, 177 providers were awarded £186m in incentive payments and £294m as a revenue bonus. This left a residual £4m of the STF fund, which was returned to the Department of Health.

The £1.8bn STF is non-recurrent and only in place until 2018/19

The original intention of the STF was that in 2016/17, it would be used to reduce provider deficits and then from 2017/18 an increasing share would be allocated towards 'transformation' funding rather than 'sustainability'. This has, for good reason, not materialised in light of the ongoing financial challenge facing the sector. Instead the national bodies have committed to a further £1.8bn in 2017/18 and 2018/19. The STF has now become such a core income stream for the provider sector, it is difficult to conceive how the sector could continue without it from 2019/20.

Providers of emergency care received a higher proportion of STF funding

The overall disposition of the £1.8bn in 2016/17 has been split between a £1.5bn general fund allocated on the basis of emergency care; a £0.1bn general fund allocated to non-acute providers; and a £0.2bn targeted fund. This means that providers with A&E services would be eligible for a much higher proportion of STF funding, relative to their turnover. This was to support the ongoing focus on improving emergency performance and a recognition that deficits have been concentrated in acute providers. However in practice all providers, irrespective of the services they provided, could benefit from the incentive and bonus scheme should they outperform on their control total. This meant that ambulance, community and mental health providers received a higher proportion of the £1.8bn than originally forecast.

WHAT HAVE CONTROL TOTALS AND STF ACHIEVED?

2

At a headline level, the financial framework introduced in 2016/17 has contributed to some notable results.

- A central tenant of public service budgeting and management is that the delivery structures of individual organisation stay within planned budgets. The NHS was in danger of overspending against the Department of Health's budget, and the Department only managed to avoid a budget breach in 2015/16 due to a technical adjustment. The setting of control totals provided a means of better ensuring that overspending was contained in the short term.
- The aggregate provider sector deficit was reduced from £2.5bn in 2015/16 to £791m in 2016/17, a £1.7bn improvement in one year which demonstrates an almost pound for pound benefit from the sustainability and transformation funding (STF). There is no doubt that this headline picture underplays the underlying financial deficit of the sector, which according to recent analysis is £3.7 bn,⁸ and overplays the underlying financial improvement since 2015/16. However, it would be wrong to underplay the achievement from providers in containing the runaway deficit position and run rate from 2015/16. In the face of all the pressures facing the provider sector in 2016/17, including constant demand increases, escalating cost pressures and workforce shortages, the return on investment from the original £1.8bn should not be underestimated. Despite this, at an underlying level, the sector still managed to improve on the deficit in 2015/16 by around £600m, and delivered £2.3bn worth of recurrent cost savings.⁹
- The framework attempted to incentivise all providers, irrespective of their financial position, to make a step change in efficiency. Whereas previous financial allocations, for example winter resilience funding, might have been perceived to have disproportionately rewarded either challenged or well performing providers, control totals required all providers to agree to additional financial stretch.
- All but £4m of the £1.8bn in STF was kept within the provider sector. This was supported by national-level reporting of exactly how much of the £1.8bn was spent and where, and the publication of the methodology undermining the bonus and incentive scheme. Although the mechanism for allocating unearned STF was far from perfect, keeping the funding within the sector is a significant achievement in improving transparency over how and where money was allocated.

PROVIDER VIEWS ON THE OPERATION OF CONTROL TOTALS AND STF?

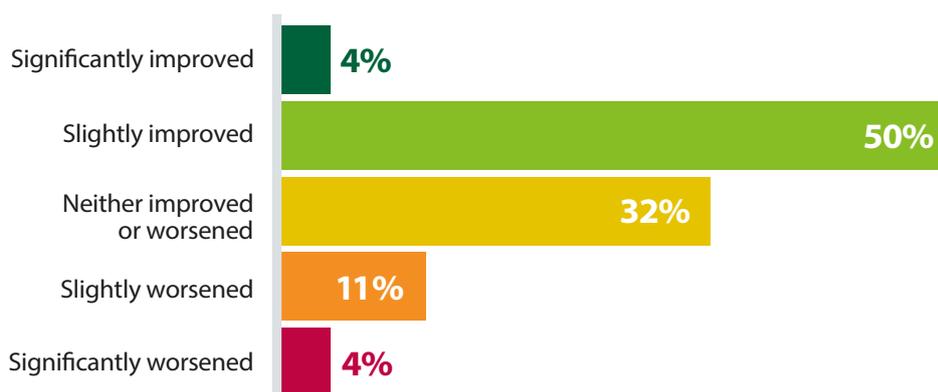
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There is acceptance that a temporary mechanism was required after 2015/16 and that the regime has been broadly effective at a national level

There is widespread acceptance across providers that some form of temporary mechanism was required to recover provider sector finances following the record deficit position in 2015/16. At a headline level, just over 50% of trusts considered that the introduction of control totals improved overall financial management within the provider sector (figure 1).

Figure 1
To what extent has the introduction of control totals improved overall financial management within the NHS provider sector?

(n=109)



There was regional variation in perspectives, with two thirds of providers (66%) in the north region considering that financial management had improved following the introduction of control totals, compared to around a third (35%) in London.

Several providers raised questions about the sustainability of the approach in future for both individual organisations and at the aggregate national level. The operation of the sustainability and transformation funding (STF) and control totals might have reduced the provider sector deficit on paper, but many suggest this does little to address the underlying financial challenges facing the sector.

- *It has had an impact but it's too early to say whether it's a sustainable reduction.* Chief Executive, mental health trust
- *It was short term non-recurrent way of reducing the deficit. I am not sure it helped the underlying position of providers.* Director of Finance, mental health trust
- *I think they [control totals] need to remain for the coming years to ensure rigid control during this period. The fund should be tapered down during that time to move toward more autonomy.* Finance Director, specialist trust

This suggests that although the framework was required in the short term, the time is fast approaching for a new way to better support the longer-term financial sustainability of the sector.

The direct allocation meant that the provider sector was able to benefit from the full £1.8bn, minimising leakage to other areas

The direct allocation from NHS Improvement to providers has been key to maximising the benefit of the STF to the provider sector. As long as the national tariff does not fully reimburse providers for the costs of delivering services, routing the £1.8bn through clinical commissioning groups (CCG) and contracts will be an imperfect way of ensuring investment reaches frontline services and improving provider sector finances.

The need for a direct allocation to providers highlights ongoing provider concerns with the mainstream financial mechanism for providers, most notably the national tariff:

- *It makes no sense to systematically underfund the tariff (prices set 12% below reference costs due to scaling factor) but then to issue some of this funding back as STF. It has encouraged short term financial fixes which will wash out in due course.*
Finance Director, acute trust
- *...it is just a sticky tape solution over the tariff inadequacies – whole system needs reform in line with improved incentives to get things right first time.*
Finance Director, acute trust
- *[It has been a] positive approach to directing money directly to providers thereby bypassing tariff/CCGs.* Chief Executive, acute trust
- *I do not support mainstreaming into tariff until the national financial challenge is clarified.* Finance Director, acute trust

Furthermore, routing the funding through the tariff would enable little or no leverage over providers' financial bottom line, in the same way control totals and STF have done. The way the STF is currently allocated provides a better guarantee that the underlying deficit can continue to come down.

Looking to the longer term, there is no doubt that routing the STF through the tariff would be the natural direction of travel. But, until the fundamental challenges with the tariff are addressed, in particular reimbursement for non-elective care, then there is a risk that the positive impact on provider deficits will simply dissipate if we move the STF away from direct allocations to providers. This is what providers widely reported when national resilience funding was mainstreamed in to CCG allocations.

The level of savings required in signing up to control totals sets unrealistic expectations about what the provider sector can deliver and forces a reliance on non-recurrent savings

The level of savings being asked of providers signing up to control totals is unsustainable. For example, providers signing up to a control total in 2017/18 would need to deliver a median cost improvement plan (CIP) of 4.2%, compared to 4% in 2016/17.¹⁰ This not only suggests that the scale of the challenge this year is higher than last year, it is also higher than providers are able to deliver on a recurrent basis. Research from Monitor and NHS England highlighted that it is reasonable to expect providers to become 1.4% more efficient each year, and that an efficiency requirement should be set between 1 - 2.5% annually.¹¹

This puts a requirement on NHS trusts and foundation trusts to deliver a rate of savings that no other advanced Western health system has ever consistently delivered. This has required providers to review all options in an attempt to meet their control total. Trusts have had to rely more extensively on one-off mechanisms, such as land sales and balance sheet and accounting adjustments, which improve the financial position on paper but do little to improve the underlying financial position. Already at quarter 1 in 2017/18, trusts delivered 19% of their CIPs through non-recurrent schemes, compared to a planned 7%.¹²

- ***[It has] had the damaging effect of enforcing a short-term, non-recurrent focus at the expense of developing medium-term sustainable solutions.***
Finance Director, acute trust
- ***It has managed to get some cash into the system that was needed however in terms of delivering a recurrent sustainable surplus it is unlikely due to increasing demand on services and the high use of non-recurrent means to balance the financial position by trusts.*** Finance Director, specialist trust
- ***I think these targets need to be more sensible and gradually phased in to balance the overall providers position...rather than being used as short term targets that are supported by non-recurrent means to hit a target. This does not get to the problem of solving the underlying financial position.*** Finance Director, specialist trust

There are obvious pitfalls in over-reliance on non-recurrent measures, and NHS Improvement has always been transparent about this. It should be recognised that these are still hard to identify savings and they have been the only way the sector has been stay afloat.

As the National Audit Office highlighted, relying on “one-off accounting adjustments to meet the requirements for sustainability and transformation funding” highlights a system under “considerable financial pressure”.¹³

Non-recurrent and one-off measures are not a permanent or sustainable solution for the sector, yet the current financial framework often supports and encourages their use. It serves to hide and obscure an underlying, unsustainable, structural deficit within the provider sector. The Nuffield Trust highlights that once you strip out the STF and other non-recurrent measures, the provider sector is actually currently running a £3.7bn deficit,¹⁴ far higher than the £791m officially reported.

The £1.8bn STF is now such an integral part of provider financing, there are major concerns that the sector is deeply vulnerable to a loss of STF after 2018/19

The £1.8bn STF has only been confirmed for a further two years, in 2017/18 and 2018/19. Given that it has become a core part of provider financing, the sector is deeply vulnerable if it were to be removed. For example, in 2016/17, simply taking £1.8bn out of the end of year position would have left the sector £2.6bn in deficit, worse than 2015/16.

It needs to be recognised that in many ways this £1.8bn should not be seen as 'new' money for the provider sector, but instead a replacement for a contribution to the reduction in tariff prices (in the order of around 10% for admitted care tariffs) and loss of nationally allocated winter resilience funding. Between 2011/12 and 2014/15, the sector received over £1.7bn in winter funding from the national level but from 2015/16,¹⁵ it was mainstreamed in CCG allocations.

Although the STF is now a core component of provider income, we need to ensure that the current machinery in place to oversee such a relatively small amount of expenditure in the NHS is proportionate. There is no other large public sector where topline individual local annual surplus/deficit budgets are set by a central delivery structure, in return for access to a small proportion of their income. In affect, this hefty financial framework has been introduced on the back of distributing just £1.8bn worth of public expenditure in the NHS, which is no more than 2.5% of total expenditure in the provider sector.

In the next chapter we look at some of the factors, which need to be taken in to account when considering the future of control totals and STF post 2018/19.

The current financial framework has undermined provider autonomy and contributed to the sector losing its sense of agency

Unsurprisingly, therefore, there is a strong feeling that control totals have undermined provider autonomy, to the detriment of board decision making, empowerment and accountability.

In our survey, we asked providers to consider the extent to which the introduction of control totals had implications for trust and board decision making. The area where respondents felt control totals created the most negative impact was the sense of ownership of plans (see *The implications of control totals on trust and board decision-making* on page 13).

- ***We have moved to a system where providers have no autonomy. The freedoms of FTs have all now been lost.*** Finance Director, community trust
- ***I believe that the autonomy should be given back to organisations that have delivered against the financial targets. It should be down to the individual organisation to set the surplus given that was one of the perceived benefits of being an FT.*** Finance Director, mental health trust

The implications of control totals on trust and board decision-making

On the positive side:

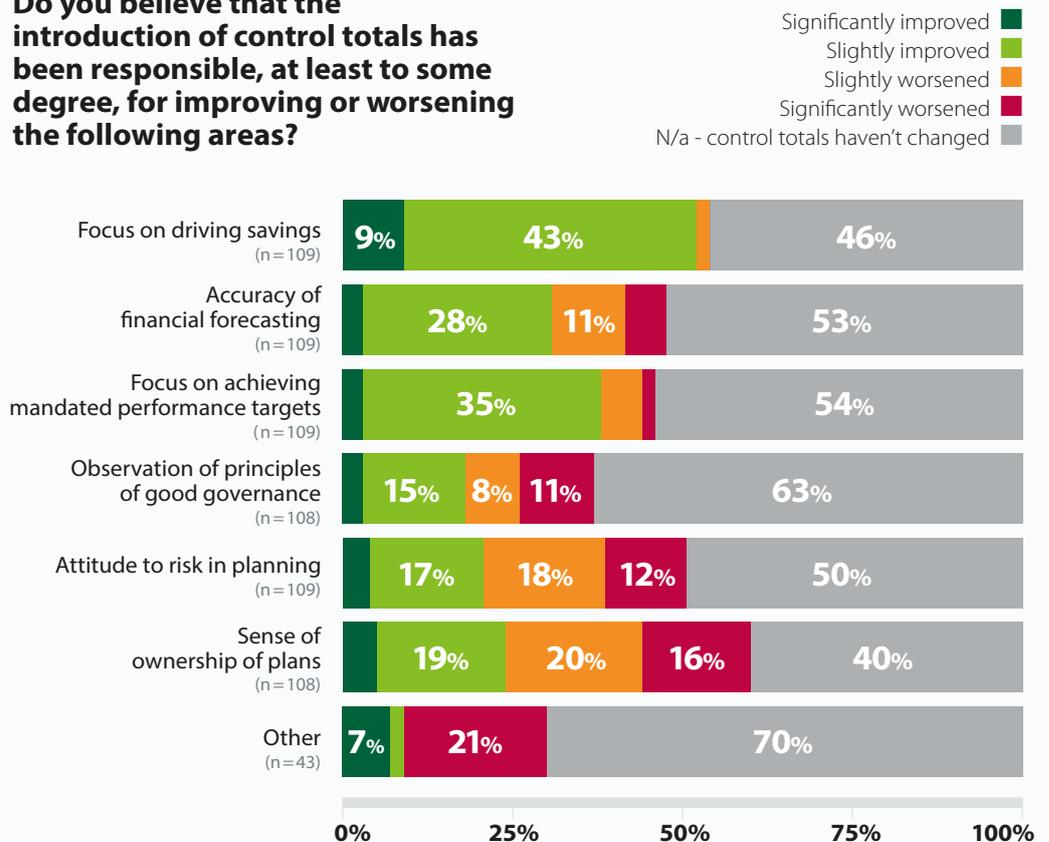
- 52% of respondents considered that it had improved their focus on driving savings.
- 31% considered that it had improved their accuracy of financial forecasting.
- 38% suggested it improved their focus on achieving mandated performance targets.

However, on the negative side:

- 19% considered that it has worsened their observation of principles of good governance, potentially because trusts felt compelled to take more risks to meet their control total.
- 30% considered that it had worsened their attitude to risk in planning.
- 36% responded that it has worsened their sense of ownership of plans.

Figure 2

Do you believe that the introduction of control totals has been responsible, at least to some degree, for improving or worsening the following areas?



There is not currently a mechanism or process for well-performing providers to earn back their autonomy. This must be a key objective in any reform of the control totals and STF framework.

The creation of control totals and STF has polarised the sector, rapidly widening the gap between trusts

There is a sense from many providers that the STF allocations have widened the gap between 'richer' and 'poorer' trusts. In particular the bonus and incentive schemes supported well performing trusts to receive a higher proportion of the STF, further exacerbating the financial problems of challenged trusts, which missed their control total or who were unable to sign up to one in the first place:

- *[It] incentivises good performance but penalises those organisations with the greatest pressures and arguably in need of greatest support. [The] STF allocation process therefore has [the] potential to broaden the gap between lowest and highest performing trusts.* Finance Director, specialist trust
- *The incentive and bonus [schemes] need to be reviewed. I am uncomfortable that trusts needing cash in an unsustainable deficit cycle are penalised further in favour of those hitting plan. [It is] not fair or appropriate.* Finance Director, mental health trust
- *STF funding needs to be targeted at organisations who need the cash, rather than organisations who are cash rich.* Finance Director, community trust

In many instances, these trusts still needed revenue support from the Department of Health so withholding cash from providers through the STF will not represent an overall 'saving' for the system. In fact, during 2016/17 trusts drew down £2.7bn of interim revenue support from the government, which was a third more than the previous year (£2bn).¹⁶

This raises questions about whether the unallocated STF should have been used to benefit those providers which had already received STF, at the expense of those trusts which didn't, but which still needed revenue support. It is right to reward success and hard work but this risks exacerbating the gap between the 'haves' and 'have nots' in the provider sector, triggering further requests for temporary support. We need to review sustainability funding in the broadest sense, taking into consideration the current £1.8bn and the other financing available to providers, to ensure that there is a coherent and consistent strategy for how we support challenged providers.

The framework reinforces organisation centric behaviours at a time when system working and transformation are being encouraged through STPs

Providers have identified that the current structure of control totals and STF has driven short-term thinking at both a national and local level, which for some areas has diverted focus away from transformation.

- *It was supposed to be about transformation which would arguably have helped in the longer term with addressing the provider deficit. But it quickly became a way of changing the bottom line and using control and command [and] it has not impacted on recurrent/underlying positions to reduce provider deficits in a meaningful lasting way.*

Finance Director, mental health trust

- *We need to look at ways of achieving system wide control totals so that there is an incentive to change service models across a system and not just improve individual organizations performance that could be detrimental to the system as a whole.*

Finance Director, acute trust

- *STF funding should be allocated to STPs to transform services – it therefore needs to be part of local discussion as to how to make the best use of limited resources.*

Finance Director, community trust

Simply reducing the aggregate deficit was felt by some to be divorced from other policy initiatives focused on collaboration and integration. For example, some providers mentioned that there was no incentive to sign up to a system control total while individual organisations were still being held to account for their own financial performance. This has understandably meant some providers have felt that they have had to choose between a focus on their own institutional position or the wider system and STP.

Where relationships at a local level aren't mature enough to support system working, the current framework forces providers to focus relentlessly on their own financial savings, but does little to support or reward the work being carried out at STP level to change the model of care which might require a shift in expenditure to different parts of the provider system.

The financial framework encourages more negative and opportunistic behaviours at both the national and local level

There was a strong sense from providers that control totals and STF could incentivise the wrong sorts of behaviour within trusts and reinforce negative behaviours at the national level.

For example, several providers considered that the process of setting a control total and administering the STF meant that they felt unable to speak with full frankness about the underlying financial challenges they were facing:

- *It encourages strange and sometimes inappropriate behaviour. The strong-arming of trusts to sign up to control totals through carrots and sticks is unlike anything I have seen in my career. It has resulted in an industry of 'achieving control totals' rather than one of making more savings, let alone better patient care.*

Finance Director, specialist trust

The quarterly approach might have also supported providers to be more opportunistic in the reporting of financial risk in order to hit quarterly savings targets. There is perception that this approach might have created an incentive for trusts to make sure their plans appeared on track for as much as the year as possible, at the expense of accurate risk planning and financial sustainability:

- *We have back-end loaded our CIPs in a way that is not realistic and is not very good from a governance perspective. We have not introduced any creative accounting and have reported in an accurate way. I believe other trusts may have been more creative.*

Finance Director, acute trust

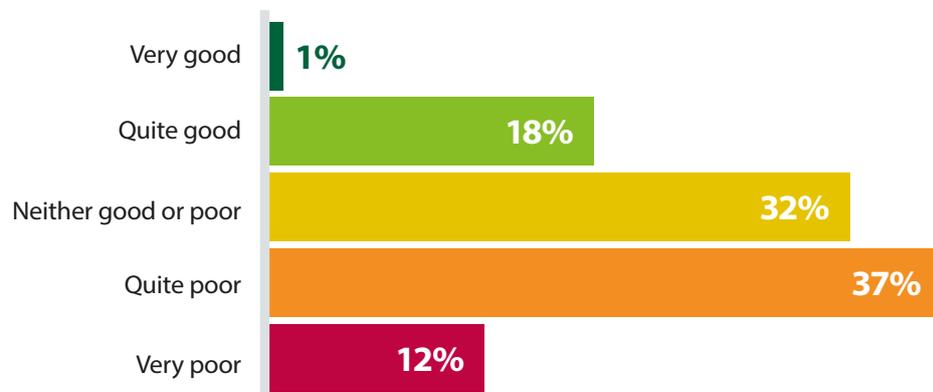
Since control totals and STF were introduced in response to the perception that the sector had lost financial credibility, it is concerning that the framework is perceived by some to be in danger of reinforcing worrying behaviours rather than tackling them.

Acceptance that administering this type of system was always going to be difficult but there are widespread concerns about the detailed operation of the framework

Introducing more central control on providers, combined with more administrative burden, was always going to be challenging, particularly in the first year of operation. Almost half of respondents (49%) rated the administration of control totals by the arms length bodies as quite or very poor (figure 3). The gap in experience of the process between different providers was marked – some felt the process was reasonable and flexible, particularly noting an improvement this year, while others felt it was too rigid and top down.

Figure 3
Regardless of the principles behind control totals and STF, how would you rate the administration of the STF and control totals by the arm's length bodies (for example thinking about issues such as transparency, communication and clarity)?

(n=109)



Concerns centre around the following themes.

The process for setting a control total and the methodology underpinning it

The process to allocate a control total and savings target was considered to be overly top down and did not take account of the underlying financial position of the trust. This is perhaps understandable as the administrative burden would be too high to enable 233 separate negotiations with individual providers about their control total. But, what is important is that there is absolute transparency and a clear justification for why a control total is being set. For example, several providers said that the savings target was based on their month six position from 2015/16, despite there being significant financial deterioration in the second half the year. It also made little allowance of factors such as the:

- underlying deficit of a provider
- non-recurrent measures which might have been employed in 2015/16
- reference cost position of the trust and therefore the ability of a trust to make savings relative to other providers
- additional financial pressures facing some trusts, such as the recruitment and retention challenges of some trusts leading to a greater reliance on expensive agency staff or the affects of a Private Finance Initiative (PFI).

Providers considered that NHS Improvement was sometimes inflexible and often unwilling to re-asses a proposed control total, despite there being evidence based and legitimate reasons to warrant an amendment. Some also report of conflicting messages between NHS Improvement regional teams and the national finance team. Respondents said that more transparency, genuine discussion and consistency are required.

The incentive and bonus scheme distorted the financial position of some providers

Providers who met their control totals were eligible for the incentive and bonus scheme. For many, this led to a substantial windfall at the end of the year, well above the original forecast. Having worked hard to motivate staff to deliver on savings and having put substantial pressure on the organisation to pull out all the stops to deliver a challenging plan, these organisations ended up having to justify a large, often unexpected end-of-year improvement. Some cite this windfall actually having a detrimental impact on staff morale and quality of discussions with commissioners. We know of several instances where CCGs and local authorities have used the more positive end of year position as justification for negative contract decisions or lower funding allocations. Although it is for individual organisations to appropriately communicate to those in and outside their organisation, further thought is needed on how we can best support the sector to manage what should be a wholly positive situation.

Support for those providers unable to sign up to control totals

There are legitimate reasons why some trusts might be unable to sign up to control totals. Compelling providers to sign up to a control total they are not confident they can deliver both undermines good governance and puts provider Boards in a near impossible position. We need to move to a situation where the national level accepts that some providers are not going to sign up to their initial control total, but are nevertheless still supported to deliver an appropriately stretching position. These tend to be some of the most financially challenged providers in the country, and we need to accept that a one size fits all methodology for setting a control total can be counterproductive.

Lack of timely communication of policy changes

In the first year of operation, unsurprisingly, some policy changes were communicated late. It is a concern that these problems have continued in to 2017/18. For example, the bonus and incentive schemes were not announced to the sector until December 2016 which made it impossible for providers in receipt of this funding to have an accurate end of year forecast until quarter four. This year, the exact methodology underpinning the release of the performance element of the STF for the first three months of the financial year was not communicated until just before the end of quarter 1. Also, STF funding continues to be received late sometimes creating a cash flow issue for trusts. There is no doubt that these delays are a symptom of the fact that the policy and approach needs to be agreed by the 'quad' of NHS Improvement, NHS England, Department of Health and the Treasury, which inevitably slows down decision making at the centre. However, these delays can negatively impact confidence and transparency in the administration of the system and can frustrate provider efforts to deliver their performance and financial targets.

Some lack of support from the system, in particular commissioners

There are still too many decisions made at the national or regional level, which undermine providers' ability to deliver financial targets. For example, the decision by some CCGs, following instruction from some regional NHS England teams, not to pay contract income in advance to support a provider's cash flow following late payment of the STF, simply undermines system working. These providers ended up having to take out interest bearing loans to cover their cash shortfall as an interim measure. This is an entirely avoidable situation. Commissioner finances are as tight as provider finances at the moment, but organisations need to be supported and encouraged to work together rather than encouraged to take decisions against each other.

LOOKING TO THE FUTURE

In-year changes

There are a number of immediate improvements which could be made to the administration of control totals and STF this year.

- **A realistic A&E trajectory for the performance element of the STF**

Providers had agreed a local trajectory with NHS Improvement, but instead are being judged for the trajectory outlined in the *Next steps on the five year forward view*¹⁷ for the release of the performance element of the STF.

- **Not double penalising providers who do not sign up to a control total or who miss their targets**

Too many policy and funding decisions are now affected by whether a provider has signed up to a control total and met their targets. For example, trusts which had not been able to sign up to a control total at the start of the financial year were unable to access capital funding to improve emergency department streaming. Providers in the most financially challenging positions should not be penalised twice.

- **Flexibility in assessment over whether a provider has met their control total**

As we have seen with the destabilising events of quarter 1, such as the cyber attack and the terrorist attacks, trusts are not always in control of variances in their financial plan. A more proportionate and flexible approach must be taken if a trust ends up missing its control total for a reason clearly outside their control.

- **Adjustments to the incentive and bonus scheme**

The incentive and bonus schemes are not currently delivering for providers. They exacerbate the financial gap between trusts in the system, and do little to improve the underlying financial challenges of the sector. National system leaders might wish to look at options which reduce the marginal gains to below a pound for pound gain, or even remove this entirely. Any unallocated element of the STF needs to remain in the sector if it is to continue to improve its financial position.

Given the current strategic context of rising cost and demand, set against historic low levels of funding increases and a growing financial gap, the withdrawal of the £1.8bn after 2018/19 would simply put providers back to square one, putting the sector on a trajectory towards a £2bn plus deficit again. The £1.8bn of sustainability funding has now become a key part of provider financing. We therefore need a clear commitment for it to be maintained beyond 2018/19.

However, as highlighted by the variety of views expressed in our survey and roundtable, there is no immediate obvious solution to replace the current direct allocation matched to a control total. There are clearly challenges with the current framework but also well-recognised challenges with the alternative of mainstreaming in to CCG allocations or the national tariff.

As NHS Improvement, NHS England, the Department of Health and the Treasury consider policy options in the future, the following principles need to be considered:

- **Any model needs to maximise benefit to the provider sector**
Given tight financial squeeze, the £1.8bn is vital to the sustainability of the provider sector. We have to find a way to minimise the inevitable leakage away from providers which might occur if funding is mainstreamed through CCG allocations and the national tariff.
- **Enabling local autonomy and ownership**
The erosion of provider autonomy through the current system cannot continue indefinitely. Any future allocation/distribution should allow trusts to work toward greater autonomy, particularly if they are high performing. This will be the only way to facilitate and support providers being active participants in their STP.
- **Supporting the system not just the institution**
For some local health economies, individual control totals are seen as a barrier to system working. We need to develop a framework that strengthens the growing focus on STPs as well as the performance of individual institutions. What is right for one organisation might not be right for a system, and the financial framework needs to enable this balance.
- **Consultation with the sector**
Control totals were introduced without proper, formal or frontline consultation or engagement. It is key that any longer-term system is designed in consultation with the provider sector, rather than imposed on it. This will be the only way to build the required credibility and transparency.

CONCLUSION

There is a danger that, because there is no immediately obvious solution to replace control totals and STF, what was conceived as a short-term solution becomes a long term design feature of the system. While it may be appealing to the national level to have this degree of control over individual providers, we believe it is deeply corrosive and incompatible with the principles of appropriate delegation and autonomy that should sit at the heart of the NHS. These principles are essential for organisations and systems to be effective, engaged and empowered in a rapidly changing and complex system.

As this report identifies, there are also consequences of continuing with the current approach that could undermine the longer-term sustainability of the sector. Providers need a clear public commitment from government that the current financial framework will only be short term and that a new approach will support appropriate local autonomy by the beginning of 2019/20 at the latest. The government also needs to commit to full provider involvement in the development of the new approach.

We need to get back to a sustainable approach to managing the provider sector. The average well-run trust, should be able to deliver its operational targets and make a sufficient surplus to invest for the future. This should incorporate delivering an appropriately stretching but realistic level of savings based on improving efficiency and productivity. Failing to hit operational targets or make a surplus should be an exception, but at the moment, it is the rule. It is now exceptional for a trust to hit its operational targets and make a surplus, and this cannot continue.

The only way to address this is either to recognise that additional funding is required or to reduce the delivery ask. We cannot carry on expecting that the significant demand, funding and workforce pressures can be absorbed by the sector on current budgets.

Providers ultimately need greater realism and honesty about what can be delivered in the short-medium and long term. The current financial framework involving greater central control and grip served a necessary purpose following 2015/16, but we now need to think long term and strategically about the financial challenges facing the sector.

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 - by March 2018, the majority of trusts need to meet 95% standard

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

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