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Effects of the NHS reforms on financial sustainability

Reza Mofidi, Carol Marrow

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ABSTRACT

The Health and Social Care Act of 2012 (HSCA2012) has transformed the operational and business environment within which NHS trusts in England operate. The Shelford Group is the leading multispecialty NHS trusts in England. The aim of this study was to assess the impact of HSCA2012 on the financial position of the Shelford Group of NHS trusts. The annual account statements produced by each of the trusts for financial years (FY) 2011–12; 2012–13; 2013–14 and 2014–15 were reviewed and the key financial indicators (KFIs) for each organisation were collected. KFIs for the period just prior to enactment of HSCA2012 (FY2011–12, FY2012–13) were compared with the corresponding values for the period after the enactment of HSCA2012. The clinical services provided by the Shelford Group increased year on year by 10.6%, 7.5% and 4% respectively as did their combined annual income. In FY2014–15, the Shelford Group collectively provided 14 735 000 patient care episodes and reported a combined annual income of £9 672 066 000. There was no significant difference in the median operating surplus returned by the Shelford group before and after HSCA2012; despite this, 5 of the 10 Shelford Group members delivered an operational deficit in FY 2014–15. The level of financial liabilities and total capital employed remained stable. There were significant improvements in total assets employed in the Shelford Group in the 2 years after the enactment of HSCA2012 compared to before. The financial standing of Shelford Group trusts has not been adversely affected by the enactment of HSCA2012, although there was some evidence that the operational finances of these NHS trusts were less robust in FY 2014–15 than previous years.

Key Words: Health and Social Care Act 2012 • Financial sustainability • NHS reforms

The NHS has been facing the simultaneous challenges of meeting growing demands in the presence of constrained resources (Jones, 2010). Consequently, it is estimated that the NHS in England needs to make annual efficiencies of 4% to sustainably provide the current level of services and cope with projected increase in demand (Roberts, 2012).

For over 25 years hospital care has been delivered as an internal quasi-market through which the primary care organisations purchase hospital services from NHS trusts (Raftery, 1996). Quazi-markets are institutional structures designed for delivery of public services. The aims of creating market-like structures for delivery of healthcare services are to promote efficiency, quality and customer choice, while maintaining equity of access to services (Le Grand, 1991). Creation and fostering of quazi-markets differ from other forms of microeconomic reform (Nicoletti, 2003; Le Grand, 2007). Market-like structures in healthcare require strong oversight and robust regulation, failure of which could lead to adverse patient outcomes and experience (Francis, 2013). Opinions regarding efficacy of quazi-markets as an instrument of public policy remains divided broadly along ideological lines. The experience with previous reforms in the NHS (often disputed) is that once established, they are associated with potential for expanding capacity to match the size of the market without adversely impacting equity of access (Cooper, 2009).

Efficiency in healthcare is measured by comparing the output of the healthcare organisation against the costs of delivering care (Marshall, 2014). Output measurements include assessing quality, as well as volume of services delivered by an organisation during a specified duration of time (Donabedian, 2005). Incomes and costs of delivering healthcare are important contributors to value of services provided. In addition to determining the output of organisations by defining the volume and quality of services it is also the numerator in the value equation (Porter, 2010):

Value provided by services = Output (volume, quality) / Cost of delivery of services

Financial sustainability of NHS trusts that deliver hospital services is a key variable in determining ability of the system as a whole to deliver quality healthcare services.

The Health and Social Care Act 2012 (HSCA2012) represents the most recent package of healthcare reform in England. In addition to structural changes—such as abolition of primary care trusts and strategic health authorities and replacing them with clinical commissioning groups (CCGs)—the HSCA2012 has expanded the marketlike structure which already exists to the private sector and in return allows trusts to use up to 50% of their capacity for delivering private services.

A year after enactment of HSCA2012 there was evidence to suggest that NHS trusts in England have been adversely affected (Lacobucci, 2014). This may in part be related to inertia in adapting to the new operational environment, including the mode of reimbursement for their services. The new contracts demand that the organisations operate much closer to their productivity frontier (Porter, 2010), and the new funding system, lack of efficiency, operational issues such as seasonal demand, bed closures and cancelled sessions would be costly to trusts as they would lose income and may have to incur further financial penalties (Chalkey and McVicar, 2008). In addition, six years of austerity have left the hospital services chronically under-resourced. Trusts need to compete with private sector providers for delivery of some of the clinical activity which was previously allocated to them. To achieve the required business model, trusts require significant changes to the way they operate. HSCA2012 came to force in April 2013, and NHS trusts had over one year to understand its implications and change their operational strategy. The Shelford Group's trusts are the leading multispecialty NHS trusts in England (Hawkes, 2013). They have an annual collective turnover which equates to 6% of NHS budget and together employ over 83 000 people. The quality of care and financial health of the group is a reflection on the conditions in the NHS in England. The aim of this study was to assess the impact of HSCA2012 on the financial position of the group.

Methods

NHS trusts are obliged to produce an annual statement of accounts which is collated and authorised by an organisation known as Monitor (Department of Health, 2013). The comprehensive versions of these reports are submitted to Parliament in accordance with the National Health Service Act 2006. These statutory documents provide the following information:

- Financial position of NHS foundation trusts
- Levels of clinical activity.

Changes in the level of clinical activity in Shelford Group trusts

Organisational capacity to provide services is an important attribute of any business model for delivery of hospital services. Annual levels of inpatient, outpatient and emergency activity are reliable surrogate markers of organisational capacity and market-share. Examining elective, emergency, inpatient and outpatient services ensured that the study was able to identify if there were any trade-offs in delivering clinical care. An example of such a trade-off would be delivering less elective clinical activity to free capacity for higher levels of emergency admissions.

Examining financial positions

Financial position of each organisation was assessed through examining annual balance sheets and statements of financial position for FYs 2011–12, 2012–13 (before enactment of the HSCA2012), FY 2013–14 and FY 14–15 (after enactment of the HSCA2012). These were obtained from the unabridged version of the annual reports of each of the 10 NHSTs which are members of the Shelford group. Accrualbased accounting methods (a process which recognises economic events at the time the activity is undertaken) were used to assess the financial position of each trust (Hodges, 2003). The significance of accrual-based accounting to the operations of a trust relates to its direct relationship with the levels of clinical activity (remunerated using payment by results contracts) as well as the treatment of fixed assets (property owned by the organisation and depreciation of medical equipment) and provisions for long-term liabilities such as private finance initiative arrangements (Rausser and Stevens, 2009).

The key financial indicators examined included the operating surplus/ deficit, annual surplus/ deficit, financial liabilities and financial liabilities ratios for FY 2011–12 through to FY 2014–15. In addition, the total capital employed as well as the total assets employed in each of the NHS trust in the last day of each FY from FY 2011–12 through to FY 2014–15 were also examined.

Operating surplus (deficit) is a measure of the extent to which operating revenue meets the costs of providing services. These include depreciation, salaries, staff benefits and material costs of delivering the service. An operating deficit indicates that some of costs incurred are not being met by the trusts income; conversely operating surplus allows the organisation to make capital expenditure over and above the level of depreciation or reduce the level of financial liabilities (Rosko, 2004). Annual surplus (deficit) includes the operating surplus/ deficit as well as impairments or adjustments caused by depreciation of the value of the assets, revaluation or sale of fixed assets such as property owned by each organisation.

Changes in the levels of financial liabilities in consecutive financial years record the level by which operational costs need to be covered by borrowings. They may also indicate significant capital expenditure over and above what is covered by the operating surplus or liquidation of assets of an organisation. Net financial liabilities ratio is a measure of annual financial liabilities against one year's operating revenues. It is an indicator of the capacity of NHS trust in meeting its financial obligations. The capital employed in each NHS trust on the last day of each FY is the value of the assets of the organisation less its current liabilities and indicated the capital investment required for the organisation to function as a going concern. Total assets employed is all the assets less all the liabilities of the organisation (sometimes called the tax payers' equity in an organisation).

Market share indicators

Clinical activity provided by NHS trusts was classed under three headings; inpatient activity, accident and emergency episodes and outpatient activity. Although it is difficult to assess each organisation's share of regional healthcare market directly, incomes from the three types of clinical activity are reliable surrogate markers of market-share of NHS trusts. These indicators also assess the ability of organisations in maintaining income by increasing clinical activity in the face of reducing tariffs.

Statistical analysis

Statistical analysis was performed using the Statistical Package for Social Sciences, version 23 (SPSS Inc, Chicago, IL). Matched sets of key financial indicators were treated as the primary units for

analysis and compared before and after enactment of HSCA2012. Key financial indicators were considered continuous variables, the values of which were compared using a paired student t-test, except where due to significant variance between the NHS trusts normal distribution could not be assumed in which case non-parametric statistics and Mann-Whitney U test was used.

Results

The Shelford Group collectively provided 11 149 175 patient care episodes in the FY2011–12; 13 197 281 in FY2012–13 and 14 188 708 in FY2013–14 and 14 735 000 in FY2014–15 representing annual increases of 10.6%, 7.5% and 4% in levels of clinical activity respectively (Figure 1). The combined annual income of these organisations was £7 494 646 000 in FY11–12, £8 472 132 000 in FY12–13 £9 084 857 000 in FY13–14 and £9 672 066 000 in FY14–15 (Figure 2), representing annual increases of 6.6%, 7.2% and 6.4%. Figure 3 illustrates annual operational surplus (deficit) for FYs 2011–12 through to 2014–15.

Assessment of financial position of the Shelford Group

Median (inter quartile range) operating surplus returned by The Shelford Group prior to enactment of HSCA2012 was £19 794 000 (£11 366 000–£27 491 000), and £34 820 000 (£20 179 000–£50 605 000) after enactment of HSCA2012 ($Z = 0.126$, $P = 0.9$), revealing no significant difference in the value of this indicator after HSCA2012, if the two years following HSCA2012 (FY13–14 and FY14–15) are compared with the two preceding financial years (FY11–12 and 12–13). It is noteworthy that FY14–15, 5 of the 10 members of the Shelford group returned operational deficits despite increasing operational revenues (Table-1). The median operating surplus of the group in the FY2014–15 was £9 621 500 (£-15 000 000– £20 000 000). Similar observations were made with respect to the annual surplus (deficit), in the financial years studied (Table 2).

Financial liabilities

Annual financial liabilities of Shelford Group trusts remained stable in the financial years studied (Table 3). Mean (standard deviation) annual financial liabilities of the Shelford group was £24 357 550 (£9 006 890) prior to the enactment of HSCA2012 and 25 006 250 (£9 139 985) after the enactment of HSCA2012 ($P = 0.95$). Figure 3 illustrates net financial liabilities ratios of the Shelford group for FY11–12, 12–13 and 13–14. There was no significant difference in median (interquartile range) net financial liabilities ratios in the years before enactment of HSCA2012 was 0.8 (0.2–1.4) compare with after 0.53 (0.21–0.85) ($P = 0.15$).

The capital employed in each of the trusts on the last day of FYs 11–12, 12–13 and 13–14 are listed in Table 3. This value remained stable for all of the 10 NHS foundation trusts with a modest increase in median value for the total assets employed after HSCA2012 compared to before (pre-HSCA2012, £503 451 000 (interquartile range (IQR): £370,973,000–£635,929,000) versus £570,083,500 (IQR: £410,026,500– £730,140,500)) ($Z = -0.7295$) ($P = 0.4654$). There were significant improvements in total assets employed in the Shelford group in the 2 years after the enactment of HSCA2012 compared to before (pre: median: £239 63 4000 (IQR: £171 480 000–£307 788 000 versus post: median: £346,300,000 (IQR: £315072000- £377528000)) ($Z=149$) ($P = 0.002$) (Table 4).

Market share indicators

Figure 4 illustrates the group's income from inpatient clinical activity for each of the 12 annual quarters studied. Enactment of HSCA2012 had no significant impact on Shelford groups' income from inpatient activity (mean pre -HSCA2012=£59 963 349 (SD: £13 118 706) versus mean post-HSCA2012 £62 275 021 (std. dev: £12 871 211), $P = 0.36$). However there was a significant reduction in income per 1,000 inpatient episodes (Figure 4), (mean pre- HSCA2012 = £1 348 718 (SD: £272 946) versus mean post-HSCA2012 value of £1 197 497 (SD: £249 437), $P = 0.003$).

Figure 5 illustrates the quarterly income from accident and emergency services provided by the Shelford group NHS trusts. No difference was observed in quarterly income from providing emergency services prior to HSCA2012 £3 738 206 (SD: £120 018) compared with after HSCA2012 £4 218 966 (SD: £139 960), ($P = 0.07$). A slight but significant increase in income per 1000 accident and emergency episodes of care was observed after enactment of HSCA2012 (pre-HCA2012 = £100 309 (SD: £14 766), post-HSCA2012 =£107089 (SD: £18 436), ($P = 0.046$)).

Figure 6 shows the group's quarterly income from outpatient activity. There was no significant difference between the Shelford groups' quarterly income from outpatient activity before and after HSCA2012 [pre HSCA2012 mean = £18 385 870 (SD: £4 285 441), post- HSCA2012 mean = £19 501 102 (SD: £4 285 475), ($P = 0.18$)]. No difference was observed in group's quarterly activity per 1000 outpatient episodes (pre-HSCA2012 mean = £70 775 (SD £10 248), post-HSCA2012 mean = £67 517 (SD £10 813), ($P=0.11$)).

Discussion

HSCA2012 has been arguably the most controversial legislation involving the NHS in recent memory. HSCA2012 involved significant shifts in power and accountability in delivery of healthcare, redesigned the commissioning superstructure of NHS, created an economic regulator and introduced competition with voluntary and private sector providers in NHS England (Department of Health, 2012).

The new public and financial management system (NPFMS), which emerged in 1980s involved significant changes in the state sector. NPFMS involves separation of planning, purchasing and provision of public services into different operational entities (Guthrie et al, 1999). Some of these services would be provided by private or voluntary sector in a competitive environment. The state became a regulator and purchaser, rather than provider of services (Hodges and Mellett, 1999). NPFMS represents the cumulative flow of public policy the developed countries for the last three decades, regardless of the political persuasion of their ruling administrations (Barzelay, 2001). Many progressive facets of NPFMS, such as use of accrual-based accounting (Olson et al, 1998), pay-for-performance; quality outcomes frameworks (Gillam et al, 2012) and rigorous audits have introduced accountability and improved outcomes to public services. Nonetheless, HSCA2012, which completes the structural change required for delivery of NPFMS in the NHS is widely seen as privatisation of NHS services or at least a significant step down that road.

Since the enactment of HSCA2012, concerns have been raised regarding the financial sustainability of NHS trusts (Lacobucci, 2014). The King's Fund projected a financial crisis in the frontline healthcare services by 2015–16 (Appleby, 2015). Evidence from this study suggests that in the first year following the enactment of HSCA2012, there was no significant change to the financial position of the Shelford Group, which had to continue to expand their clinical activity to meet significant increases in demand for services. There is some evidence however that in the second year following the enactment of HSCA2012, the group is operationally less robust and half of the members despite

increases in the operational income failed to deliver an annual surplus. Considering that the group has the largest and best performing NHS trusts in England, such a finding is concerning. In 2015, a report from Monitor revealed that almost 2 out of 3 NHS trusts reported an annual deficit in FY 2014–15 (Dunhill, 2015). Although a sizable minority of NHS trusts reported a surplus; with so many organisations at risk, it is hard not to see a tipping-point which could threaten sustainability of hospital services in England.

This study was focused on the finances of the Shelford Group as a representative group of hospital services in England. It highlights the fact that enactment of HSCA2012 has altered the environment in which NHS trusts operate but had not rendered their business plan unviable. Despite the fact that HSCA2012 has opened the door to competition, demand for services provided by the group increased after HSCA2012. Acute hospitals are mandated by the annual NHS contract to deliver relatively expensive emergency care for patients who are referred to them. This care needs to be delivered safely and meet quality of care standards. Since the scandal at Mid-Staffordshire NHS Foundation Trust, the policy of practicing cost-control at the expense of quality of care is no longer a viable strategy. Organisations which have already practiced cost-control and cut capacity can only regain lost capacity by cancelling scheduled care episodes. This would result in further impairment of their financial position, as scheduled care episodes are the activity which can be planned and if the services to deliver them designed properly, tend to deliver a surplus.

The HSCA2012, unlike healthcare reforms a decade previously, was enacted during a time of budgetary constraint. Unlike the preceding years when the NHS budget grew; there has been no increase in NHS spending in England in the last 5 years. The nature of economic recovery and the political climate means that it is safe to assume that the budgetary constraints are likely to continue, in the face of increased demand (Appleby et al, 2014). This is likely to create a funding gap of £20–30 billion in 5 years (Health Select Committee (HSC), 2013). In previous decades, the NHS would have responded to the funding constraint through cost control and restricted supply, resulting in waiting lists for treatment to grow and quality of care to suffer, such an approach is not acceptable today.

Closing the current funding gap involves a number of programmes aimed at improving efficiency and productivity. QIPP (Quality, Innovation, Productivity and Prevention), are a series of transformational programmes which aim to reduce the layers of management, centralise care, use innovative care pathways to reduce the costs and the need for limited and expensive inpatient resources.

The greatest burden of making the NHS more productive and efficient has been through efficiency savings in frontline providers of acute services (HSC, 2013; Appleby et al, 2014). NHS trusts have attempted to achieved this through pay-control, improved productivity (increasing income per unit cost), or redistributing central savings achieved from such activities as reforming management structure to capture productive activity (Appleby et al, 2014) or simply withdrawing from providing clinical activities which are not cost-efficient within the constraint of the NHS contract. This needs to be achieved within a business-plan designed to deliver 1% surplus with a fixed-tariff structure (Majeed 2013). It appears that this task was beyond the abilities of many of the senior leaders of NHSFTs in England.

Appleby performed structured interviews with 26 senior managers from 6 NHS providers in England. He encountered two different strands of opinion; the first viewed the relentlessness of the cuts coupled with the potential 10-year duration of efficiency drive as a threat. Five years into the QIPP programme all the 'low hanging fruits' of an efficiency drive have been exhausted and with the strict quality controls it is not possible to 'ration healthcare anymore' (Appleby 2015). The second approach recognised that delivering a first-rate health service purely from taxation and national insurance contributions means that such a system needs to run close to efficiency frontier or grapple

with financial difficulties as has been the case with the NHS since the 1970s (Appleby, 2015). There was consensus among healthcare managers interviewed on the fact that due to the extent of cuts and the duration of austerity, usual NHS approaches towards efficiency would not be sufficient and transformational change was needed (Appleby, 2015).

There are similarities between the recent banking crisis and the looming funding crisis in NHS trusts in England. While it is true that deficits generated by trusts are small in comparison to the banks, there are over 150 foundation trusts. A sector-wide collapse could trigger similar economic instability. The banking crisis of 2008 led to a sovereign debt crisis, austerity and debt buyouts which continue in the Eurozone today (Varoufakis, 2011). This is why financial sustainability of NHS trusts has implications beyond the regional health economies and is a national imperative.

A study such as this one, while useful, provides only a limited view of the health economy in England following the enactment of HSCA2012. It will take many years for the full effects of HSCA2012 on the regional health economies to become apparent. The involvement of private sector in the provision of NHS services will take time. Many other factors such as the economic turmoil caused by the UK's withdrawal from the European Union and a shortage of trained staff will impact the financial sustainability of NHS organisations in England for some time to come.

References

Appleby J, Galea A, Murray R (2014) The NHS productivity Challenge: Experience from the Frontlines. The King's Fund. Available at: <http://tinyurl.com/ndsk96v> (accessed 20 October 2016)

Appleby J (2015) UK NHS: Less money (but more bangs per buck)? *BMJ* 350: h1037. doi: <http://dx.doi.org/10.1136/bmj.h1037>

Barzelay M (2001) *The New Public Management. Improving Research and Policy*. University of California Press, London

Chalkey M, McVicar D (2008) Choice of contracts in the British National Health Service: An empirical study. *J Health Econ* 27(5): 1155–67. doi: 10.1016/j.jhealeco.2008.05.005

Cooper ZN, McGuire A, Jones S, Le Grand J (2009) Equity, waiting times and NHS reforms: retrospective study. *BMJ* 339: b3264. doi: 10.1136/bmj.b3264

Department of Health (2012) *Health and Social Care Act 2012: Chapter 7, Explanatory Notes*. The Stationery Office, London

Department of Health (2013). *NHS foundation trusts: annual reporting manual 2013/14*. <https://www.gov.uk/government/publications/nhs-foundation-trusts-annual-reporting-manual-2013-to-2014>

Donabedian A (2005) Evaluating the quality of medical care. *Milbank Q* 83(4): 691–29

Dunhill L (2015) Updated: NHS provider sector reports £822m deficit. *HSJ* 22 May. Available at: <http://www.hsj.co.uk/news/updated-nhs-provider-sector-reports-822m-deficit/5085271.article?blocktitle=Foundationtrust-news&contentID=1569>

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.(Report)*. The Stationery Office, London

Gillam SJ, Siriwardena AN, Steel N (2012) Pay-for performance in the United Kingdom: impact of the Quality and Outcomes Framework—a systematic review. *Ann Fam Med* 10(5): 461–8. doi: 10.1370/afm.1377

Guthrie J, Olson O, Humphrey C (1999) Debating developments in new public financial management: the limits of global theorising and some new ways forward. *Financial Accountability & Management* 15(3–4): 209–228

Hawkes N (2013) Welcome to the most exclusive club in the NHS. *BMJ* 347: f318 doi: <http://dx.doi.org/10.1136/bmj.f7318>

Health Select Committee (2013) Meeting the Nicholson Challenge to 2015 and beyond. Available at: <http://tinyurl.com/nybles8> (accessed 20 October 2016)

Hodges R, Mellett H (2003) Reporting public sector financial results. *Public Management Review* 5(1): 99–113

Hodges R, Mellett H (1999) Accounting for the private finance initiative in the United Kingdom national health service. *Financial Accountability & Management* 15(3–4): 275–90

Jones R (2010) The nature of healthcare costs and financial risk in commissioning. *BJHCM* 16(9): 424–30

Lacobucci G (2014) Foundation trusts in England record overall deficit for first time. *BMJ* 349: g5769. doi 10.1136/bmj.g5769

Le Grand L (1991) Quasi-Markets and Social Policy. *The Economic Journal* 101(408): 1256–67

Le Grand L (2007) *The Other Invisible Hand: Delivering Public Services through Choice and Competition*. Princeton University Press, Princeton, NJ

Majeed A (2013) Re: Welcome to the most exclusive club in the NHS. *BMJ* 347: f7318. doi: 10.1136/bmj.f7318

Marshall L, Charlesworth A, Hurst J (2014) *The NHS Payment System: Evolving Policy and Emerging Evidence*. Nuffield trust. Available at: <http://tinyurl.com/zzb2xbv> (accessed 20 October 2016)

Nicoletti, G Scarpetta S (2003) Regulation, productivity growth: the OECD experience. *Economic Policy* 18(36): 9–72

Porter ME (2010) What is value in health care? *N Engl J Med* 363: 2477–81

Raftery J, Robinson R, Mulligan JA, Forrest S (1996). Contracting in the NHS quasi-market. *Health Econ* 5(4): 353–62

Rausser G, Stevens R (2009) Public-private partnerships: goods and the structure of contracts. *Annu Rev Resour Econ* 1(1): 75–98

Rosko MD (2004) The supply of uncompensated care in Pennsylvania hospitals: motives and financial consequences. *Health Care Manage Rev* 29(3): 229–39

Roberts A, Marshall L, Charlesworth A (2012) A decade of Austerity? Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report_1.pdf (accessed 20 October 2016)

Varoufakis Y, Holland S (2011) A Modest Proposal for Overcoming the Euro Crisis. Available at: <https://yanisvaroufakis.eu/2011/03/11/a-modest-proposal-forovercoming-the-euro-crisis-version-2-0/> (accessed 20 October 2016)

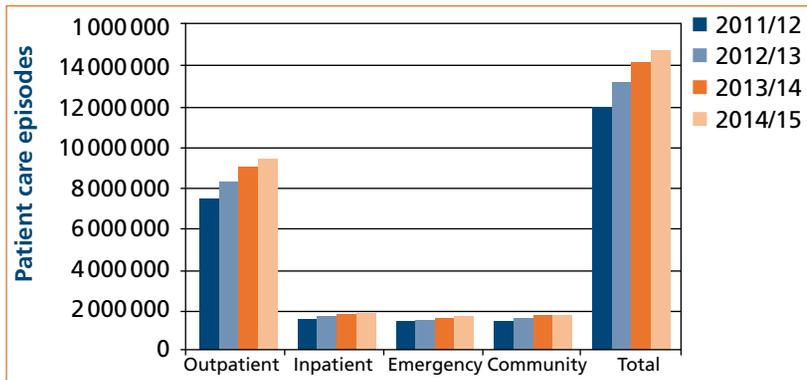


Figure 1. Levels of clinical activity provided by the group

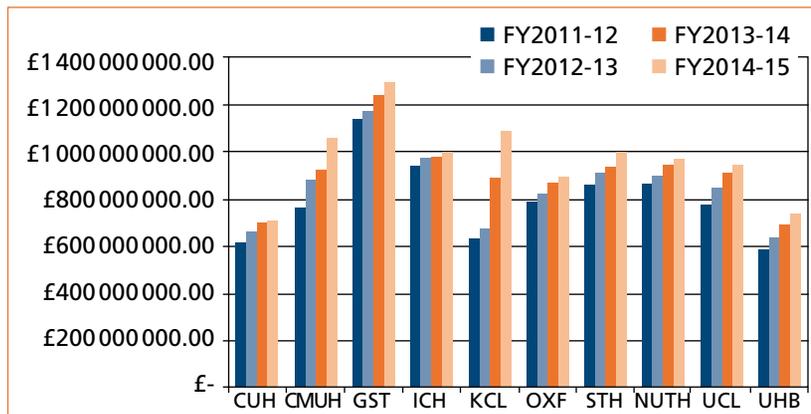


Figure 2. Annual operating incomes of each of the Shelford trusts for FYs 2011-12; 2012-13 and 2013-14

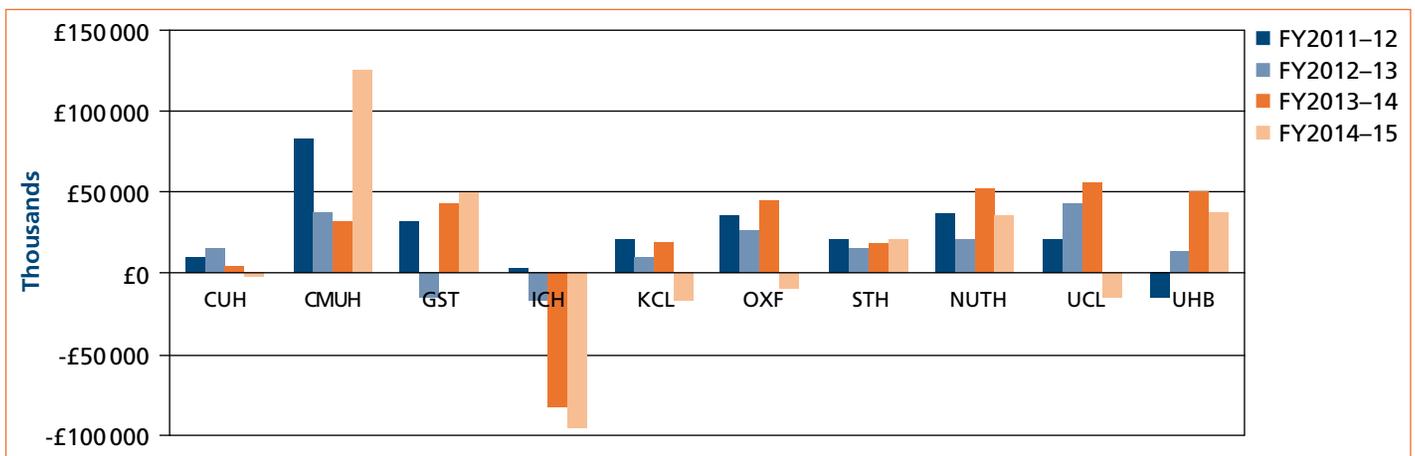


Figure: 3 Annual operating surplus-deficits of each of the Shelford NHSTs for FYs 2011-12, 12-13, 13-14 and 14-15

CUH = Cambridge University hospitals NHSFT; OXF = Oxford University NHST; CMUH = Central Manchester hospitals NHSFT; STH = Sheffield Teaching Hospitals NHSFT; GST = Guys & St Thomas' NHSFT; NUTH = Newcastle upon Tyne Hospitals NHSFT; ICH = Imperial College Healthcare; UCL = University College Hospital NHSFT; KCL = King's College Hospital NHSFT; UHB = University Hospitals Birmingham NHSFT

Table 1. Operating surplus (deficit) of the Shelford Group

Operating surplus/deficit	FY 11-12	FY 12-13	FY 13-14	FY 14-15
CUH	£10 170 000	£16 791 000	£ 4 479 000	£(2 157 000)
CMH	£83 812 000	£38 866 000	£33 299 000	£125 004 000
GST	£31 943 000	£5 214 000	£42 839 000	£51 277 000
ICH	£3 402 000	£(17 370 000)	£(82 970 000)	£(94 550 000)
KCL	£18 772 000	£11 366 000	£20 179 000	£(15 930 000)
NUTH	£23 725 000	£22 116 000	£52 665 000	£36 341 000
OXF	£36 992 000	£27 491 000	£44 987 000	£(8 727 000)
STH	£20 816 000	£15 677 000	£20 147 000	£21 400 000
UCL	£22 325 000	£44 192 000	£56 826 000	£(15 294 000)
UHB	£(14 839 000)	£15 090 000	£50 605 000	£38 067 000
Median	£21,570,500	£16 234 000	£38 069 000	£9 621 500

Table 2. Annual surplus (deficit) of NHS the Shelford Group

Annual surplus/deficit	FY 11-12	FY 12-13	FY 13-14	FY 14-15
CUH	£2 457 000	£4 080 000	£8 392 000	£(2 157 000)
CMH	£50 051 000	£78 274 000	£1 191 000	£97 745 000
GST	£5 368 000	£(7 455 000)	£113 349 000	£71 318 000
ICH	£(15 572 000)	£(27 389 000)	£15 128 000	£15 405 000
KCL	£8 371 000	£3 953 000	£117 368 000	£(31 679 000)
NUTH	£33 888 000	£33 358 000	£32 954 000	£34 982 000
OXF	£15 340 000	£1 374 000	£36 784 000	£(21 339 000)
STH	£10 023 000	£9 787 000	£18 266 000	£16 676 000
UCL	£42 000	£1 607 000	£21 821 000	£(31 200 000)
UHB	£30 005 000	£7 734 000	£37 266 000	£18 010 000
Mean	£14 658 960	£18 113 480	£33 775 160	£16 040 500

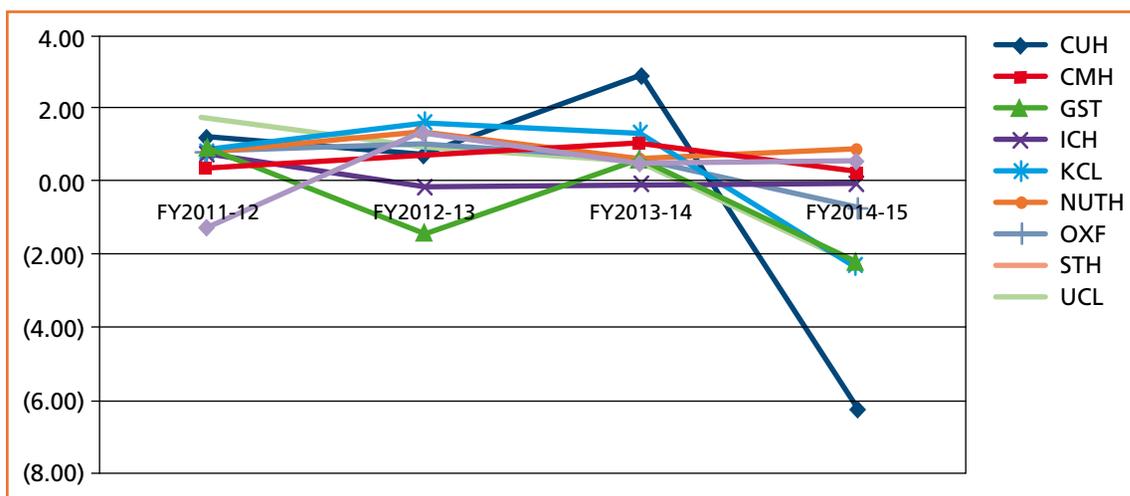


Figure 4. Net financial liabilities ratio of Shelford Group NHS trusts

Table 3. Annual financial liabilities of the Shelford group of NHS trusts

Net finance costs	FY 11-12	FY 12-13	FY 13-14	FY 14-15
CUH	£12 627 000	£12 711 000	£12 871 000	£13 512 000
CMH	£27 706 000	£31 573 000	£33 299 000	£33 019 000
GST	£20 756 000	£20 330 000	£21 800 000	£27 029 000
ICH	£1 939 000	£1 791 000	£857 000	£812 000
KCL	£17 877 000	£18 021 000	£27 250 000	£36 642 000
NUTH	£30 238 000	£28 262 000	£27 967 000	£29 843 000
OXF	£29 389 000	£28 807 000	£27 555 000	£6 120 000
STH	£12 837 000	£13 261 000	£12 883 000	£13 009 000
UCL	£38 469 000	£38 851 000	£33 441 000	£33 346 000
UHB	£18 793 000	£21 290 000	£21 562 000	£22 248 000
Mean	£23 257 300	£25 457 800	£24 554 700	£24 638 500

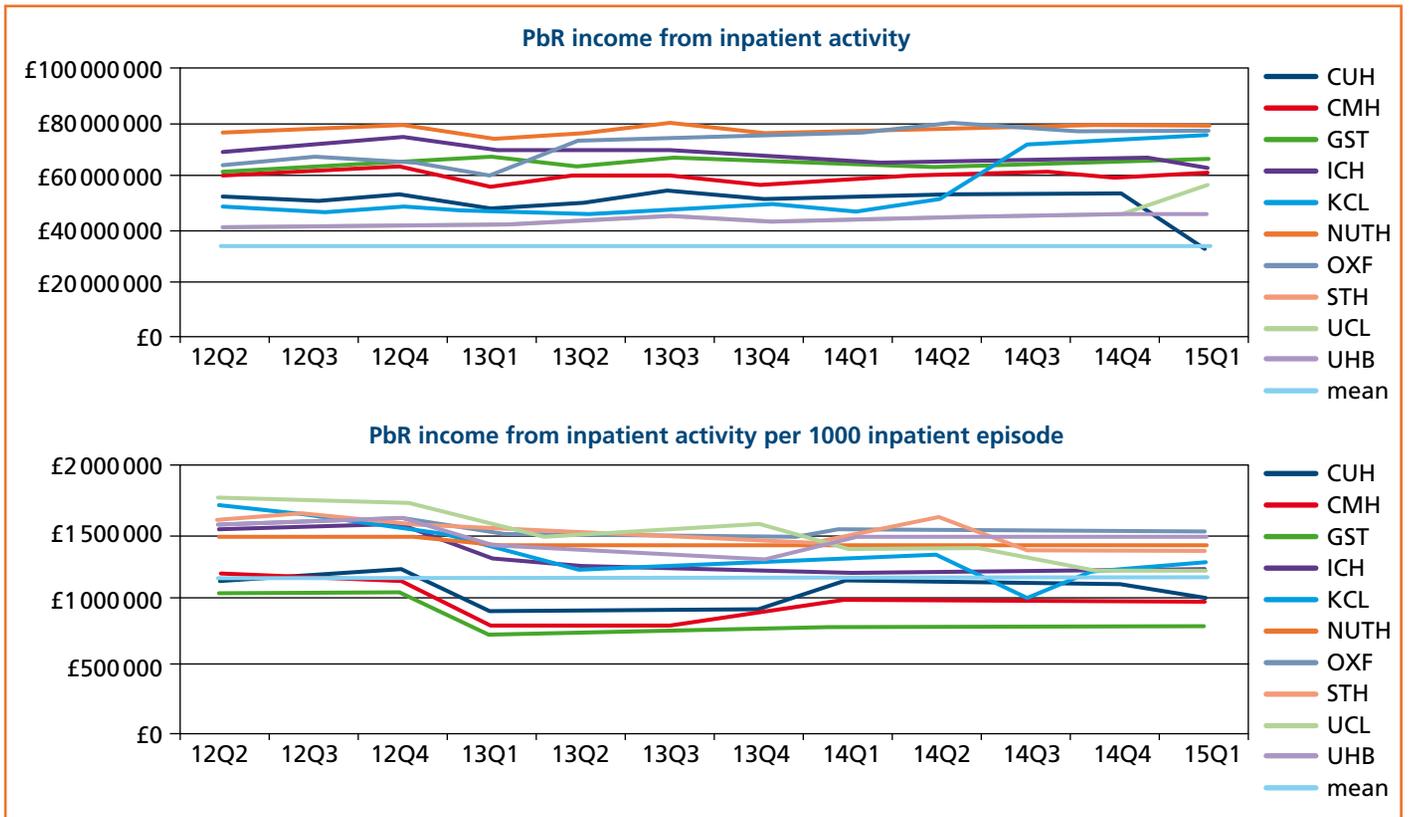


Figure 5. Shelford Group's payment by results income from inpatient activity compared with mean value for NHS England

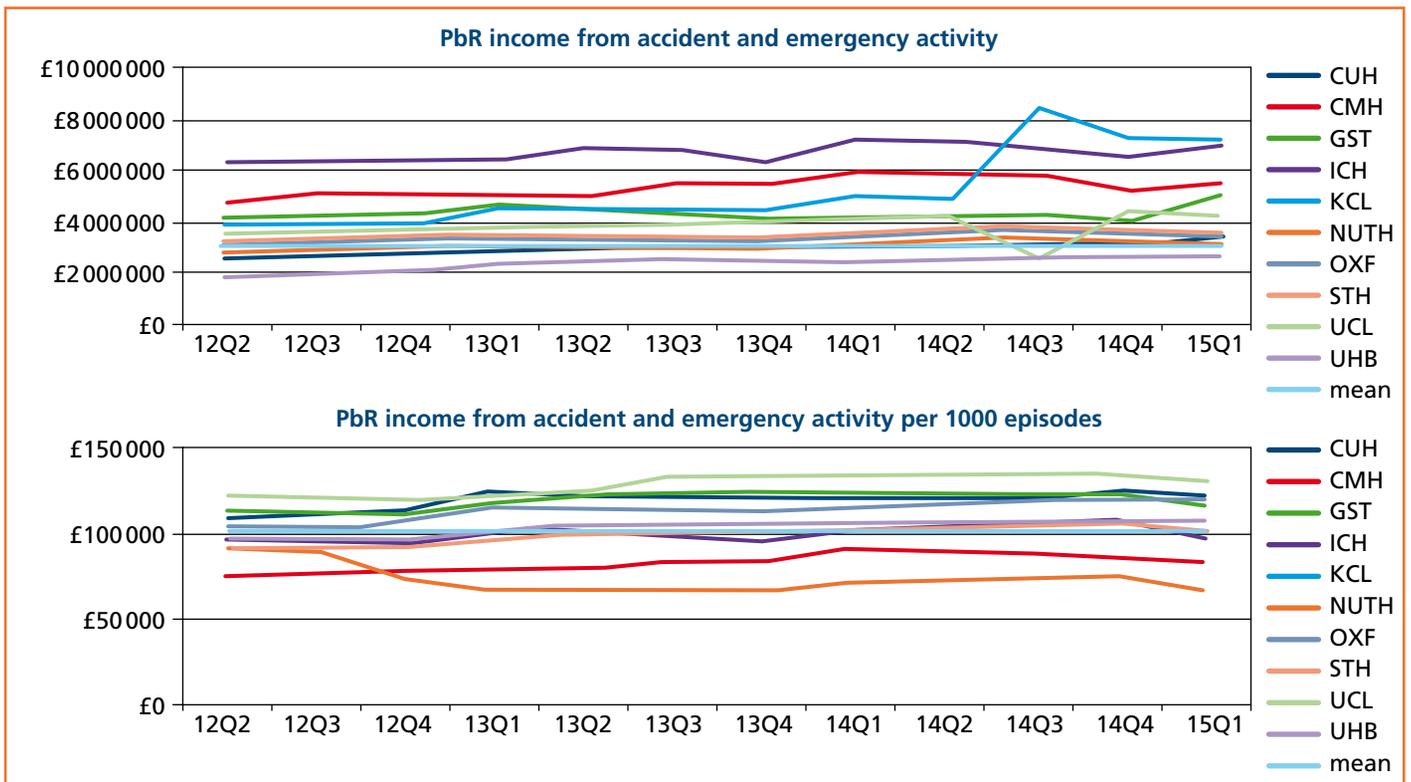


Figure 6. Shelford Group's payment by results income from accident and emergency activity compared with mean value for NHS England

Table 4a. The capital employed in the Shelford Group

Assets less current liabilities	31 March 2012	31 March 2013	31 March 2014	31 March 2015
CUH	£312 777 000	£335 661 000	£363 641 000	£379 346 000
CMH	£471 874 000	£559 472 000	£546 721 000	£682 025 000
GST	£948 619 000	£968 983 000	£1 155 836 000	£935 798 000
ICH	£716 441 000	£687 395 000	£601 899 000	£448 514 000
KCL	£359 589 000	£356 173 000	£616 361 000	£603 276 000
NUTH	£597 270 000	£571 165 000	£593 446 000	£666 024 000
OXF	£132 478 000	£152 414 000	£181 642 000	£160 057 000
STH	£433 194 000	£441 043 000	£458 189 000	£473 096 000
UCL	£710 038 000	£723 426 000	£738 875 000	£703 587 000
UHB	£517 296 000	£489 606 000	£510 627 000	£473 096 000
Mean	£519 957 600	£528 533 800	£576 723 700	£552 481 900

Table 4b. The total assets employed in the Shelford Group

Total assets employed	31 March 2012	31 March 2013	31 March 2014	31 March 2015
CUH	£192 854 000	£220 922 000	£214 266 000	£228 068 000
CMH	£98 239 000	£188 422 000	£189 634 000	£307 925 000
GST	£936 613 000	£929 941 000	£1 049 786 000	£1 124 404 000
ICH	£45 046 000	£23 362 000	£37 858 000	£416 662 000
KCL	£262 561 000	£258 346 000	£402 910 000	£374 411 000
NUTH	£316 176 000	£291 573 000	£325 241 000	£415 340 000
OXF	£116 829 000	£117 910 000	£148 794 000	£128 234 000
STH	£376 153 000	£385 940 000	£405 892 000	£422 735 000
UCL	£401 239 000	£393 906 000	£418 102 000	£367 359 000
UHB	–£60 063 000	–£68 154 000	–£31 228 000	–£2 861 000
Mean	£268 564 700	£274 216 800	£316 125 500	£378 227 700

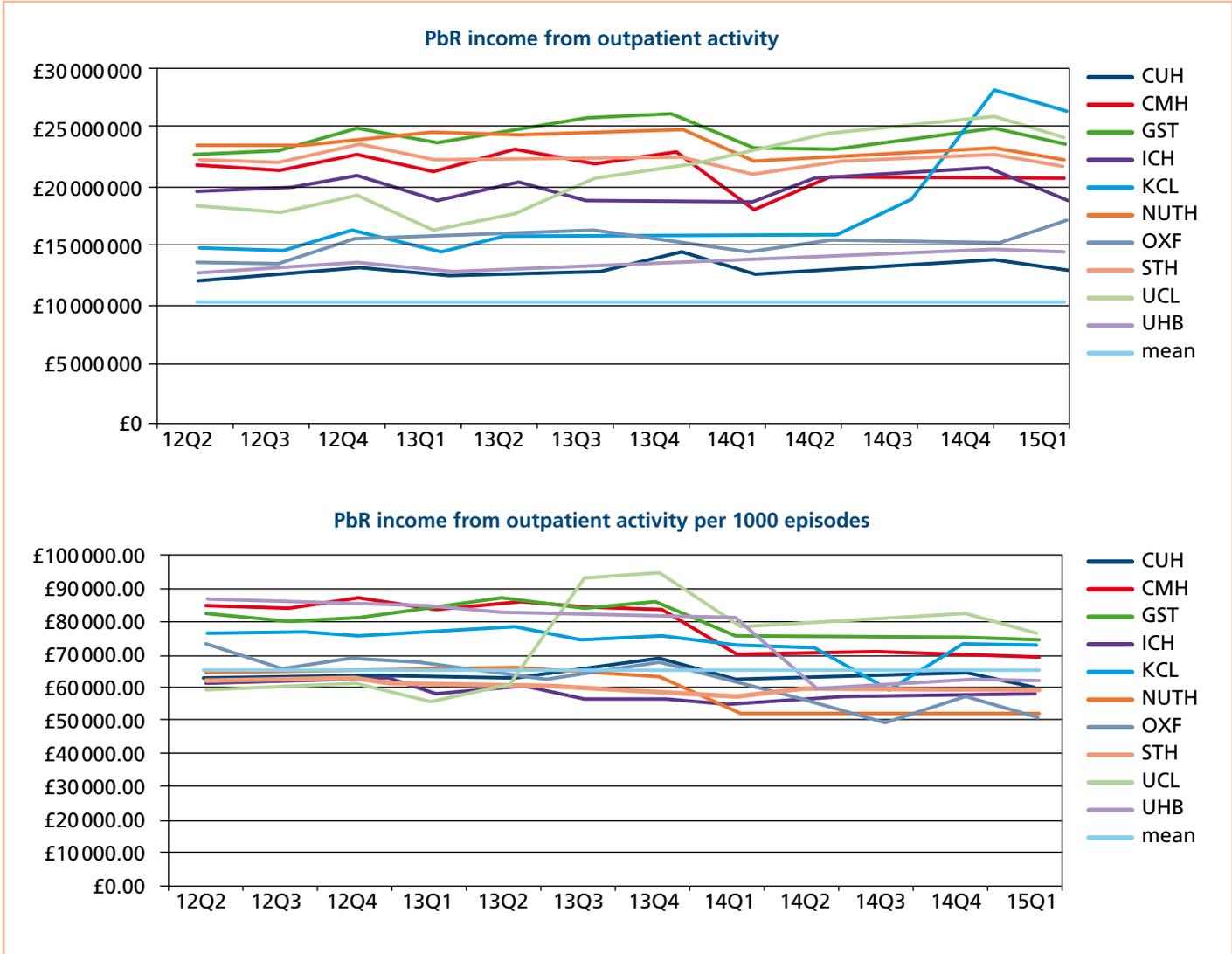


Figure 7. The group's PbR income from outpatient activity compared with mean value for NHS England