National Audit Office

REPORT

NHS Financial Management and Sustainability

Department of Health & Social Care, NHS England

SESSION 2024-25
HC 124

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National Audit Office

NHS Financial Management and Sustainability

Department of Health & Social Care, NHS England

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

3 July 2024

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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.

Part One

NHS financial position and operating context

1.1 This part of the report sets out:

- the current financial position of the NHS in England;
- recent trends in financial performance; and
- the NHS's wider operating context.

How NHS England is funded

1.2 NHS England (NHSE) receives funding from the Department of Health & Social Care (DHSC) to provide health services for England. It passes most of this funding to Integrated Care Boards (ICBs) which plan and commission the majority of services from NHS providers in their Integrated Care System (ICS) (**Figure 1** on pages 17 and 18), including NHS trusts and primary care providers.[6] ICBs agree financial, capital, and operational plans with NHSE on behalf of their wider ICS and, alongside this, provider trusts also submit their own plans to NHSE. ICBs and trusts have separate budgets, but trusts' financial plans must agree with those submitted by their ICB. ICBs and their constituent providers are jointly responsible for ensuring their annual spending plans do not exceed the total available annual funding provided by NHSE. NHSE received a £168.8 billion commissioning budget at the start of 2023-24, of which £114.3 billion was passed to ICBs and £32.3 billion was used for direct service commissioning by NHSE.[7] The NHS capital allocation in 2023-24 was £7.7 billion, of which £4.1 billion was passed to NHS systems for operational capital investment and £3.6 billion was used for national programmes. In this report we use 'NHS systems' to refer to the commissioning board and its constituent NHS trusts.

6 There are 42 Integrated Care Systems (ICSs) in England. 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.

7 The £168.8 billion commissioning budget at the start of 2023-24 does not reflect subsequent changes in the classification of depreciation in NHSE's accounts and includes all parts of the NHSE Group. Therefore it cannot be directly compared with the amounts presented at Figure 2.

Figure 1

The key bodies and structures involved with Integrated Care Systems (ICSs)

ICSs bring together NHS organisations, local authorities, and other partners

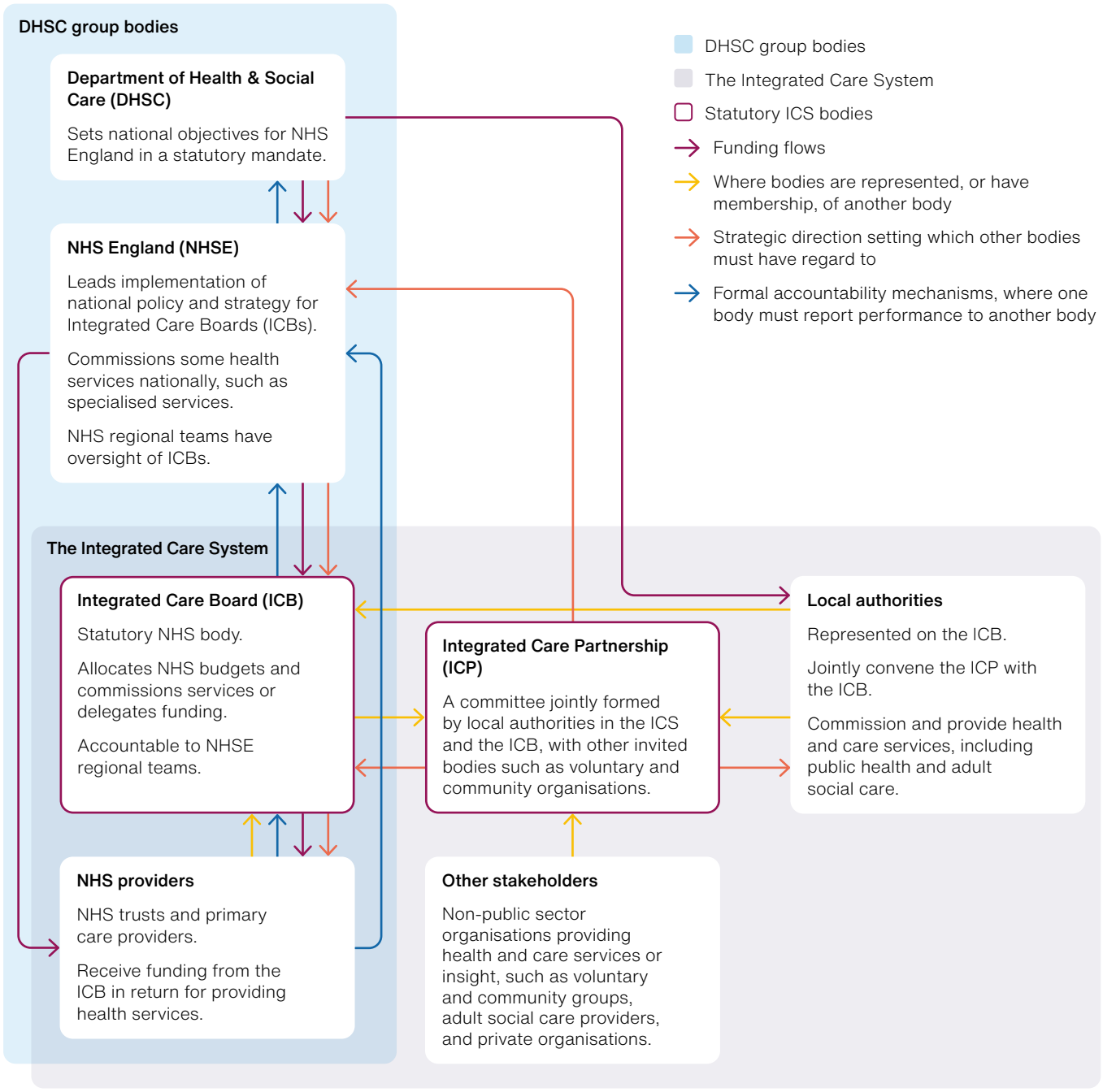


Figure 1 *continued*
The key bodies and structures involved with Integrated Care Systems (ICSs)

Notes

1 This figure provides an overview of arrangements for ICSs and does not set out differences between different types of NHS or NHS-funded organisations, or different types of local authorities, such as district, borough, city, or county.

2 This figure does not include Care Quality Commission which will provide independent reviews and assessments of ICSs following government's approval of its methodology, the Ministry of Housing, Communities & Local Government which provides funding and oversight of local authorities, or local authorities' democratic accountability arrangements.

3 This figure is based on a review of NHS England information as of July 2024.

Source: National Audit Office review of NHS England information

Trends in NHSE expenditure

1.3 Over the decade from 2014-15 to 2023-24, NHSE's revenue expenditure on day-to-day operational spending grew by an average of 3.2% per year in real terms (**Figure 2**). By comparison, from 1950-51 to 2013-14, expenditure on health grew by 3.6% on average each year in real terms. The annual funding increases that NHSE received in the 10 years to 2023-24 varied, and it should be noted that the calculation of growth over time is highly sensitive to the starting point used.

- Between 2014-15 and 2018-19, revenue expenditure increased between 2.0% and 2.9% each year in real terms, rising from £116.3 billion to £128.5 billion over this period.
- From 2019-20 to 2021-22 the increases were between 4.9% to 9.9%, with expenditure rising from £135.9 billion to £156.6 billion.
- Since then, expenditure has fallen slightly in real terms and is planned to be £153.5 billion for 2024-25, a total drop of 2%. It will fall from £155.1 billion in 2022-23 to an expected £153.2 billion in 2023-24 (a real-terms reduction of 1.2%) and is projected to rise to £153.5 billion in 2024-25 (a real-terms increase of 0.2%).

All amounts are given at 2022-23 prices.

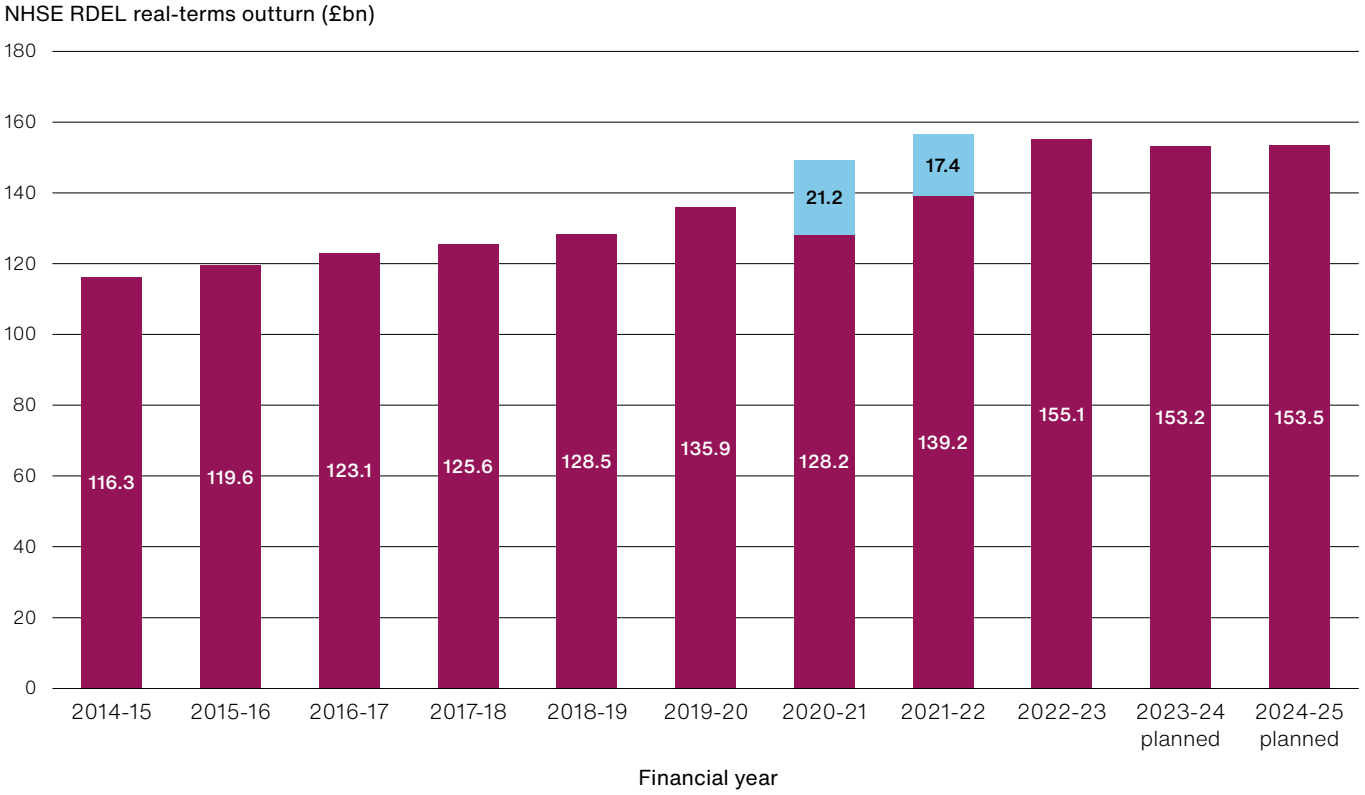
1.4 During COVID-19, most of the additional funding the government provided was to support the NHS's pandemic response. At 2022-23 prices, COVID-19 funding accounted for £21.2 billion of the £149.3 billion revenue funding in 2020-21, and £17.4 billion of £156.6 billion in 2021-22. Excluding this additional COVID-19 funding, real-terms revenue expenditure only increased 1.5% per year on average in 2020-21 and 2021-22. Significant funding for COVID-19 ceased at the end of 2021-22.[8] As shown in Figure 2, NHS England's baseline funding was increased so the total resource available to the NHS was broadly flat between 2022-23 and 2023-24. The real-terms average growth per year in the four years since COVID-19 funding began, from 2020-21 to 2023-24, was 3.1%. If NHSE's budget for 2024-25 is included, the rate of growth drops further. For the five years from 2020-21 to 2024-25, real-terms annual growth is set to be 2.6%.

8 As part of an overall settlement which required NHSE to make savings in certain areas, it received funding specifically for COVID-19 activities of £3.3 billion in 2023-24 and £1.7 billion in 2024-25. We discuss NHSE's performance on efficiency savings further in Part Three.

Figure 2

NHS England (NHSE) real-terms outturn and planned expenditure from 2014-15 to 2024-25, based on 2022-23 prices

The NHSE resource department expenditure limit (RDEL) outturn has generally increased year on year in real terms, with greater increases during the COVID-19 pandemic, but has fallen slightly since 2021-22



Notes

1 Data shown in real terms based on 2022-23 prices.

2 'RDEL' refers to amount of government budget allocated to NHSE's spending on day-to-day operational spending, known as revenue spending. It does not include funding for capital projects such as buildings.

3 Planned expenditure is reported for 2023-24 because accounts were provisional at time of publication.

Source: National Audit Office analysis of the Department of Health & Social Care and HM Treasury data

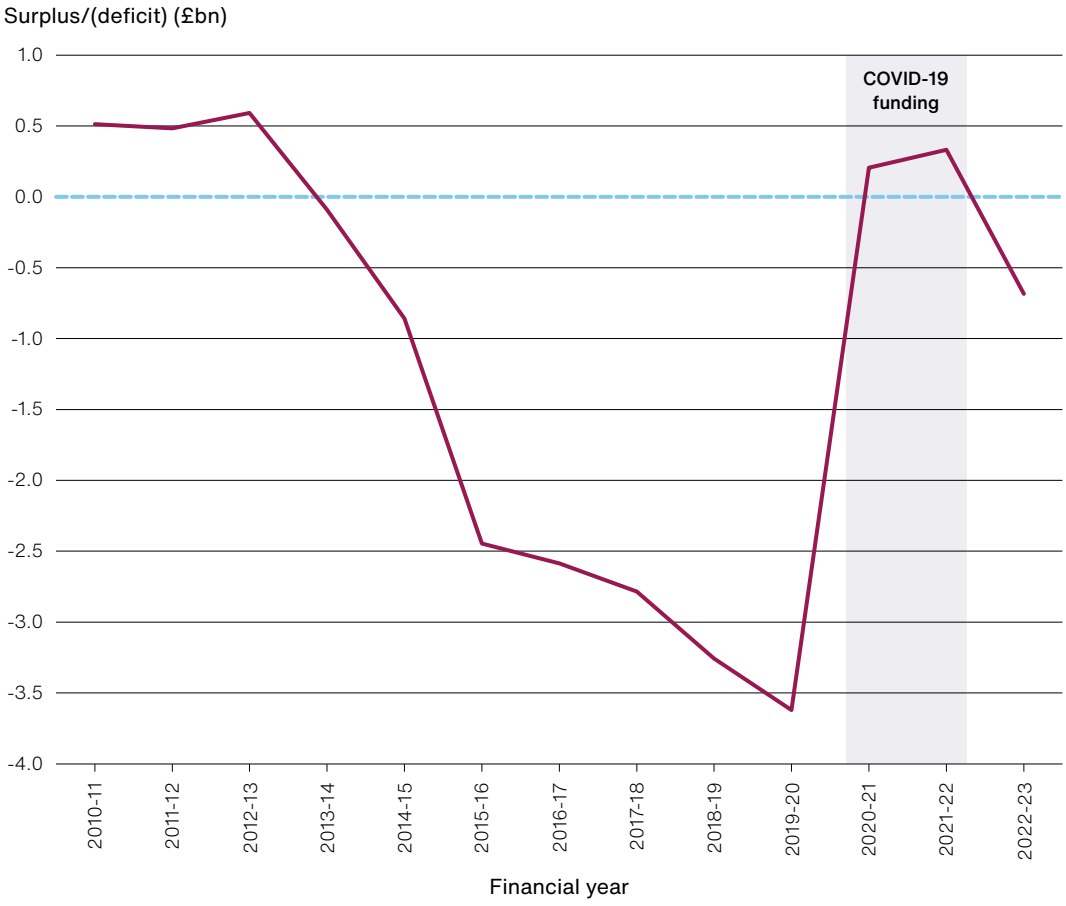
NHSE's financial position in 2022-23 and 2023-24

1.5 In 2013-14, NHS trusts collectively entered a negative financial position with an aggregated deficit of £91 million, and this deficit continued to increase annually to reach £3.6 billion by 2019-20 (**Figure 3**). Between 2020-21 and 2021-22, NHS trusts collectively generated a surplus due to increased financial support provided by the government in response to the COVID-19 pandemic, posting a net surplus of £205 million in 2020-21 and £331 million in 2021-22. However, much of the additional funding for COVID-19 ended in 2022-23 and NHS trusts returned to a deficit position, with a net shortfall of £685 million.

Figure 3

Total surplus or deficit across NHS trusts in England from 2010-11 to 2022-23

After a period of net surplus during COVID-19, NHS trusts returned to a long-term trend of an aggregated deficit position in 2022-23



Note

1 Data has not been adjusted for inflation.

Source: National Audit Office analysis of NHS England financial data

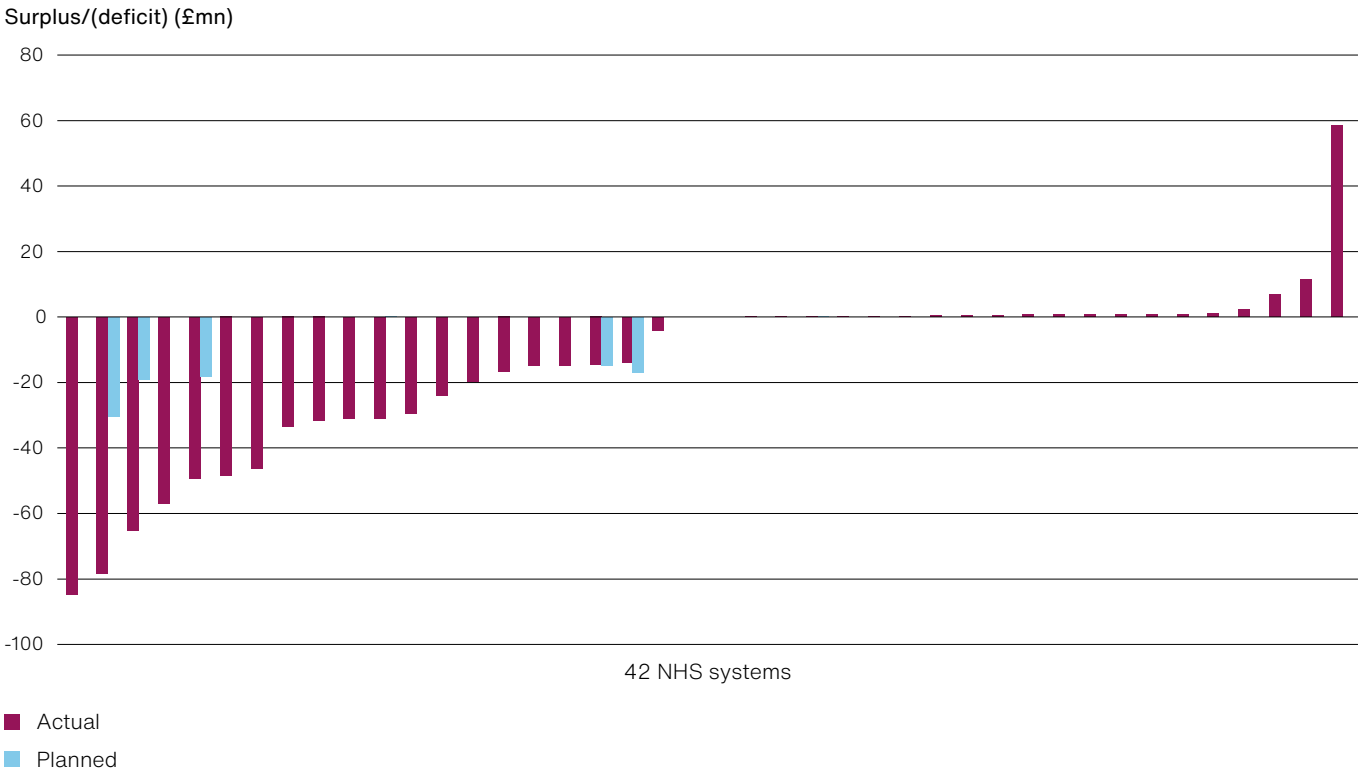
1.6 In their original agreed plans for 2022-23, 35 NHS systems planned to break even, five planned a deficit, and two planned a surplus, resulting in an overall planned aggregated deficit of £99 million across the 42 NHS systems, against a total allocation of £119 billion. However, at year-end the aggregated deficit for all NHS systems was £621 million, £522 million higher than planned, with only two breaking even, 20 in deficit and 20 in surplus (**Figure 4**).

1.7 To provide additional financial support to NHS systems and to cover their deficits, NHSE reduced planned spending against its own central core budget in 2022-23 by £1.2 billion. NHSE informed us this underspend did not involve explicit reprioritisation of existing budgets but was achieved through reduced spending in several areas, including NHSE's core programme budgets (£238 million), its reserves (£235 million), specialised commissioning (£221 million) and primary care and secondary dental care (£220 million). Of the £1.2 billion, NHSE used £1 billion to offset cost pressures from providers. After all these actions, NHSE achieved a surplus of £175.2 million.

Figure 4

NHS systems' planned and actual surpluses and deficits in 2022-23

NHS systems were in an aggregated deficit of £621 million by the end of 2022-23 against a planned deficit of £99 million, with 20 of the 42 NHS systems in deficit



Note

1 'NHS systems' refers to commissioning Integrated Care Board bodies and the constituent NHS trusts and foundation trusts within their Integrated Care System area.

Source: National Audit Office analysis of NHS England financial data

1.8 In May 2024, NHSE calculated that it had ended 2023-24 with an overall surplus of £30 million (0.02%). In their agreed plans submitted in May 2023, NHS systems planned for an aggregated deficit of £720 million, but their 2023-24 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 again reduced planned spending against its own central budget in 2023-24 – this time by £1.7 billion – as it sought to offset deficits within NHS systems. 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. It is important to note that NHSE's central underspend and the aggregated deficit of 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. All amounts are provisional pending the completion of the audited annual accounts.

The NHS's operating context

1.9 The NHS has been facing significant operational challenges, which help to explain its worsening financial performance.

The legacy of the pandemic

1.10 While NHSE continued to receive some funding for COVID-19 in 2023-24 and 2024-25, this funding was much lower than the level received during the pandemic (paragraph 1.4). However, the NHS must still contend with the continuing impacts of the pandemic. In addition to backlogs (which we consider in Part Three), these include providing care to patients with long-term COVID-19 symptoms, continuing COVID-19 services such as vaccination and testing, capacity and operational constraints due to ongoing enhanced infection control processes (for example, the NHS maintains a policy of leaving beds unoccupied if they are next to patients infected with COVID-19, reducing its efficiency), and greater complexity in some patients' needs. It also took time to unwind some of the changes that the NHS made in 2020 and 2021 to enable it to deal with large numbers of COVID-19 patients. This is a diffuse range of issues, and it is difficult to be precise about the additional costs that they cause. NHSE told us that, following the pandemic, NHS systems found it increasingly difficult to distinguish between COVID-19 costs and normal service pressures. This meant NHSE was unable to tell us whether the ongoing financial costs of COVID-19 are more or less than the COVID-19 funding it has continued to receive.

Staffing challenges

1.11 The NHS has several ongoing staffing challenges, which either cause additional costs or reduce the efficacy of spending.

- **Sickness absence rates** are higher than before the pandemic, in common with many other sectors, at 5.3% of days lost in October 2023 compared with 4.6% in October 2019.
- **Industrial action and staff pay awards.** Strikes about NHS pay continued throughout 2023-24. These resulted in cancelled appointments and other disruption, and had direct costs for NHS bodies, for which the government provided £1.7 billion in 2023-24 (paragraph 1.8). Some disputes were resolved, but in other cases, notably junior doctors, industrial action continued into 2024-25. When disputes are settled, the settlements can also bring unplanned costs. NHSE estimates that each additional 1% pay increase across NHS staff increases costs by around £1 billion.
- **Agency spending.** Strikes can cause the NHS to look to agency workers to provide cover, but the NHS has also typically made extensive use of agencies to fill other gaps. Despite NHSE re-introducing spending controls in 2022, spending with agencies supplying temporary health workers increased as a percentage of the total wage bill from £2.4 billion (3.7%) in 2020-21 to £3.5 billion (4.5%) in 2022-23. NHSE draft figures show that agency spend reduced in 2023-24 to £3.0 billion, or 3.8% of the total wage bill.
- **Welfare and satisfaction.** In 2023, 30.4% of NHS staff surveyed by NHSE reported feeling burnt out because of their work. A 2022 survey by the General Medical Council found 57% of UK GPs were dissatisfied with their day-to-day work. These issues can influence people's likelihood to remain in the service or to undertake paid or unpaid overtime.

Inflation

1.12 Inflation has increased NHS costs, such as for the delivery of capital projects, prescribing medicines, energy and fuel. The government makes allowance for inflation when it finalises annual NHS budgets, but in recent years the real level of inflation the NHS experienced has been higher. NHSE estimates that non-pay inflation will have cost an additional £1.4 billion (around 1% of the total budget) above what was budgeted for in 2023-24.

Estates maintenance

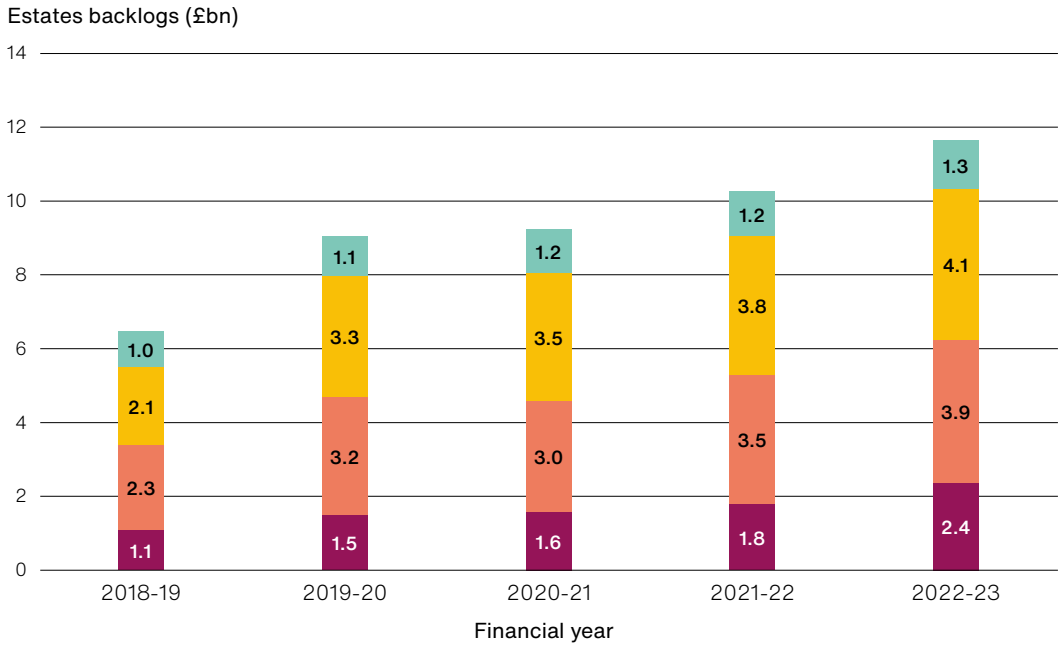
1.13 The backlog of work required to move the condition of the NHS estate to an adequate level has been allowed to increase each year (**Figure 5**). DHSC told us that some of this increase may be attributable to inflation and a better understanding of risk across the estate. In 2022-23, the total backlog was £11.6 billion, which had increased from £6.5 billion in 2018-19. NHSE assessed £2.4 billion (20.3%) of this total backlog as high risk, meaning there was potential for catastrophic failure, major disruption to clinical services, or prosecution. Without an increase in capital investment to maintain or replace existing structures, the cost of the maintenance backlog is likely to continue growing. Day to day, some backlog maintenance can mean that parts of hospitals or other NHS buildings are taken out of use or have their capacity reduced, and there are costs associated with keeping old buildings open until they can be repaired or replaced. As we reported in our study on the New Hospital Programme, this is most notably the case in hospitals that have reinforced autoclaved aerated concrete (RAAC).[9]

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

Figure 5

Backlog of investment needed to maintain the NHS estate by risk category, 2018-19 to 2022-23

Total backlogs have increased from £6.5 billion to £11.6 billion during this period, with high-risk backlogs increasing from £1.1 billion to £2.4 billion



Notes

1 Risk categories are calculated by assigning a consequence score and a likelihood score to the failure of an element of the estate and multiplying these together.

2 The monetary value for risks is based on how much it would cost to bring an element of the estate up to an improved condition for five years, based on information from local partners, the Department of Health & Social Care, and professional bodies.

3 Data has not been adjusted for inflation.

Source: National Audit Office analysis of NHS England financial data

Part Two

NHS financial management processes

2.1 This part of the report examines the key financial management processes of the NHS in England. It sets out:

- how NHS England (NHSE) allocates funding;
- annual Integrated Care Board (ICB) financial planning processes; and
- NHSE's identification of and support for bodies in financial difficulty.

Allocating funding

2.2 NHSE and the Department of Health & Social Care (DHSC) agree a set of spending priorities and performance targets with HM Treasury for each spending review. The spending review outlines the annual budgets available to the NHS over the spending review period for administration, revenue and capital, and other ring-fenced projects, such as the New Hospital Programme. Annual budgets given by NHSE to local ICBs cover the majority of NHS spending, with NHSE retaining responsibility for commissioning some services nationally in key areas, including parts of primary care, highly specialised services, and public health. For 2024-25, NHSE's allocations to ICBs totalled £122 billion.

ICB revenue allocations

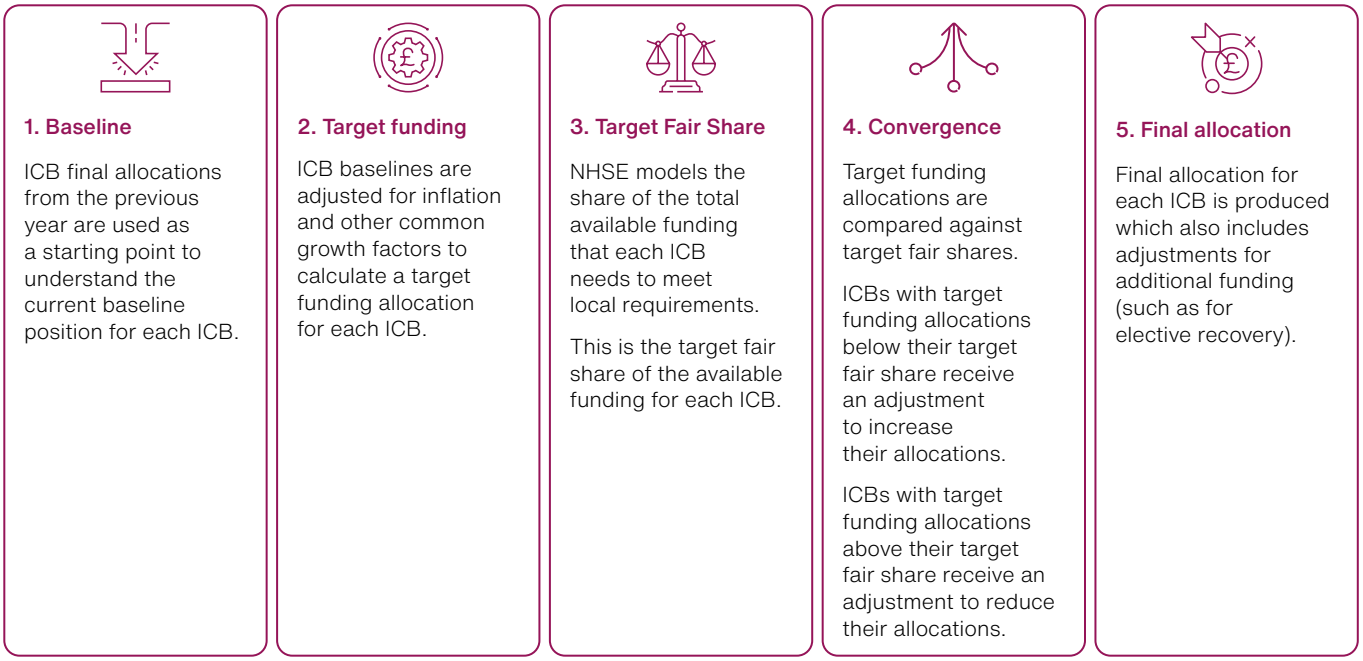
2.3 NHSE allocates revenue resources (for day-to-day spending) between ICBs based on population need. To support allocation decisions, it uses a statistical formula that calculates a share of national budgets for each ICB area. This assesses factors such as demography, morbidity, and deprivation. NHSE applies the formula to different ICB funding streams, including core services, primary care, and specialised commissioning.

2.4 NHSE's fair-share process apportions the total available ICB resource budget into revenue funding allocations for each ICB. The starting point is each ICB's final allocation in the previous financial year (after adjusting for growth factors), which is compared to what NHSE's funding formula says each ICB's fair share of the available funding would be. NHSE then carries out an adjustment called convergence to produce a final allocation for each area (**Figure 6**). Convergence lessens, but does not necessarily remove, the difference between an ICB's actual funding and what its fair share of available funding is calculated to be. The aim is to move ICBs towards fair funding without destabilising immediate service provision or risking value for money by providing or withdrawing large amounts of funding that is already tied up in local service provision. NHSE told us it had conducted analysis and considers that convergence, along with similar adjustments it has carried out in the past, has succeeded in moving ICBs closer towards their target fair share over time. The process is transparently documented in publicly available guidance.

Figure 6

The fair-share allocations process for Integrated Care Boards' (ICBs') core budgets

NHS England (NHSE) applies a series of judgements to calculate an annual core allocation for each ICB



Source: National Audit Office analysis of NHS England information

2.5 For 2024-25, NHSE's convergence adjustments added an additional £13.3 million in total to the core allocations of six ICBs that were below the level of funding its formula said would be a fair share. Conversely, following the convergence adjustments to achieve a fair share, 2024-25 allocations for 36 ICBs were £958.2 million lower than would have been expected if total available funding had increased in line with modelled pressures.

2.6 Separate to the annual core resource allocation process, NHSE releases ring-fenced funding to support specific programmes, such as service development funding for mental health, new technologies, or cancer treatment. Some of this funding is allocated at the start of the financial year, while a small percentage is allocated through the year. This means that, aside from often needing in-year support to tackle financial and other problems, ICBs receive more annual funding than the core allocation they start with.

ICBs' views on the allocation process

2.7 Of the 19 ICB chief financial officers responding to our survey, four felt that their organisation received a fair share of available NHSE funding. Respondents who felt they did not receive a fair share noted that funding always struggled to keep pace with demands and innovations in health, and that NHSE's allocation formula did not sufficiently factor in local cost differentials due to deprivation, health inequalities, and rurality. Similar issues were raised by the senior ICB leaders we interviewed. Only five ICB chief financial officers responding to our survey felt that NHSE allocations currently prioritised the right things, and some criticised the convergence process for its unrealistic pace and for being biased towards reducing overfunding rather than improving the position of underfunded ICBs. We have not conducted our own review of the detailed operation of the revenue allocation system.

2.8 Respondents to our survey reported negative perceptions about the adequacy of funding. Fifteen ICB chief financial officers (out of 19 responding to our survey) stated their underlying financial position had deteriorated in 2023-24, with seven respondents saying it had deteriorated significantly.

Financial planning for NHS systems

2.9 NHSE issues annual planning guidance, setting out the financial and operational objectives it expects ICBs and providers to work towards. NHSE has said it wants to publish this guidance as early as possible, allowing at least three months for local NHS systems to develop and submit budgets before the start of the financial year. It has not achieved that aim since 2017. Based on the guidance, NHS systems must agree an annual financial plan with NHSE. For 2022-23 and 2023-24, NHSE did not approve these final plans until June and May respectively, after the financial year had already begun. Despite NHSE sharing draft guidance with the government in November 2023, planning guidance for 2024-25 was not released until approval was received from HM Treasury on 27 March 2024, seven working days before the financial year began. NHSE explained that it had faced delays in agreeing priorities and a final budget with DHSC and wider government for the year ahead.

2.10 The annual planning process is resource intensive. Each NHS system submits an initial draft plan to NHSE and negotiates with regional and national NHSE teams to agree a final position. This often involves multiple meetings between senior NHSE and ICB officials, and numerous plan iterations. NHS systems submitting a deficit plan are subject to more challenge than those forecasting they will break even or deliver a surplus. In March 2023, NHS systems' initial 2023-24 plans would have resulted in a £6.7 billion deficit for the NHS in England. NHSE told us the scale of this deficit necessitated further work to improve NHS systems' plans and deliver a more balanced position. Following discussions with NHSE, NHS systems submitted final plans on 4 May 2023 with an aggregated deficit of £720 million. At the time we finalised this report in early July 2024, NHSE told us that all NHS systems had submitted their final plans for 2024-25 and these were due to be approved imminently.

2.11 NHSE revisits its initial planning throughout each financial year in response to emerging trends in expenditure and external, sometimes unforeseen, events. In November 2023, it asked NHS systems to take steps to help manage the financial and operational pressures created by industrial action. This followed an agreement with the government to allocate an additional £800 million to NHS systems, and to reduce targets for elective activity for the rest of the year. NHSE gave NHS systems two weeks to reprofile their financial plans. NHSE also required NHS systems to submit fully developed efficiency plans, elective plans that focused on improving productivity, and to identify new waiting list initiatives. NHSE senior leaders told us that they regretted the frequency with which major in-year reprioritisations of this kind had been occurring in recent years, but noted that this was mainly the result of plans being disrupted unexpectedly.

ICBs' views on financial planning

2.12 ICB senior leaders and finance staff expressed several frustrations to us about NHSE's current financial planning processes.

- Some ICB chief financial officers responding to our survey were concerned that the initial annual planning process put pressure on their ICBs to agree unrealistic plans which relied on savings and assumptions that they knew were unlikely to be delivered. Only five out of 19 survey respondents felt the targets they had agreed with NHSE at the start of 2023-24 were realistic and achievable at the time they were set, while 13 respondents felt this was not the case. ICB finance staff also told us that the subsequent – and in their view inevitable – need for in-year funding top-ups from NHSE damaged their professional credibility.

- In our case studies, senior ICB leaders said that lateness and the annual nature of most NHS spending decisions reduced their ability to spend new funding effectively or to transform how current funding is spent. ICBs were supposed to have more autonomy in determining how to allocate resources locally compared to predecessor NHS structures, including more freedom to shape future local health services. There was general agreement that achieving service transformation was harder because of tight funding. But those we spoke to also said NHSE's approach to planning and governance further reduced their real-world autonomy. NHSE considers the control that it exerts to be an unavoidable consequence of needing to deliver overall financial balance.

- Several ICB staff raised issues about the one-off and short-term funding pots which NHSE makes available for ring-fenced purposes, sometimes midway through financial years. In 2023-24, this included £1 billion to support capacity in urgent and emergency services, £250 million of capital investment, £200 million to increase ambulance hours, and £300 million to support discharges from hospitals. Some chief financial officers responding to our survey criticised the inflexibility of such pots, noting that the national priorities attached to them did not always match local needs. Some would prefer additional funding to be made available without such detailed constraints.

- ICB senior leaders and finance professionals repeatedly raised capital funding as an issue. They particularly criticised the short deadlines they sometimes faced when making applications for capital funding. This made it harder to spend the investment effectively and placed additional pressure on finance teams.

2.13 More fundamentally, some ICB leaders said their ability to improve local healthcare would be helped by longer-term certainty of funding, and they would prefer to agree multi-year budgets with NHSE. NHSE previously gave multi-year allocations and indicative allocations to Clinical Commissioning Groups (the bodies that ICBs replaced in July 2022) and NHS trusts between 2016-17 and 2020-21, following confirmation from the government of a five-year NHS funding settlement. The COVID-19 pandemic then led to the government taking an alternative approach, with NHS funding settlements subsequently being agreed for shorter periods of either six or 12 months and allocations correspondingly being set for shorter timeframes. However, in 2021, NHSE set capital allocations for three years and in 2022, it published revenue allocations to cover 2022-23 to 2024-25 after agreeing a two-year funding settlement with the government. DHSC told us that guaranteeing longer-term budgets to ICBs would be challenging given the budget-setting process maintained by HM Treasury and the need to maintain flexibility for unexpected challenges.

Identifying and supporting bodies in financial difficulties

2.14 ICBs, which have only existed on a statutory basis since July 2022, continue to vary in terms of financial maturity and capability. NHSE is responsible for oversight of ICBs and NHS providers and may provide targeted support for individual organisations if it feels this is needed.

2.15 NHSE monitors NHS systems in several ways. Overall, its analysis is that there is a link between an NHS system's current financial and wider performance and the extent to which NHS bodies within it collaborate between themselves and with other local partners. NHSE receives regular monthly returns reporting information about year-to-date positions on key financial and operational areas. This is reviewed by NHSE regional teams and aggregated monthly in reporting packs that are shared with DHSC. If reports highlight significant variance from planned positions, it may prompt NHSE to provide additional support or intervene directly in an NHS system.

Oversight framework

2.16 Based on its monitoring, NHSE assigns each ICB and provider trust a classification in its oversight framework (**Figure 7** overleaf). This classification is scaled from one to four, with one indicating exemplary performance and four indicating the need for mandated support from NHSE via its Recovery Support Programme (RSP). NHSE consulted on updates to its oversight framework between May and June 2024.

Figure 7

NHS England's (NHSE's) oversight framework for Integrated Care Boards (ICBs) and NHS trusts

NHSE's oversight framework classifies organisations into four categories

Classification	Criteria for ICBs	Criteria for trusts	Scale and nature of support needs
1	Consistently high performing across all oversight themes. Well-developed capability and capacity to deliver the statutory and wider responsibilities of an ICB.	Consistently high performing across national oversight themes. Play an active leadership role in supporting and driving key local place-based and ICB priorities.	No specific support needs identified. Trusts are encouraged to offer peer support. ICBs can direct improvement resources to support places and organisations, or co-design support packages.
2	Still developing, but demonstrating many characteristics of an effective ICB. System partners support plans to address areas of challenge.	System partners support plans to address areas of challenge. Targeted support may be required to address specific identified issues.	Flexible support delivered through peers, clinical networks, the NHSE universal support offer, or bespoke support through a regional improvement hub.
3	Significant support needs against one or more oversight theme Considerable gaps in the capability and capacity needed to deliver the statutory and wider responsibilities of an ICB.	Significant support needs against one or more national oversight theme. In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts).	Bespoke mandated support, potentially through a regional improvement hub, drawing on relevant local and national expertise.
4	Very serious, complex issues becoming critical quality and/or finance concerns that require intensive support.	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts), with very serious, complex issues becoming critical quality and/or finance concerns requiring intensive support.	Mandated intensive support through the Recovery Support Programme.

Notes

1 All ICBs and trusts are assessed against five national themes reflecting the ambitions of the 2019 *NHS Long Term Plan*: quality of care, access, and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability. ICBs are also assessed against a sixth theme, local strategic priorities, which evaluates their contribution to the local priorities of their wider Integrated Care System.

2 The Recovery Support Programme aims to provide focused, intensive support that is coordinated between ICBs and regional and national NHSE teams.

Source: National Audit Office analysis of NHS England information

2.17 Organisations in the RSP receive mandated additional support, which is agreed by NHSE regional teams and delivered by its national team or, where NHSE considers it appropriate, from an external third party such as a management consultancy. Mandated support includes allocation of an improvement director, increased oversight and monitoring by NHSE, additional scrutiny of senior appointments, plans and expenditure, and enhanced reporting requirements and financial controls.

2.18 As of March 2024, NHSE assessed that three ICBs needed mandated support, a reduction on the five that it assessed as needing such support in July 2022. Two of the current ICBs (along with their predecessor bodies) in the RSP have been in the programme since its launch in 2021, for shared reasons of financial deficits and performance in urgent and unscheduled care. NHSE also continues to use the RSP to support individual trusts that are in difficulty. As of June 2024, it was supporting 21 trusts, seven of which had been part of the RSP since 2021. This may indicate some ICBs and trusts have underlying structural issues beyond the scope of support that NHSE can provide.

ICBs' views on NHSE support

2.19 ICB senior leaders and finance professionals had mixed views on NHSE's support. Nine of the 19 respondents to our survey of ICB chief financial officers had received some form of support; of these, five respondents found this at least somewhat useful and four did not. We heard positive reports about NHSE national teams being open to engaging with NHS systems and about their willingness to provide input and perspective during planning, and about experienced professionals within NHSE regional teams being available to help NHS systems manage their finances. However, others questioned the added value of the support they received beyond re-identifying issues they already knew needed addressing. One NHS system appreciated the support received but felt it had not made a difference due to the scale of challenge it faced.

2.20 An evaluation of the RSP in 2023 by the National Institute of Healthcare Research concluded that the RSP takes a more facilitative and sustainable approach to organisational improvement compared with previous national support programmes. However, it recommended the RSP required more transparent and standardized entry and exit criteria, metrics to determine segmentation decisions, and methods for assessing organisational capacity and capability. It stated that, once developed, these should be used consistently, and communicated openly, to ensure accountability, organisational memory, public and staff's acceptance and trust in the process, and to benchmark progress.

Part Three

Performance, productivity and efficiency

3.1 This part of the report examines the NHS's performance in key areas and the progress NHS England (NHSE) has made in understanding and improving the productivity and efficiency of services.

Performance in key recovery areas

3.2 NHS performance standards in terms of accessibility, quality and choice for patients are summarised in the *NHS Constitution* and key objectives are set out in planning guidance for organisations delivering NHS services. NHS service providers may have more specific indicators and operational standards in their contracts with NHSE and commissioners. For providers of non-primary care services, the NHS standard contract specifies national requirements, such as accident and emergency (A&E) waiting times, ambulance response and handover times, and urgent and community health response. The standard of service that the NHS provides to patients is a vital determinant of how well it is spending its funding. The following sections are not exhaustive, but instead provide information about the recent performance of key NHS services.

Acute services

3.3 The NHS last met its official target for 95% of A&E patients to be admitted, transferred or discharged within four hours of arrival in July 2015. The government's January 2023 *Delivery plan for recovering urgent and emergency care services* created an interim target to improve performance to 76% in March 2024, from a low of 65.2% in December 2022. This ambition was not met, but performance improved by March 2024, with 74.2% of patients being dealt with within four hours.

3.4 Ambulance response times have also deteriorated in recent years. The urgent and emergency care recovery plan created an interim target to improve response times for Category 2 ambulance incidents (these are emergency call-outs and include, for example, suspected strokes), so responses happened within an average of 30 minutes during 2023-24. This was compared to a high of 50 minutes throughout 2022-23, and the national constitutional standard of 18 minutes. The most recent data indicate an average of 36 minutes and 23 seconds in 2023-24, a significant year-on-year improvement, but still more than double what patients should have to wait.

Elective services

3.5 The number of patients waiting to start treatment following a referral has increased since 2010 apart from a lockdown-related decline in early 2020. Since April 2013, NHS regulations have included 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. The NHS last achieved this standard in February 2016 and only 58% of patients started treatment or were seen by a specialist within 18 weeks in April 2024 (**Figure 8** on pages 36 and 37). Around 3.2 million patients had waited for more than 18 weeks in April 2024, compared to 0.3 million in February 2016.

3.6 The government's February 2022 *Delivery plan for tackling the COVID-19 backlog of elective care* set out ambitions to eliminate:

- two-year waits by July 2022;
- 18-month waits by April 2023;
- waits longer than 65 weeks by March 2024; and
- waits longer than a year by March 2025.

3.7 The number of patients waiting to start treatment is down from the peak of September 2023, but performance is still outside the targets set for long waiters in the recovery plan.[10] The total number of patients waiting to start treatment in January 2020, prior to the COVID-19 pandemic, was 4.6 million (**Figure 9** on page 38). Numbers reached a peak of 7.8 million in September 2023 and then fell to 7.6 million in April 2024, of which:

- 275 waited longer than two years;
- 4,738 waited between 18 months and two years;
- 45,384 waited between 65 weeks and 18 months; and
- 252,192 waited between a year and 65 weeks.

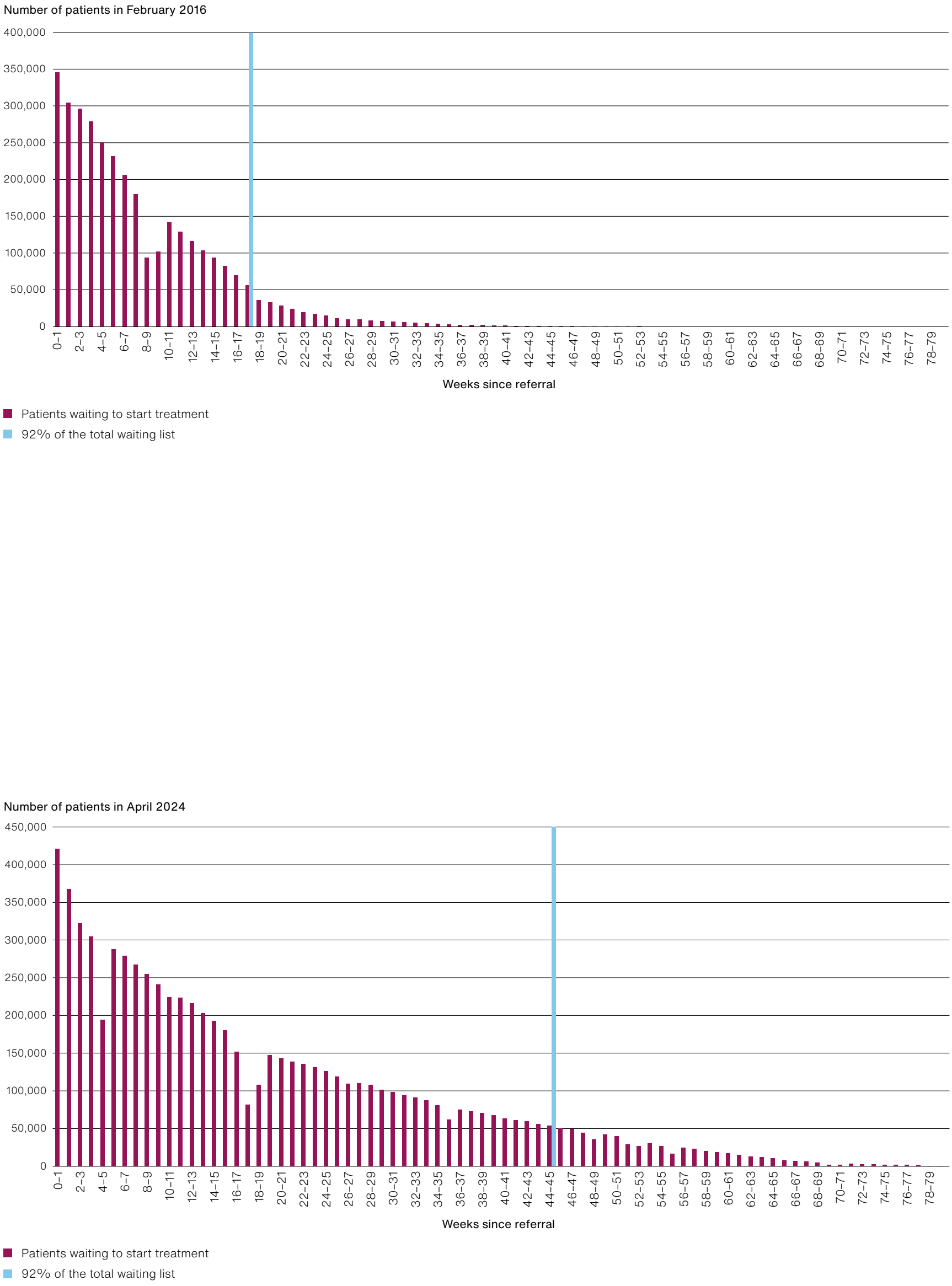
For comparison, just before the pandemic, in February 2020, there were only 1,600 patients waiting one year or longer for elective care.

10 The elective care system counts the number of pathways which have started but not yet completed, rather than the number of people. Patients may be on more than one elective pathway, so the total number of individuals will be lower than the number of incomplete pathways. NHSE estimated that the elective care waiting list of 5.6 million pathways in July 2021 comprised around 4.9 million waiting individuals. Throughout this report, we follow the convention of referring to 'the number of patients' on the elective waiting list because of uncertainty over how the ratio of pathways to patients may have changed over time.

Figure 8

Comparison of the elective waiting list in February 2016 and April 2024

Waiting times for elective care have increased since the statutory requirement for 92% of patients to wait less than 18 weeks was last met in February 2016; in April 2024, 92% of patients waited less than 45 weeks



Note

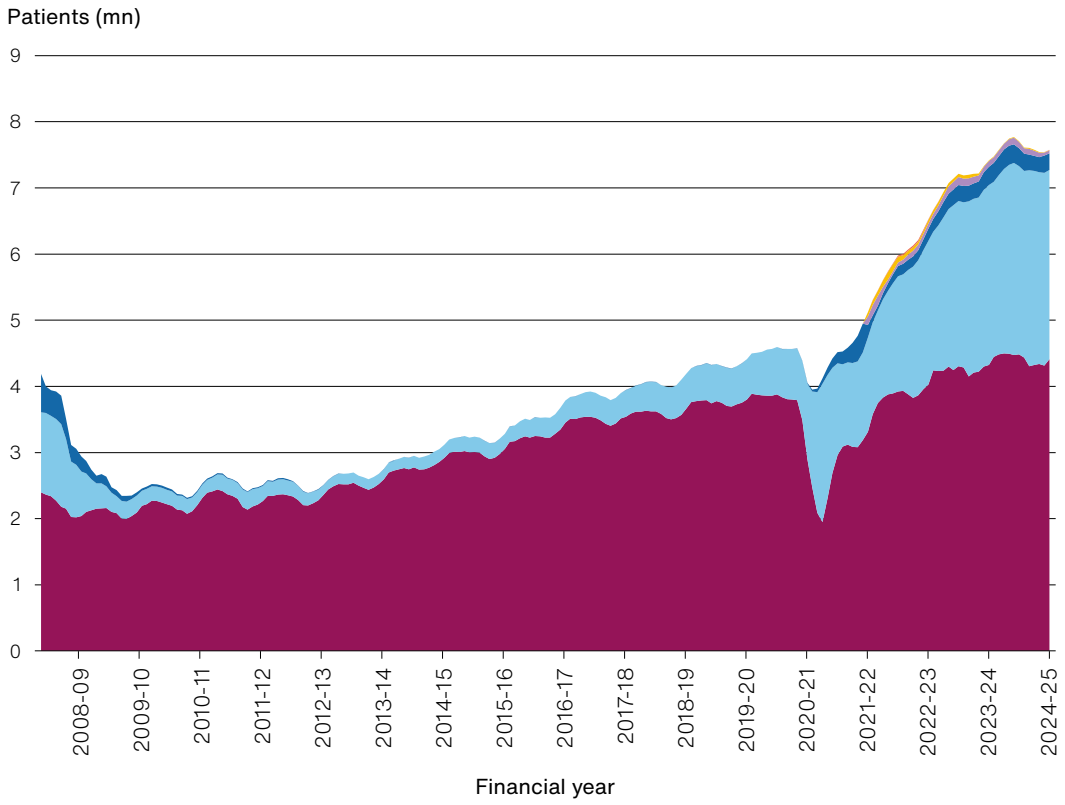
1 NHS regulations include a statutory requirement for 92% of patients on the waiting list to start treatment (or be seen by a specialist and leave the waiting list) within 18 weeks.

Source: National Audit Office analysis of NHS England data

Figure 9

Waiting times from referral to treatment in England, August 2008-09 to April 2024-25

The number of patients waiting to start treatment reached a record high of 7.8 million in September 2023



- Within 18 weeks
- Between 18 weeks and one year
- Between one year and 65 weeks
- Between 65 weeks and 18 months
- Between 18 months and two years
- Longer than two years

Notes

1 The data show waiting times for patients waiting to start treatment at the end of a month.

2 Data collection was expanded in April 2021 to provide more detail on waits longer than 52 weeks; this detail was not collected prior to this date.

Source: National Audit Office analysis of NHS England data

3.8 On cancer care, the elective care plan aimed to reduce the number of people waiting more than 62 days following an urgent referral to pre-pandemic levels by March 2023. NHSE has previously stated that this was equivalent to 14,266 patients and this initial target is yet to be met, with 14,916 waiting longer than 62 days in March 2024. Because of the high level of demand since the pandemic, NHSE subsequently changed the target from an absolute number to one based on an estimated proportion of the waiting list. This had the effect of revising the target for 2023-24 up to 18,755. On this basis, NHSE considers the target has now been met. The elective care plan also aimed by March 2024 for 75% of patients suspected of having cancer to have a diagnosis or cancer ruled out within 28 days. This aim was met in February and March 2024, but not in April 2024.

3.9 In January 2024, the Comptroller and Auditor General issued a qualified opinion on the Department of Health & Social Care's (DHSC's) 2022-23 accounts in three respects, one of which was because the department allowed NHS trusts to retain funding intended to incentivise elective recovery, despite elective care targets being missed. NHSE reduced elective activity targets during 2023-24 to release additional funding for Integrated Care Boards (ICBs) and take account of the impact industrial action had on the amount of activity that they could undertake.

Productivity

3.10 Productivity is a measure of the output (for example, a good or service) achieved for a given set of inputs (for example, people, money, equipment). NHS productivity has generally improved since 1996-97.

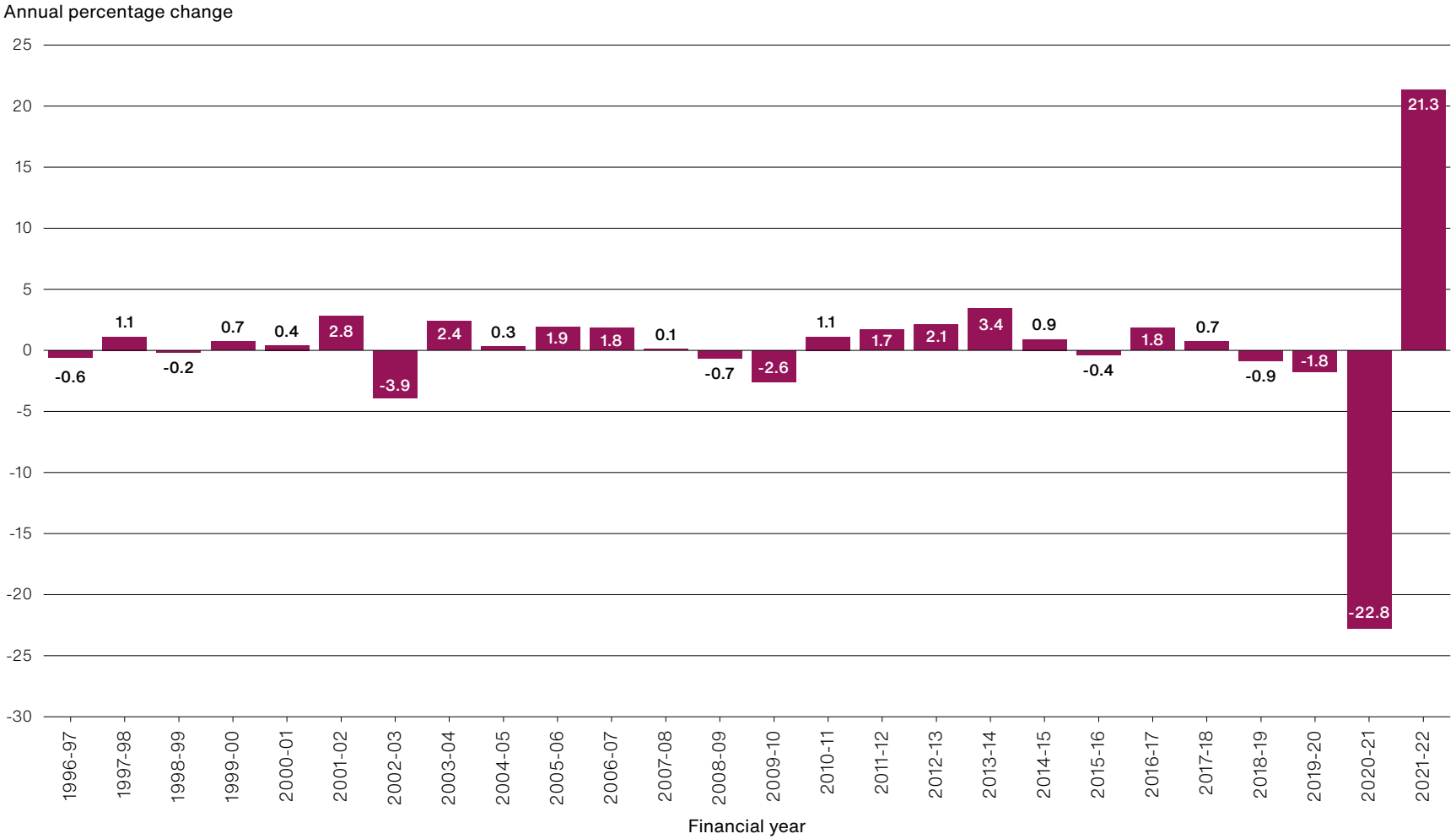
3.11 According to official measures, NHS productivity declined during the pandemic and has not fully recovered. The Office for National Statistics (ONS) produces a time series of productivity changes in healthcare in England. Long-term productivity gains before the pandemic (1996-97 to 2018-19) averaged around 0.6% annually (this is a non-quality adjusted figure).[11] However, productivity declined after 2017-18 before reducing by around 23% in 2020-21 as the NHS responded to the pandemic, postponing many elective surgeries and other healthcare to treat COVID-19 patients (**Figure 10** overleaf). The reductions in output during the pandemic came at a time when NHS staff numbers and resources were increasing.

11 The ONS produces quality-adjusted measures of public service productivity in the five areas of healthcare, education, public order and safety, children's social care and adult social care, alongside non-quality adjusted measures. Quality-adjusted measures intend to account for changes in outcomes achieved as well as any changes to outputs.

Figure 10

Annual percentage change in public service healthcare productivity, 1996-97 to 2021-22

Total healthcare productivity decreased sharply during the first full year of the COVID-19 pandemic



Notes

1 The Office for National Statistics produces quality-adjusted measures of public service productivity in the five areas of healthcare, education, public order and safety, children's social care and adult social care, alongside non-quality adjusted measures. Quality-adjusted measures intend to account for changes in outcomes achieved as well as for any changes in outputs.

2 Data show non-quality adjusted values.

Source: National Audit Office analysis of Office for National Statistics data

3.12 In the latest statistics for 2021-22, the total amount of output the NHS is producing had not yet recovered to pre-pandemic levels. 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 ONS's data collection, but for 144% of the inputs (the percentages for quality-adjusted productivity were 137% and 144%). There are other established measures of productivity. York University also measures the productivity of the NHS in England using a different methodology to the ONS. In April 2024, it reported that productivity grew by 14% to 15% between 2020-21 and 2021-22. However, it assessed that productivity in 2021-22 was around 13% lower than in 2019-20, prior to the pandemic. NHSE informed us that its internal analysis suggested productivity in hospital settings improved 1.2% between 2022-23 and 2023-24, although we have not verified these figures.

3.13 There are difficulties with measuring NHS productivity. The size and complexity of the NHS make accurately capturing the totality of its inputs and outputs in a timely manner challenging. The ONS and York University produce authoritative measures, but these are only available annually, at a national level, and following a lag of one to two years. Additionally, NHSE believes that some types of productivity improvement are poorly counted in these metrics, in particular increases in activity outside hospital and in new settings, such as virtual wards. NHSE is in discussions with the ONS about future changes to the measurement approach. We think it is important for there to be robust and widely accepted measures of health productivity, and we look forward to the conclusion of the discussions between NHSE and the ONS. In particular, it is important that efforts to move the healthcare system more towards prevention of serious ill health (paragraphs 4.11 to 4.16) can be measured and credited fairly, so as not to create perverse disincentives for those charged with managing the NHS.

3.14 NHSE and DHSC produce internal productivity measures which are more current, and NHSE has been using these to try to understand the drivers behind recent changes to NHS productivity. In addition to methodological issues, NHSE sees workforce factors (such as the impact of industrial action and increased staff absence) and structural factors (such as depreciation of strategic investments and increased costs for drugs, and education and training) accounting for most of the decrease. Of an overall 16% decrease in acute care productivity since the pandemic, there is only 2.2% that NHSE cannot explain using its existing data and analyses.

3.15 In March 2024, the government announced that the NHS would receive an additional £3.4 billion capital investment for digital improvements between 2025-26 and 2027-28, which included aims to upgrade medical equipment and reduce the time spent by staff on administration. As part of these plans, the NHS has committed to 1.9% average annual productivity growth from 2025-26 to 2029-30, reaching 2% in the last two years. Similarly, in the *NHS Long Term Workforce Plan*, published in June 2023, NHSE stated that annual productivity improvements of 1.5% to 2% would be possible over the plan's 15 years. Both these ambitions are well above the long-term pre-pandemic average, and NHSE recognises that they are ambitious but believes that, with sufficient investment and transformation, they are achievable. NHSE informed us these ambitions assume a period of recovery from the pandemic's impact on productivity as well as further expansion of how productivity is measured. NHSE estimates that 1.9% productivity growth by 2030 can be achieved through improvements to operational and clinical processes (1%), workforce (0.15%), by delivering equivalent care in lower cost settings (such as moving services from primary to community care) (0.1%), and in technology and digital areas (0.65%). These are initial estimates, and NHSE is carrying out further detailed work. As we note in Part Four, appropriate capital investment will also be needed to achieve productivity growth (paragraph 4.21).

Efficiency

3.16 The January 2019 *NHS Long Term Plan* aimed to achieve the greatest possible value from every pound of taxpayer's investment. To increase the NHS's focus on efficiency, the government sets targets. In 2022-23, the government doubled the NHS's annual efficiency savings target from 1.1% to 2.2%, with the aim of releasing £4.75 billion for priority NHS areas over the following three years. This target was substantially higher than what the NHS had achieved historically. NHSE's own analysis indicates that, between 2008-09 and 2017-18, NHS trusts' average annual efficiency improvement was only 0.9% each year.

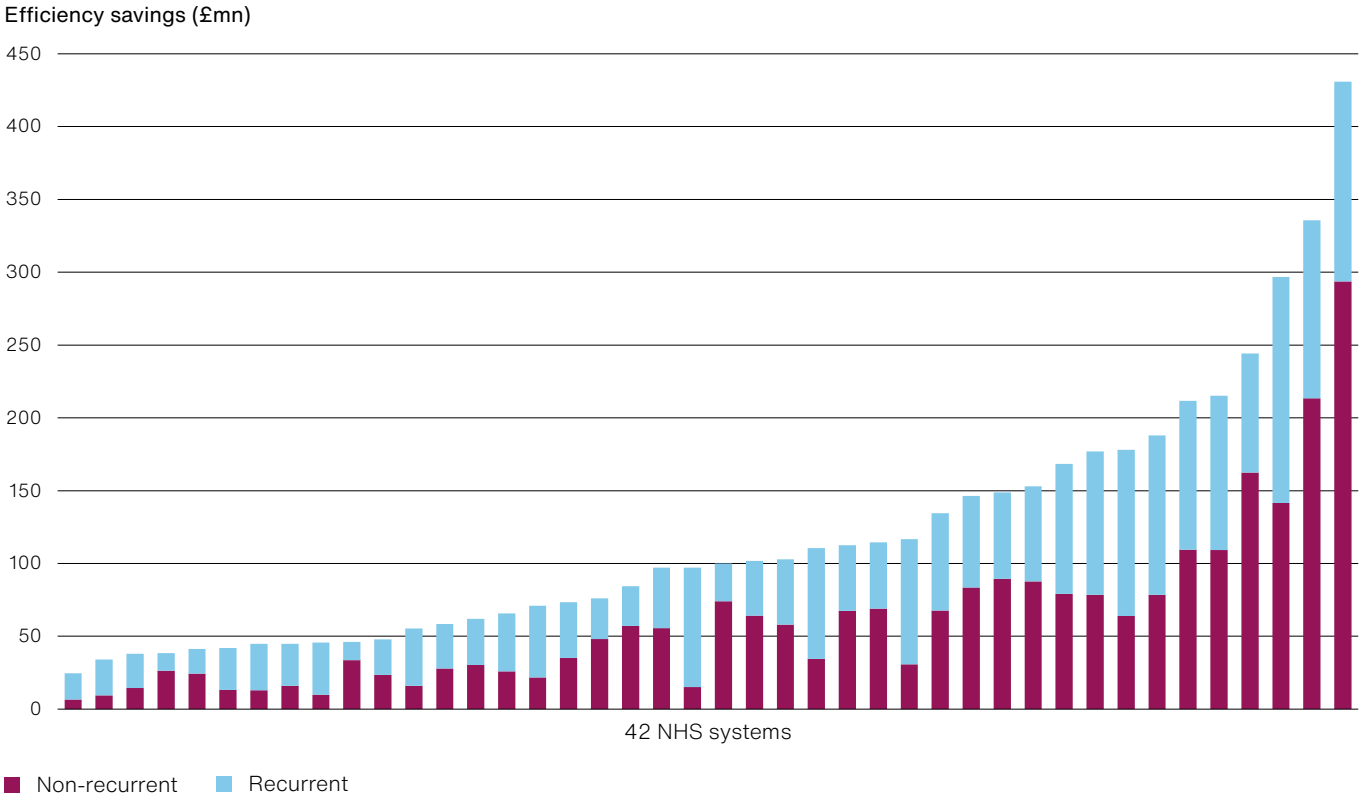
3.17 In 2022-23, NHSE reported that NHS systems surpassed the 2.2% efficiency target, freeing up funding worth £5 billion (4.2% of their total funding allocation) to spend on priority areas. This means the targeted three-year saving of £4.75 billion was surpassed in just one year. In 2022-23, the NHS was facing significant operational pressures such as industrial action and inflation. However, NHS systems may have been able to report higher levels of efficiency than previously because they were withdrawing funding from some pandemic-related activities. Of the 2022-23 savings, £1.4 billion was achieved by ICBs and £3.7 billion was achieved by NHS trusts.

3.18 It is important to note that just over half of the efficiencies were non-recurrent. This means they involved one-off reductions in spending (which was then re-allocated to other purposes), rather than recurrent savings which reduce expenditure on an ongoing basis. New sources for such savings must be found in future years. Of the £5 billion, £2.6 billion (51.9% of the total) was non-recurrent, while £2.4 billion (48.1%) was recurrent (**Figure 11**).

3.19 In 2023-24, NHSE again required NHS systems to achieve efficiencies significantly above the 2.2% target, to free up funding worth £7.9 billion, equivalent to 6.7% of the total funding allocation for NHS systems. NHSE reported that in 2023-24 NHS systems had delivered £7.3 billion of these savings, equal to 6.2% of their total funding allocation. This was £600 million lower than planned, but £2.3 billion higher than was achieved in 2022-23. We have not carried out a detailed analysis of the efficiencies NHS systems made as this is beyond the scope of this report.

Figure 11
NHS systems' recurrent and non-recurrent savings in 2022-23

A significant proportion of the savings achieved by NHS systems in 2022-23 was non-recurrent



Note

1 'NHS systems' refers to commissioning Integrated Care Board bodies and the constituent NHS trusts and foundation trusts within their Integrated Care System area.

Source: National Audit Office analysis of NHS England data

Part Four

Long-term financial sustainability

4.1 This part of the report examines factors that will influence the financial sustainability of the NHS in the longer term. It considers:

- trends in demand for NHS services;
- actions to mitigate demand; and
- the wider determinants of NHS sustainability.

Long-term trends in activity and demand for health services

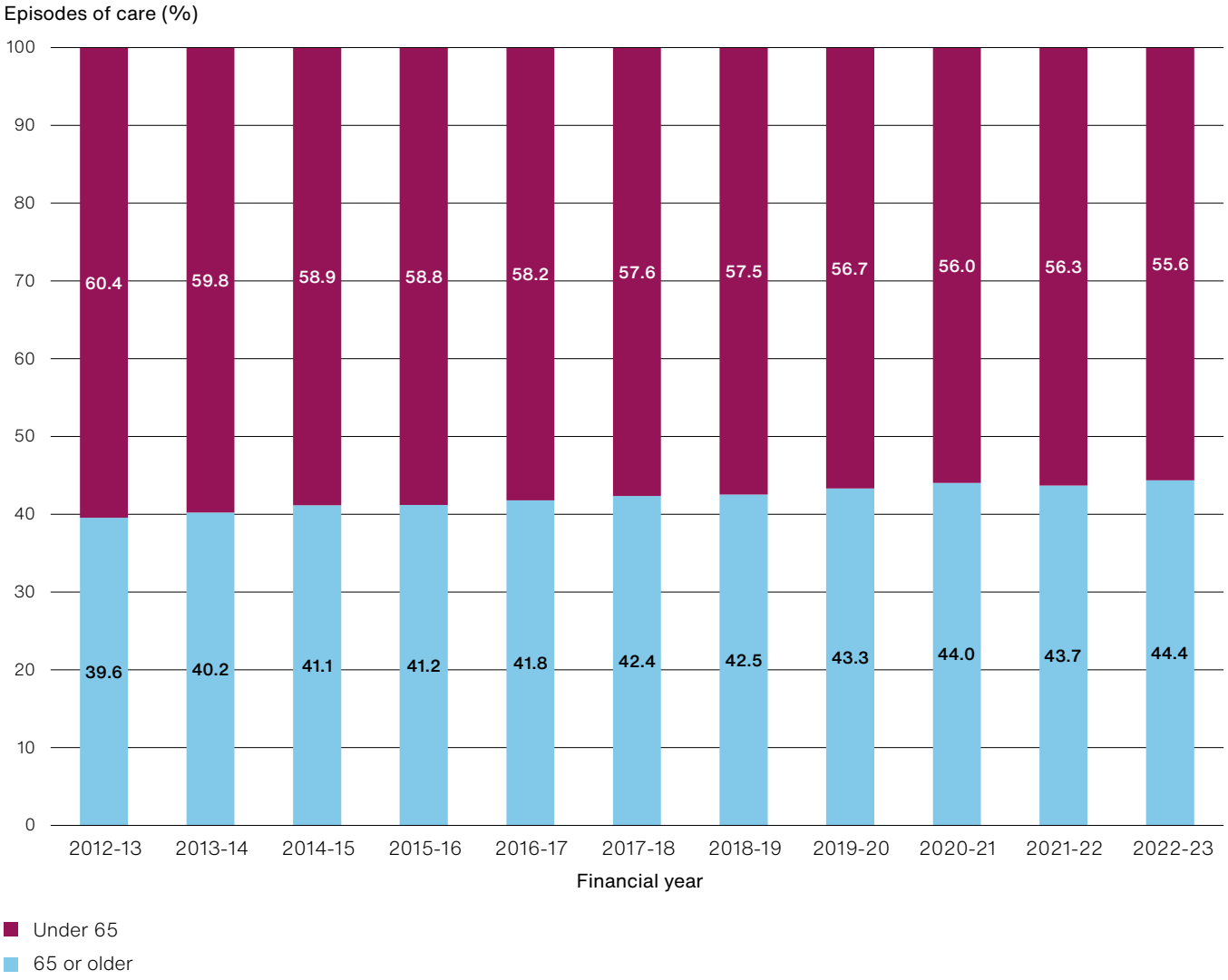
Hospitals

4.2 Admissions to hospitals were increasing in the years leading up to the COVID-19 pandemic, from 15.5 million in 2013-14 to a record 17.2 million in 2019-20. They fell sharply to 12.8 million in 2020-21 but have since climbed back toward pre-pandemic levels with 16.4 million in 2022-23, representing an increase of 400,000 over 2021-22. Rising hospital admissions provide an indication that the level of demand for care is increasing (though, like other measures of NHS activity, they do not give a complete picture because of the healthcare demand that the NHS is not able to meet, or the demand met by hospitals without admitting the patient). One hospital admission may include multiple episodes of care under different consultants. Looking at these episodes can tell us about the changing nature of the demand the NHS is facing. Over the last decade, episodes of care for patients aged 65 or older increased from 7.0 million in 2012-13 to 8.8 million in 2022-23, a rise of 26% compared with an increase of just 3.4% for those under 65 (from 10.7 million to 11.0 million). The proportion of episodes attributable to patients aged 65 or over has steadily increased, from 39.6% in 2012-13 to 44.4% in 2022-23 (**Figure 12**), and the average age of a patient receiving care in hospital increased from 52 years to 55 years over the same period.

Figure 12

Proportions of hospital episodes of care for patients under 65 and 65 or above, 2012-13 to 2022-23

The proportion of episodes of care in hospitals attributable to patients aged 65 or above has increased over the last 10 years



Source: National Audit Office analysis of NHS Digital data

4.3 The NHS had 103,843 general and acute beds in its hospitals in quarter four of 2023-24. This represents an increase of 2,245 since the start of the COVID-19 pandemic. The utilisation of these beds matches previous record levels at 92.6% in the fourth quarter of 2023-24. NHS England (NHSE) considers that, nationally, 92% bed occupancy is the tipping point beyond which accident and emergency (A&E) performance can be adversely affected. In July 2023, NHSE estimated that, without intervention to change current trends, growth in demand will result in the NHS requiring around 133,000 general and acute beds by 2036-37. This would mean the NHS needing around an extra 29,000 general and acute beds by 2036-37 when compared with the beds available in quarter four of 2023-24.

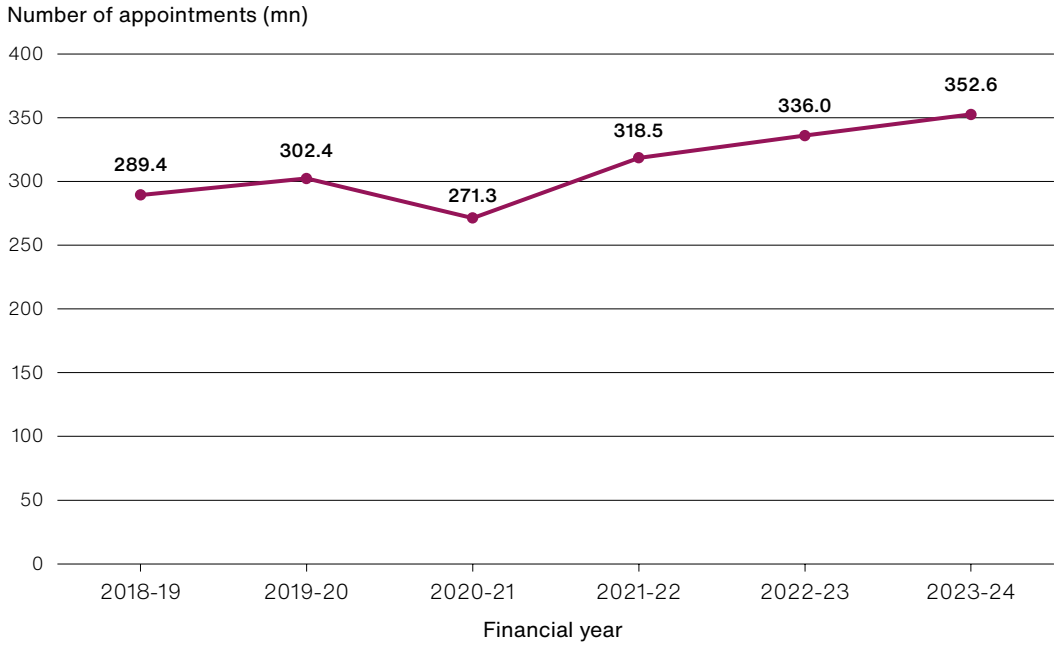
Primary care

4.4 This has been a time of great change for GPs, with many more consultations now provided by telephone or online. This is in line with NHSE's vision for a digital health and social care service and the Department of Health & Social Care's (DHSC's) plan to recover access to primary healthcare. The provision of GP appointments had increased prior to the COVID-19 pandemic, with 302.4 million appointments provided in 2019-20 compared to 289.4 million in the previous year (**Figure 13**). Numbers of appointments fell to 271.3 million in 2020-21 but then quickly surpassed pre-pandemic levels, rising to a record 352.6 million in 2023-24.

4.5 Nonetheless, there are indications of growing patient dissatisfaction with the GP appointments they are offered. The Office for National Statistics (ONS) Opinion and Lifestyle Survey, between May 2023 and May 2024, reported that on average 43% of people found it very easy or easy to contact their GP but 34% found it very difficult or difficult. The January to April 2023 GP Patient Survey highlighted that patients are finding it harder to see their preferred GP at their preferred times. In 2023, 65% of patients reported only seeing their preferred GP 'some of the time or never', up from 52.0% in 2019. In 2023, 26% of patients were dissatisfied with the GP appointment times available to them, up from 18% in 2019. This may reflect difficulties in providing choice of appointments.

Figure 13
GP appointments provided in England, 2018-19 to 2023-24

Appointments provided by GPs rose to record levels in 2023-24



Source: National Audit Office analysis of NHS Digital data

Urgent care

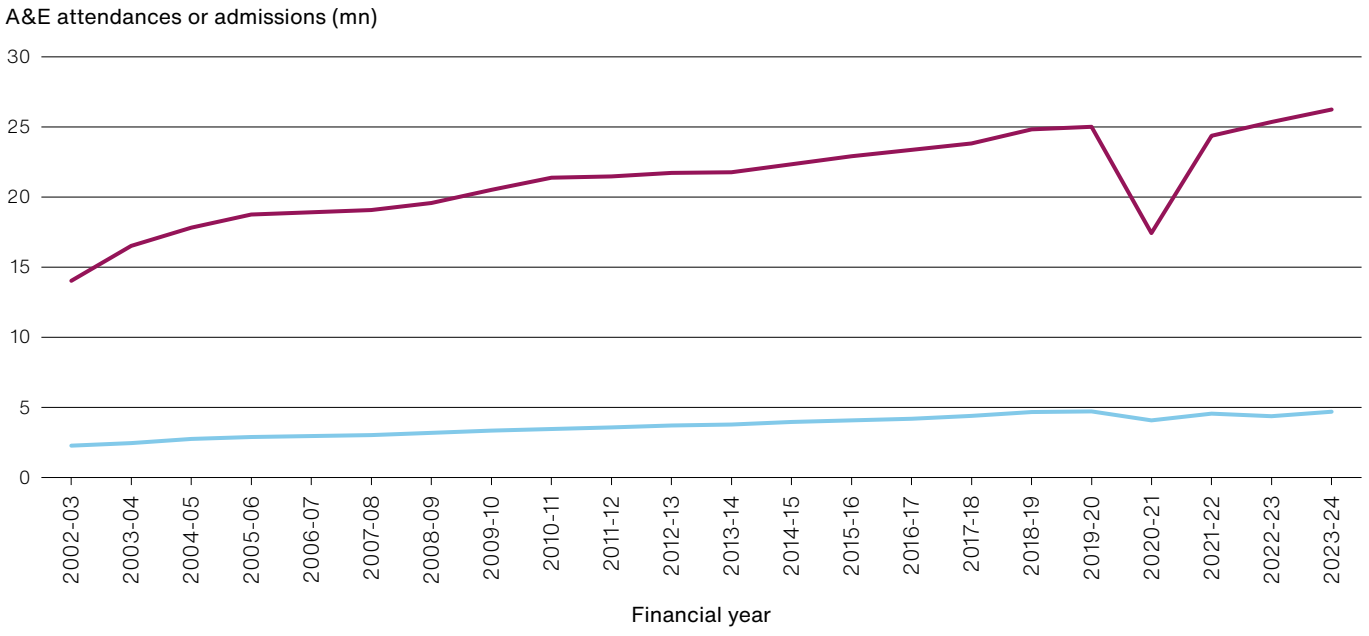
4.6 Attendances and emergency admissions to A&E rose continuously from the start of current data collection in 2002-03 until the onset of the COVID-19 pandemic, with attendances reaching 25.0 million and admissions reaching 4.82 million in 2019-20 (**Figure 14**). Both attendances and admissions declined sharply in 2020-21 but have risen since. The most recent data show a record 26.2 million attendances in 2023-24, while the 4.78 million admissions was close to the 2019-20 record. Despite increasing levels of activity and provision, A&E patients are having to wait longer to be seen (paragraph 3.3), indicating that demand may be increasing ahead of available capacity.

4.7 Calls to NHS 111 reached a record 23.2 million in 2021-22 and the most recent data show they were still close to this level with 22.3 million calls in 2022-23. Numbers of ambulance incidents have fluctuated since 2018-19, peaking at 8.9 million in 2021-22. The most recent data show 8.6 million incidents in 2023-24.

Figure 14

Accident and emergency (A&E) attendances and admissions, 2002-03 to 2023-24

Attendances reached record levels in 2023-24 and admissions were close to the previous record



Note

1 'Attendance' refers to anyone who comes to an A&E department unplanned. 'Admission' refers to when a patient is admitted to hospital on an urgent basis in response to an emergency.

Source: National Audit Office analysis of NHS England data

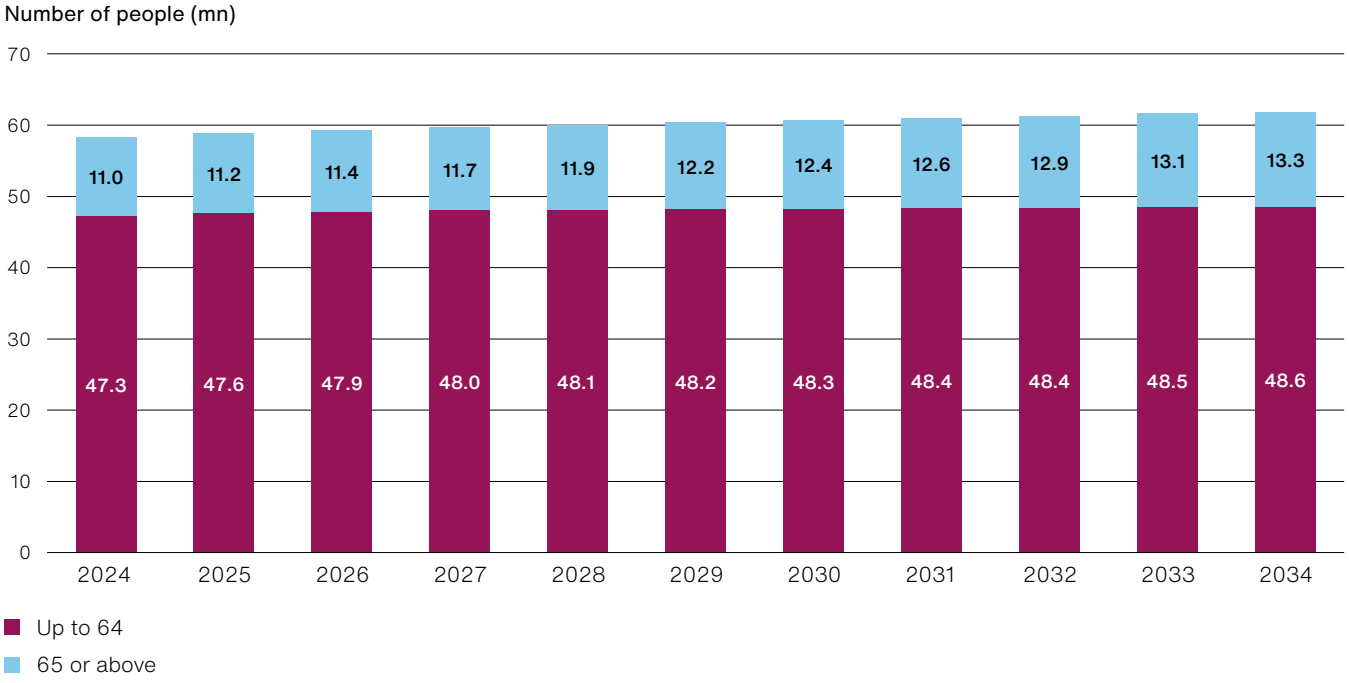
Demographic growth

4.8 The population in England is increasing and becoming older. The Office for National Statistics (ONS) estimates the population at 58.3 million in 2024 and projects it to grow by 3.6 million to become 61.9 million by 2034. Most of this growth is accounted for by a predicted 2.3 million increase in people aged 65 or over (**Figure 15**).

4.9 An established body of evidence links increasing age with a greater likelihood of multiple chronic, complex, or long-term health conditions. Stakeholders we spoke to, and other commentators, consider that the changing population demographics of England will lead to significant additional demand for healthcare, with people potentially living longer and spending an increasing portion of their lives in poor health.

Figure 15
Projected change in England population, 2024 to 2034

People aged 65 or above are predicted to account for 2.3 million of an overall 3.6 million population increase from 2024 to 2034



Note
1 Based on projections published in January 2024.

Source: National Audit Office analysis of Office for National Statistics data

4.10 People over 65 are already responsible for the majority of acute spend and activity in hospitals, accounting for 50% of non-elective admissions and 67% of occupied bed days. NHSE forecasts two-thirds of those over 65 will have multiple health conditions by 2037, based on current trends. More widely, the Health Foundation projects the number of people diagnosed with major illness will be 9.3 million by 2040 compared with 6.7 million in 2019, an increase of 39%.[12] Over the same period, the ONS projects that the population will increase by just 13.1%.

Managing demand

4.11 The government has a long-standing aim to move the health system more towards preventing ill health, rather than treating it, to help manage continually rising demand for services. Shifting from treatment towards prevention aims to achieve better outcomes for citizens in the long term by delaying, shortening, or avoiding periods of ill health, in addition to potentially freeing up NHS funding and resources or reducing the rate at which they would otherwise have to grow. Our 2020 report on financial sustainability found the NHS was treating more patients but had not yet achieved the fundamental transformation in services and finance regime needed to meet rising demand.

4.12 Actions to strengthen the NHS's contribution to prevention were an important component of the 2019 *NHS Long Term Plan,* and earlier intervention to prevent ill health is one of five service transformations in NHSE's current medium-term strategy. NHSE has ongoing national clinical prevention programmes, addressing issues including diabetes and tobacco addiction. The budgets for these totalled £156.6 million in 2023-24, including £85.2 million for long COVID treatment services. This is a significant increase. In 2020-21, NHSE allocated £43 million for national and regional prevention schemes. As well as these national programmes, the NHS aims to support people staying healthy through routine activities such as delivering vaccines and screening, and through advice from GPs and pharmacists.

4.13 The government's establishment of Integrated Care Systems (ICSs) on a statutory basis in 2022 was intended to provide greater impetus towards prevention by bringing NHS organisations and wider partners together to plan the best way to meet the health needs of local populations. Since their creation, Integrated Care Boards (ICBs) and Integrated Care Partnerships within ICSs have fulfilled their statutory obligation to produce Joint Forward Plans and Integrated Care Strategies for their areas. DHSC instructed them to consider prevention aims in these documents.

12 The Health Foundation, *Health inequalities in 2040: current and projected patterns of illness by deprivation in England,* April 2024.

4.14 Our 2022 report on the introduction of ICSs noted that, while 77% of senior ICS staff we had surveyed (229 of 298 responses) reported their organisation intended to invest in prevention, only 31% (91 of 298 responses) felt they had capacity to do so at the time.[13] Our fieldwork with ICBs for this current report, both case study visits and written responses to our survey of chief financial officers, indicated that many felt the situation had not changed. The most important reason for this was the current focus on other pressing national priorities – elective care recovery and A&E and ambulance services, in particular. At a time when overall funding is falling in real terms, this meant ICSs did not have the 'headroom' to grow preventative services and transform service design as much as they might have wanted to. Our 2022 report highlighted the inherent tension in ICSs between meeting national targets and addressing local needs, noting that, in the context of financial, workforce and wider pressures, ICSs may find it challenging to fulfil the high hopes stakeholders had for them.

4.15 NHSE does not track spend and activity on prevention by ICBs at local levels due to limitations on the availability and granularity of data, in addition to a lack of consistency across ICBs about what counts as prevention activities. This means it does not have a full and complete understanding of ICBs' contribution to wider prevention aims, and also makes it hard to be sure about how preventative healthcare spending is changing.

4.16 DHSC funds prevention activities that sit outside the NHS, primarily through its Office for Health Improvement and Disparities (OHID), and through the UK Health Security Agency, vaccines, and other areas. DHSC estimates the budgets for these activities in OHID totalled £3.9 billion during 2023-24, including £3.3 billion passed to local authorities for the Public Health Grant. DHSC estimates that budgets for similar activities in 2024-25 will increase funding by £239.8 million to £4.2 billion. These figures are indicative because, similarly to NHSE, DHSC does not currently have a precise definition of what counts as prevention spending.

Wider determinants of NHS sustainability

Wider government

4.17 The NHS considers that clinical interventions are only responsible for around 20% of health outcomes and a wide range of factors beyond health and care services affect individual health and wellbeing. While the NHS can take steps to prevent existing health conditions from materialising or deteriorating, other government departments can also help prevent ill health from occurring through policies that influence individual behaviour and the wider environment. The government can influence many factors such as diet, exercise, health education, and air quality. Improving health outcomes and the longer-term sustainability of the NHS relies on sustained joined-up working across government.

13 Comptroller and Auditor General, *Introducing Integrated Care Systems*, Session 2022-23, HC 655, National Audit Office, October 2022.

4.18 Currently, DHSC engages wider government in several ways. Significant proportions of the £3.9 billion funding it provided in 2023-24 for prevention outside of NHS budgets (paragraph 4.16) was passed to other parts of government. In addition to £3.3 billion passed to local authorities for the Public Health Grant, this included funding from other departments to support drug offenders, physical activities in schools, and for early years development. As part of the government's Levelling Up mission on health, DHSC has established a working group to coordinate activity on a wide range of issues relating to health. The attendees of the working group represent a range of government departments. During 2023, it facilitated senior cross-government engagement to develop DHSC's major conditions strategy. DHSC also launched a call for evidence in autumn 2023 on possible changes to legislation to make it easier to pool budgets between NHS bodies and local authorities to support integrated care.

Local government

4.19 Local authorities are responsible for aspects of public and environmental health and play an important part in many of the non-clinical factors impacting health at local levels, such as housing, employment, and family or social support. There are also well-established critical dependencies between local authority adult social care services and health services. The *Health and Care Act 2022* gave local authorities equal responsibility with NHS organisations to plan health strategies for their local populations, including addressing wider determinants of health and wellbeing. However, local government stakeholders we spoke to, including the Local Government Association and the Chartered Institute of Public Finance and Accountancy, noted that ongoing differences in accountability arrangements and misaligned strategic objectives have made progress with joint working challenging.

4.20 Local authorities are experiencing significant financial and operational pressures which may constrain their capacity to make meaningful contributions to extending their work on health outcomes in the short and medium term. The government's *2021 Spending Review* committed to maintaining the Public Health Grant paid by DHSC to local authorities for preventative health services in real terms until 2024-25, based on Office for Budget Responsibility forecasts of inflation at the time. However, the grant is expected to fall by £193 million (5.5%) in real terms over the course of the spending review (at 2022-23 prices), reducing councils' ability to spend on public health commissioned services. The real-terms fall in the grant is even greater when considered over a longer timescale, with its value decreasing by £846 million (20.1%) between 2015-16 and 2024-25 (at 2022-23 prices).

Capital investment

4.21 Both DHSC and NHSE told us they recognise the importance of making the most of the capital they receive. NHSE assesses that sustained increases in capital investment are needed to replace ageing equipment, expand capacity to accommodate increased demand, and enable staff to benefit from new technologies, as well as repairing its ageing and deteriorating estate. Such investment is likely to be important for improving NHS productivity in the long term. But demand for capital investment in the NHS continues to outstrip supply and must compete with many other priorities across the public sector. Recent analysis by The King's Fund noted that the UK lagged behind other countries in terms of capital investment in its health system, with the UK spending 0.33% of GDP in 2019 compared with 0.48% for comparable countries in the Organisation for Economic Co-operation and Development.

4.22 NHSE's initial estimate of its capital funding requirements at the start of 2022-23 was some £930 million higher than forecast in the 2021 Spending Review. In 2023-24, the difference from the 2021 Spending Review forecast had risen to £1.5 billion. Capital investment does not always achieve the level of infrastructure originally planned. For example, our report on the New Hospital Programme noted that the programme had encountered cost over-runs and time delays, with a risk that future hospitals would be too small.

4.23 The NHS's current need for capital investment has partly been increased by DHSC's previous failure to invest fully the capital funds it was allocated. Our 2020 *Review of Capital Expenditure in the NHS* noted that DHSC transferred £4.3 billion from capital to revenue funding between 2014-15 and 2018-19, partly to prioritise day-to-day spending for NHS providers whose financial position had deteriorated, but at the cost of forgoing longer-term investment in buildings and other long-term assets. In November 2023, the House of Commons Public Accounts Committee concluded that "the raiding of capital budgets in the recent past is an underlying cause of the estates crisis the NHS is now in". It recommended that DHSC "should not reduce planned capital investment to meet day-to-day spending needs in future".

4.24 In 2022-23, DHSC transferred £0.4 billion from its capital to its revenue budget. This included £140 million from inventory costs for the NHS Test and Trace service, £150 million from DHSC's Living with Covid policy, and £68 million from the New Hospital Programme. In 2023-24, the amount transferred by DHSC more than doubled to £0.9 billion, which included £0.5 billion from capital underspends which was used to address the impacts of NHS pay and industrial disputes, £0.3 billion redirected towards NHS technologies, and £0.1 billion for the New Hospital Programme to cover costs for staff and development work. DHSC informed us that around £315 million of the capital transferred in 2023-24 related to routine capital to revenue switches within the New Hospital and NHS technologies programmes.

NHSE plans for recovery and longer-term sustainability

4.25 Sixteen out of 19 ICB chief financial officers answering our survey about NHS financial management felt there was currently no clear vision of what a financially sustainable NHS would look like in the long term. NHSE has several plans in place to recover and transform NHS services, including the *NHS Long Term Plan,* which pre-dated the COVID-19 pandemic, and more recent plans focused on elective care, primary care, urgent and emergency care, and the NHS workforce.

4.26 While these plans are ambitious, some aspects depend on wider enablers which are subject to significant uncertainties. For example, the fifteen-year *NHS Long Term Workforce Plan* only has £2.4 billion funding confirmed for its first five years to cover training costs, with funding to implement the plan beyond 2028-29 currently unclear. In addition, our recent report on the workforce plan's modelling noted it assumed workforce productivity will improve by 1.5% to 2% per year up to 2036-37, far higher than the ONS's long-term non-quality adjusted productivity average of 0.7% per year (now updated to 0.6% per year) for the wider healthcare system between 1996-97 and 2018-19. These measures are not directly comparable due to methodological differences, and we have previously recommended NHSE should more clearly explain both internally and publicly how its productivity measures relate to ONS national statistics. Our report also noted that the plan's 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.

Appendix One

Our audit approach

Our scope

1 Our independent conclusions on NHS England (NHSE) and the Department of Health & Social Care's (DHSC's) financial management of the NHS were reached by analysing evidence collected between September 2023 and July 2024. The analytical framework underpinning our conclusions examined whether the NHS can manage its current operations with the resources available to it while making progress towards its long-term goals.

2 Our analytical framework comprised four evaluative criteria which considered: the extent the NHS is living within its means following the COVID-19 pandemic; whether the NHS's financial management systems and processes support accurate and timely decision-making; whether NHSE is making effective use of available resources to recover NHS services in the short-term; and the extent to which DHSC and NHSE have a detailed strategy to improve NHS financial sustainability in the long term.

Our evidence base

Interviews

3 We conducted interviews with a range of organisations and stakeholder groups during scoping and fieldwork to inform our audit, including:

- government bodies, including with officials from NHSE, DHSC and HM Treasury responsible for managing NHS finances, to understand the government's views of key issues and risks, and its future plans;
- sector bodies including NHS Providers, NHS Confederation, Local Government Association (LGA), the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Healthcare Financial Management Association (HFMA) to understand wider views about NHS financial management; and
- health think tanks, including the Health Foundation, Nuffield Trust, and The King's Fund.

Case studies

4 We carried out case study examinations of five Integrated Care Board (ICB) areas, including site visits to one, to understand more about the day-to-day impacts and realities of operating in the current financial environment. We developed case study selection criteria to ensure that we engaged a representative range of ICBs in terms of scale (measured by population size served), organisational maturity (measured by NHS oversight framework ratings), and geographical spread. Our ICB case study areas were:

- Frimley;
- Hertfordshire and West Essex;
- North East and North Cumbria;
- Shropshire, Telford and Wrekin; and
- Somerset.

Survey

5 We surveyed chief financial officers of ICBs in England to gather views about NHSE's financial planning and allocations process. We requested contact details from NHSE to target our survey and engaged NHSE on the wording of the survey's questions and its design. We also liaised with internal National Audit Office survey experts to quality assure our survey approach. Our questions covered the finances of respondents' organisations, views on NHSE's financial management and support, and views on long term financial sustainability.

6 We emailed respondents an online link to the survey, which ran from 16 January 2024 to 21 February 2024; this included an extension to the originally planned 13 February 2024 closing date. We sent targeted reminders to those that did not initially respond and received responses from 19 of 42 ICB chief financial officers. We note the risk that chief financial officers who are less engaged with our work may not have responded to the survey.

Financial analysis

7 We analysed financial information to understand the current and historical financial performance of NHS bodies and ICBs, and the causes and scale of underlying financial pressures. We reviewed consolidated trust account returns from 2019-20 to 2022-23, ICB and Clinical Commissioning Group returns from 2022-23, estates backlogs data from 2018-19 to 2022-23, NHS financial performance data for 2022-23, data on forward ICB financial allocations for 2023-24 and 2024-25, and NHS national budget data from 2014-15 to 2022-23, as well as planned budgets for 2023-24 and 2024-25. Unless otherwise stated, all financial data is presented in cash terms. Where we have adjusted for inflation and presented real terms figures, we used the Budget 2024 GDP deflators for 2022-23 published by HM Treasury in March 2024.

Quantitative analysis

8 We analysed publicly available data to understand recent and longer-term trends in the demand for and performance of key NHS services. This included data on hospital admissions, accident and emergency (A&E) attendances and wait times, GP appointments, hospital bed capacity, ambulance incidents, elective backlogs, cancer treatments and 111 call volumes. We used the latest available data at the time of concluding our fieldwork. In most cases this is April 2024, with the notable exceptions of 62-day referrals for cancer where we report against the month when performance was closest to NHSE's original calculation of the pre-pandemic level, and acute services where, due to seasonal impacts on demand, it is more appropriate for us to report against March 2024.

Document review

9 We reviewed around 200 published and unpublished documents, which included documents provided by NHSE, DHSC and HM Treasury in response to our evidence requests.

10 We reviewed policy and strategy documents, internal briefings, operational planning guidance and good practice guides, NHSE and DHSC board papers and minutes, previous National Audit Office reports, publicly available articles, and think-tank pieces and analyses.

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