National Audit Office

REPORT

NHS Financial Management and Sustainability

Department of Health & Social Care, NHS England

SESSION 2024-25
HC 124

Key facts

£153bn

expected NHS England (NHSE) resource expenditure in 2023-24

£1.4bn

estimated aggregated deficit of the 42 NHS systems in 2023-24 (provisional figure, subject to audit)

15

out of 19 Integrated Care Board (ICB) chief financial officers responding to our survey stated their ICB's underlying financial position had deteriorated in 2023-24

£1.7 billion funding from the government to mitigate the impact on the NHS of industrial action in 2023-24

£1.4 billion NHSE's estimate of the additional cost to the NHS of non-pay inflation in 2023-24, above what was budgeted for in its funding settlement

7.6 million patients waiting to start treatment in April 2024, compared with 4.6 million in January 2020, prior to the COVID-19 pandemic

352.6 million number of GP appointments provided in 2023-24, a record high, compared with 302.4 million in 2019-20

26.2 million accident and emergency (A&E) attendances in 2023-24, compared with 25.0 million in 2019-20

9.3 million the Health Foundation's estimate of the number of people who will have a major illness in 2040, compared with 6.7 million in 2019, a 39% increase

£11.6 billion the 2022-23 estimate of the cost of work required to bring NHSE's estate assets up to an adequate physical condition, of which £2.4 billion (20.3%) was high-risk

Summary

1 The Department of Health & Social Care (DHSC) has overall responsibility for healthcare services, and their financial management and sustainability. DHSC is accountable for ensuring that its spending, as well as that of NHS England (NHSE), other arm's-length bodies and local NHS bodies, is contained within the overall budget authorised by Parliament. DHSC is also responsible for ensuring those organisations perform effectively and have governance and controls in place to secure value for money. Within this context, NHSE is responsible for achieving a balanced budget, meaning it should not spend more than DHSC provides.

2 This is our ninth report on the financial management of the NHS in England. We published our last report in February 2020, finding that, in order to bring about lasting stability, NHSE needed to engage in financial restructuring. We stated that the delivery of long-term financial sustainability would remain at risk unless all NHS bodies were on a realistic path to breaking even.[1]

3 Since we last reported, the *Health and Care Act 2022* has introduced Integrated Care Systems (ICSs) on a statutory footing, which bring together NHS bodies, local government, and other organisations. There are 42 ICSs covering England, each with an Integrated Care Board (ICB) – an NHS body with members nominated by NHS trusts, providers of primary medical services, and local authorities. ICBs receive funding from NHSE, and commission and pay for NHS services in their area. Our October 2022 report, *Introducing Integrated Care Systems: joining up local services to improve health outcomes,* concluded that NHSE and DHSC needed to tackle those pressures on ICSs that required national-level strategies and solutions, including workforce shortages, financial sustainability, and social care demand.[2]

1 Comptroller and Auditor General, *NHS financial management and sustainability*, Session 2019-20, HC 44, National Audit Office, February 2020.
2 Comptroller and Auditor General, *Introducing Integrated Care Systems: joining up local services to improve health outcomes*, Session 2022-23, HC 655, National Audit Office, October 2022.

4 The scope of this report is NHSE and DHSC's financial management of the NHS in England. Specifically, we look at the extent to which the NHS is able to manage its current operations within the financial resources it has available while making progress towards its long-term goals. The report sets out:

- the NHS's current financial position and operating context, (Part One);
- whether NHSE's financial management processes allow accurate and timely decision-making and support for NHS bodies that are struggling (Part Two);
- the relationship between financial management and NHS performance, productivity, and efficiency (Part Three); and
- the challenges to the NHS's financial sustainability in the longer term (Part Four).

Responsibility for healthcare is devolved to the governments of Northern Ireland, Scotland and Wales. The situation in the NHS in those nations is not considered in this report. In this report, we use the term 'NHS systems' to refer to commissioning ICB bodies and the constituent NHS trusts and foundation trusts within their ICS area.

Key findings

Financial position and operating context

5 Over the decade from 2014-15 to 2023-24, the resource expenditure of the NHS grew on average by 3.2% a year in real terms, which was less than the long-term average. From 1950-51 to 2013-14, resource expenditure on health grew on average by 3.6% each year in real terms. In the 10 years to 2023-24, expenditure increased by less than this and at markedly different rates at different times.

- NHS expenditure rose by 2.0 to 2.9% a year in real terms from 2014-15 to 2018-19.
- It then rose by 4.9% to 9.9% a year from £136 billion in 2019-20 to £157 billion in 2021-22. This jump was because of the COVID-19 pandemic.
- Since 2022-23, NHS expenditure has fallen slightly in real terms. Many of the costs associated with the pandemic have now ceased, allowing funds to be used for other healthcare and to address rising costs resulting from inflation and industrial action.

In the four years since it received its first block of COVID-19 funding in 2020-21, NHS expenditure rose 3.1% per year in real terms. NHSE's resource expenditure was £155.1 billion in 2022-23, and it expects to have spent a total of £153.2 billion in 2023-24, a real-terms year-on-year reduction of 1.2%. Planned expenditure for 2024-25 is £153.5 billion, a real-terms year-on-year increase of 0.2%. All amounts are given at 2022-23 prices (paragraphs 1.3 and 1.4).

6 Many NHS bodies failed to break even in both 2022-23 and 2023-24, although NHSE calculates that in 2023-24, after receiving additional funding from the government and re-allocating central funding, it underspent against its overall budget by an estimated £30 million (0.02%).

- In 2022-23, the 42 NHS systems planned for an aggregated deficit (overspend) of £99 million against their total allocation of £119 billion, but their outturn was an aggregated deficit of £621 million. At the start of 2022-23, only five NHS systems planned a deficit. However, at year end, 20 were in deficit. To provide additional financial support to NHS systems and cover their deficits, NHSE reduced planned spending against its own central budget in 2022-23 by £1.2 billion.
- In 2023-24, the 42 NHS systems planned for an aggregated deficit of £720 million, but their outturn was calculated to be an aggregated deficit of £1.4 billion. To manage pressures faced by NHS systems, NHSE received extra funding from the government during 2023-24, including £1.7 billion to support pay deals for non-medical staff and £1.7 billion to mitigate the impact of industrial action. NHSE also reduced planned spending against its own central budget in 2023-24 by £1.7 billion. These actions did not prevent NHS systems' deficits increasing beyond what was planned at the beginning of the year. NHSE also received an additional £1.1 billion from government in 2023-24 specifically to address the costs of new pay agreements for doctors and dentists. NHSE has calculated that at year end it had a £30 million surplus overall. All amounts for 2023-24 are provisional, pending final audited annual accounts (paragraphs 1.2 and 1.6 to 1.8).[3]

3 Note that NHSE's central underspend and the aggregated deficit of all NHS systems do not exactly sum to the value of NHSE's surplus, as the latter includes technical adjustments and other unrelated areas of spending.

7 **The NHS's financial position is worsening because of a combination of long-standing and recent issues, including failure to invest in the estate, inflationary pressures, and the cost of post-pandemic recovery.** Significant funding for COVID-19 and large-scale pandemic-related activities have now ceased. However, the NHS is still dealing with the pandemic's legacy, including ongoing enhanced infection controls, operational and capacity constraints, and greater complexity in patient need. For example, the NHS maintains a policy of leaving beds unoccupied if they are next to patients infected with COVID-19, reducing its efficiency. Higher-than-expected inflation has increased the cost of medicines and other items beyond what the government allowed for in NHS budgets. NHSE estimates that, in 2023-24, non-pay inflation cost an additional £1.4 billion above what was budgeted for. The backlog of work needed to improve the NHS estate to an adequate level has increased greatly in recent years because of under-investment, reaching £11.6 billion in 2022-23, of which £2.4 billion (20.3%) related to the highest risk category of work. As we reported in our study *Progress with the New Hospital Programme*, backlog maintenance can increase the NHS's day-to-day running costs, most notably in hospitals that have reinforced autoclaved aerated concrete (RAAC) (paragraphs 1.10 to 1.13 and 4.3).[4]

8 **The impact of strikes and increased sickness absence has required the NHS to spend more on expensive agency staff since 2020-21, although this expenditure fell in 2023-24 compared to the previous year.** Sickness absence rates for NHS staff are higher than before the pandemic, reflecting a wider trend across the economy. Strikes about pay continued throughout 2023-24 and are, in some cases, ongoing. They disrupted NHS performance and can lead to additional spending on strike cover. Meanwhile, NHSE estimates that each additional 1% of pay for NHS staff costs around £1 billion. Despite NHSE re-introducing spending controls in 2022, spending with agencies that supply temporary health workers increased from £2.4 billion (3.7% of the total wage bill) in 2020-21 to £3.5 billion (4.5%) in 2022-23. NHSE estimates that agency spend reduced in 2023-24 to £3.0 billion, or 3.8% of total staff costs (paragraph 1.11).

4 Comptroller & Auditor General, *Progress with the New Hospital Programme*, Session 2022-23, HC 1662, National Audit Office, July 2023.

Key financial management processes

9 Delays in HM Treasury and DHSC's approval of NHSE's overall budget and planning guidance have meant NHSE has not agreed NHS systems' spending plans until after the start of each financial year, making it very difficult for them to plan effectively. In 2022-23, NHSE did not approve NHS systems' final spending plans until June, three months into the financial year, and in 2023-24, not until May. It did not issue NHS systems with planning guidance for 2024-25 until late March 2024, days before the financial year began, meaning the same pattern is repeating. NHSE explained that this was because of delays in agreeing with DHSC and wider government what the NHS's priorities and affordable levels of activity should be for the year ahead. ICB chief financial officers and senior leaders told us that annual discussions on NHSE's planning timetable and processes require significant management effort. When they were established, ICBs were supposed to have considerable autonomy in determining how to allocate resources locally and shape the future of local health services. However, some NHS finance professionals told us their credibility in this regard was undermined by the degree of control NHSE exerted when negotiating plans in a tight funding environment. NHSE considers this an unavoidable consequence of needing to deliver overall financial balance. When it directs funding from central budgets to NHS systems in-year, this often comes with strict requirements and time restrictions that also limit NHS systems' autonomy (paragraphs 2.6, 2.9, 2.10 and 2.12).

10 Three of the 42 ICBs are in NHSE's mandatory Recovery Support Programme due to financial sustainability issues but stakeholders have mixed views on NHSE's financial management support and advice. Our 2022 report on ICSs noted the tension between meeting national targets and addressing local needs. We said that, in a context of financial, workforce and wider pressures, this meant ICSs might find it challenging to fulfil the high hopes many stakeholders had for them. ICSs continue to vary in their financial maturity and capability and in the level of support they need from NHSE. We heard positive accounts from some ICB chief financial officers about NHSE's support, but others questioned the added value of help they had received. As of June 2024, NHSE's Recovery Support Programme was providing mandated assistance to three ICBs, two of which had been in the programme since 2021 (along with their predecessor bodies), and to 21 trusts, seven of which had been in the programme since 2021. This indicates some ICBs may have persistent underlying issues beyond the scope of the support NHSE currently provides (paragraphs 2.18, 2.19 and 4.14).

Performance, productivity, and efficiency

11 The NHS has delivered record levels of activity in many key areas in the last year. In 2023-24, GPs provided a record 352.6 million appointments compared with 302.4 million in 2019-20, and accident and emergency (A&E) attendances reached 26.2 million, also a record high, compared to 25.0 million in 2019-20. There were 16.4 million hospital admissions in 2022-23, which was over 400,000 more than in 2021-22, though still some way below the previous peak of 17.2 million in 2019-20 (paragraphs 4.2, 4.4 and 4.6).

12 NHS performance has been well below what patients have been told to expect, despite NHSE revising some performance targets downwards. The timeliness of NHS treatment is generally poor.

- NHSE last met its official target for 95% of A&E patients to be admitted, transferred, or discharged within four hours in July 2015. The government's January 2023 *Delivery plan for recovering urgent and emergency care services* created new, less stretching interim targets for four-hour A&E performance and for average Category 2 ambulance response times (for emergency call-outs), but these new ambitions were also not met during the first year of the plan.

- Progress in reducing the backlog of elective care cases has been slower than the government promised in the February 2022 *Delivery plan for tackling the COVID-19 backlog of elective care*. While the number of people waiting to start treatment has fallen slightly since September 2023, there were 7.6 million people on the waiting list in April 2024, compared with 4.6 million in January 2020, prior to the COVID-19 pandemic. The NHS has a statutory requirement for 92% of patients on the waiting list to start treatment (or be seen by a specialist and leave the waiting list) within 18 weeks, but this standard was only met for 58% of patients in April 2024. As at April 2024, some 302,600 patients had been waiting for more than a year, compared with 1,600 in February 2020.

- On cancer care, the elective care plan also aimed to reduce the number of people waiting more than 62 days following an urgent referral back to pre-pandemic levels by March 2023. NHSE originally stated the pre-pandemic level to be 14,266, but subsequently revised this to 18,755 using a different basis for its calculation. In March 2024, 14,916 patients had been waiting longer than 62 days, meeting the threshold for NHSE's revised target but not the original target. NHSE also undertook that at least 75% of urgent GP referrals for cancer patients would either have a diagnosis or cancer ruled out within 28 days by March 2024. The NHS met this commitment in February and March 2024, but not in April 2024 (paragraphs 3.3 to 3.8).

13 According to official measures, NHS productivity declined during the pandemic and has not fully recovered, meaning recent increases in NHS inputs have not been matched by equivalent increases in NHS outputs. The productivity of public service healthcare in England, as measured by the Office for National Statistics (ONS), was falling before the pandemic, then dropped sharply during the pandemic, only partially recovering since. According to the latest ONS indices for non-quality-adjusted productivity, in 2021-22 the NHS produced 135% of its output in 2013-14 (the year with the largest annual growth in productivity prior to the pandemic and since the start of the ONS's data collection) but for 144% of the inputs. NHSE recognises that stalling productivity growth may, in part, be the result of under-investment in infrastructure that could help healthcare staff work more efficiently. We describe some of the actions NHSE is taking on infrastructure improvement in paragraph 14 below. NHSE has publicly committed to achieving a large increase in productivity growth in return for digital investments, targeting annual improvements of between 1.5% and 2% between 2025-26 and 2029-30, much higher than the official non-quality adjusted long-term pre-pandemic average of 0.6% between 1996-97 and 2018-19. NHS productivity is hard to measure. External measures by the ONS and York University have a lag of one to two years. Additionally, NHSE is in discussion with the ONS about revising the ONS's measure, believing that it may undervalue some NHS activity (paragraphs 3.11 to 3.15 and 4.21).

Long-term financial sustainability

14 NHSE has plans to transform aspects of NHS services, but some of these plans have faced difficulties and some are subject to significant dependencies and uncertainties. Our report on the New Hospital Programme showed that it was behind schedule and its costs had increased, and there was a risk that future hospitals would be too small. Without further capital investment, NHSE expects the NHS maintenance backlog to exceed £15 billion by 2027-28. The fifteen-year *NHS Long Term Workforce Plan*, published in June 2023, has £2.4 billion of funding confirmed up to 2028-29, but our recent report shows that the aim to double and nearly double training places for medical and nursing students, respectively, by 2031-32 depends on major expansion in both the UK higher education sector and the NHS's own training capacity. In March 2024, the government announced £3.4 billion of capital investment in the NHS for digital improvements between 2025-26 and 2027-28, with aims to upgrade medical equipment and reduce the time staff spend on administration. Overall, the demand for capital investment in the NHS outstrips supply, and the UK lags behind other countries, spending 0.33% of GDP on health capital investment in 2019 compared with 0.48% for comparable nations of the Organisation for Economic Co-operation and Development. DHSC and NHSE told us they recognise the importance of making the most of the capital they receive. However, in 2023-24, DHSC re-designated £0.9 billion of capital funding as revenue as part of measures to assist NHS systems with their in-year finances and support national programmes (paragraphs 1.13, 3.15, 4.21 to 4.24 and 4.26).

15 There is scope for NHSE to make better use of the funds it receives, but the NHS's longer-term financial sustainability depends greatly on how elected governments decide to address steeply increasing demand for healthcare. NHS systems are reporting efficiency savings (reductions in spending in one area that release funding for other areas) at a higher rate than what the NHS has achieved historically, although more than half of these in 2022-23 were one off reductions that will not recur in future years. Meanwhile, there is widespread consensus that England's changing demographics are creating and will continue to create significant additional demand for NHS services. Our 2020 report on NHS financial management and sustainability found the NHS was treating more patients but had not yet achieved the fundamental transformation in services required to meet rising demand. People are living longer and spending more years in ill health. The Health Foundation projects the number of people diagnosed with a major illness will reach 9.3 million in 2040, compared with 6.7 million in 2019, a 39% increase over a period when the ONS predicts the population will only increase by 13.1%. Without intervention to change current trends, the NHS would need around 29,000 additional general and acute beds by 2036-37. If current and future governments continue to see the NHS as the main solution to dealing with increasing ill health in society, the service will need to become much bigger and more expensive, and may well continue to struggle with backlogs and to recover the timeliness of its care (paragraphs 3.16 to 3.18, 4.3 and 4.9 to 4.11).

16 The NHS's future financial sustainability will be significantly affected by what happens in other parts of government and in wider society. The NHS considers that clinical interventions only account for around 20% of health outcomes. Other government departments are responsible for many policy areas that affect individuals' health. While the NHS can take steps to prevent existing health conditions from materialising or deteriorating, other government departments can also help prevent ill health occurring in the first place through influencing wider determinants of health such as diet, exercise, education, and the environment. As part of the government's Levelling Up mission on health, DHSC established a working group to coordinate activity on health issues. This group facilitated senior cross-government engagement on the development of DHSC's Major Conditions Strategy during 2023. In autumn 2023, DHSC also began consulting on possible changes to legislation to make it easier to pool budgets between NHS bodies and local authorities to support integrated care. Beyond these institutional arrangements, it is our view that the extent to which citizens choose to and are assisted to lead active lives and have healthy diets, and get access to good social care when they need it, is critical to determining what kind of financial future awaits the NHS (paragraphs 4.17 and 4.18).

17 NHSE has increased spending on national clinical prevention programmes, but the pandemic, including the resultant longer NHS waiting times, has negatively affected the population's health. NHSE's budget for national clinical prevention programmes totalled £156.6 million in 2023-24. This is a significant increase. In 2020-21, NHSE allocated £43 million for national and regional prevention schemes. The 2023-24 budget is only part of the NHS's overall spending on prevention. At their creation in 2022, ICSs were intended to provide impetus towards prevention by bringing relevant partners together to manage population health needs proactively. ICBs and Integrated Care Partnerships within ICSs have fulfilled their statutory obligation to produce Joint Forward Plans and Integrated Care Strategies, and DHSC instructed them to consider prevention aims in these documents.[5] However, the realisation of ICSs' aims is not guaranteed. ICBs told us that the short-term focus on post-pandemic national priorities, while understandable, along with tight funding, limited their ability to enact long-term plans. The government's *2021 Spending Review* committed to maintain DHSC's Public Health Grant to local authorities in real terms until 2024-25. But the level of the grant is expected to decrease in value by £193 million (5.5%) over this period (at 2022-23 prices), reducing councils' ability to commission services. Efforts at preventing serious ill health are contending with the after-effects of the pandemic. In particular, long waits for treatment inevitably mean that many patients' conditions may worsen before the NHS can address them. Both NHSE and DHSC currently lack a precise definition of what counts as prevention spending, making it difficult to focus attention on prevention and track spending trends (paragraphs 4.12 to 4.14 and 4.20).

5 Integrated Care Systems (ICSs) comprise Integrated Care Boards (ICBs), which are statutory NHS bodies, and Integrated Care Partnerships (ICPs), formed jointly between ICBs, local authorities and wider partners. In broad terms, ICPs are responsible for creating a strategy to address their local population's health and care needs and ICBs are responsible for planning and commissioning services to meet those needs.

Conclusion on value for money

18 The scale of challenge facing the NHS today and foreseeable in the years ahead is unprecedented. Following the statutory introduction of ICSs in 2022, we concluded that they needed time and capacity to build relationships and design services that could better meet local needs. While some transformation is occurring, the pace of change has been slow as ICSs struggle to manage the day-to-day pressures of elective recovery following the pandemic, continual rising demand for NHS services, and significant workforce and productivity issues.

19 As they are statutorily required to do, NHSE and NHS systems have prioritised trying to live within their allocated funding. But, despite great in-year efforts to do so – some of which privilege the short term at the expense of the long term – an increasing number of NHS bodies have been unable to break even. When we consider how the health needs of the population look set to increase, we are concerned that the NHS may be working at the limits of a system which might break before it is again able to provide patients with care that meets standards for timeliness and accessibility. Our report identifies operational improvements which can help the NHS to do more with the resources it has. However, there is a wider question for policymakers to answer about the potential growing mismatch between demand for NHS services and the funding the NHS will receive. Either much future demand for healthcare must be avoided, or the NHS will need a great deal more funding, or service levels will continue to be unacceptable and may even deteriorate further.

Recommendations

a **DHSC, NHSE and ICSs need to intensify their efforts to manage current and future demand for healthcare by preventing more serious ill health.** This should include:

- work to improve understanding of what ICBs and providers have had success doing so far, and how much is spent on prevention outside national programmes;
- an agreed definition of what counts as prevention to help track spending over time and to identify whether funding is being used in the most effective way; and
- greater collaboration across government, including work to identify options to address the wider determinants of poor health.

b **As part of the next spending review, DHSC and NHSE should identify and explain to HM Treasury what further capital investments across government could have the greatest impact on NHS productivity and preventing serious ill health.** As part of this assessment, they should determine the opportunity costs of not making this investment, including the potential impact in future years on NHS services, employees, and patients.

c **NHSE needs to deliver on its commitments to increase NHS productivity.** It should identify the factors that have limited growth in productivity both before and since the pandemic and develop plans to tackle them. It should work with ONS to agree an official measure of healthcare productivity that captures the full value of activity the NHS currently performs, including care outside hospital settings and prevention activities.

d **NHSE needs to complete its annual planning processes with ICSs well in advance of each financial year starting.** All key players, including NHSE, DHSC and HM Treasury, have roles to play to enable planning guidance to be provided in a timely manner and should work together to facilitate this, agreeing and adhering to an annual deadline for publishing the guidance. NHSE should work with ICBs and providers to identify opportunities to start the planning process earlier.

e **NHSE and DHSC should revisit their understanding of the reasons some ICBs and other NHS bodies have persistent underlying weaknesses that lead them to struggle with their finances.** They should then develop a plan to remove these barriers.

f **To facilitate greater efforts at medium- and longer-term financial planning, DHSC and NHSE should propose to HM Treasury ways to deploy more health funding on a longer timeframe than annual allocation and planning cycles allow.** Remedies could include greater flexibility between funding pots, multi-year allocations to provide certainty over longer periods (as the government has done in the past), and more discretion for ICBs and providers to direct national funding towards local priorities.