QMR 22 MARCH 2017

Sicker patients the main reason for A&E winter pressures

ABOUT THIS REPORT

Despite the recent media focus on access to GPs, our latest survey of finance directors finds that the rising number of patients with complex health needs is the key factor behind the increasing pressures on A&E departments.

REPORT AUTHORS

Richard Murray, Joni Jabbal, James Thompson

2017 has not started well for the NHS. More than half of finance directors from the trusts and CCGs we surveyed believe quality of care in their area has deteriorated over the past 12 months.

However, from our survey it is clear that the deterioration over winter was not due to any lack of effort by NHS providers, commissioners and their staff.

70%

of trusts surveyed increased their staff to prepare for increased pressure on services during the winter.

80%

of clinical commissioning groups surveyed paid for extra resources in primary care.

A wide range of other measures were also used to cope with winter pressures including more step-down facilities, paying higher rates for agency staff or using more outsourcing for elective care. It is sobering to consider what would have happened to performance if the NHS had not pulled out all the stops in an effort to meet increased demand.

"It is clear that the NHS pulled out all the stops and the pressures on hospitals would have been far worse without extensive planning, the heroic efforts of staff and relatively low levels of norovirus and flu."

Richard Murray, Director of Policy

80%

of NHS finance directors identified higher numbers of patients with severe illnesses and complex health needs as key reasons for A&E pressures.

of NHS finance directors cited delays in discharging patients from hospital as a reason for increased pressure on A&E.

Relatively few finance directors identified either poor access to general practice or shortages of clinical staff in A&E as key factors in increased pressure on A&E services.

Since 2013, A&E performance has been one of the top three concerns for trust finance directors in every QMR but one (and it remains the focus of media reporting). However, its disappearance from the top three now may suggest that finance directors are increasingly concerned about the underlying drivers of poor performance rather than the standard itself.

This winter, flu and norovirus have not put a significantly greater demand on health services than in previous years, nor has it been a particularly cold winter.
Rather, sustained increases in demand over many years, rising delayed transfers of care and seven years of low growth in NHS and social care spending have taken their toll.

Finance directors say that they are very unlikely to meet either the A&E four-hour or 18-week referral-to-treatment waiting time standards by the end of this financial year (2016/17). This will be the first year since it was introduced that the elective waiting time standard has not been met for a whole year.

"Recent media attention has focused on A&E departments and funding of social care, with rather less attention on patients waiting to begin elective care."

James Thompson, Senior Research Analyst

Looking ahead, 53 per cent of trusts and 63 per cent of CCGs are fairly or very pessimistic about reaching financial balance in 2017/18. For CCGs, this has doubled from 30 per cent who were fairly or very pessimistic when they predicted their financial position for 2016/17 this time last year, underlining the spread of financial distress into the commissioning sector.
These financial pressures mean some trusts are planning to reduce their workforce.

29%

of finance directors report that their organisations have plans to reduce permanent clinical headcount.

However, it will be very challenging to reduce the clinical workforce at a time when many NHS hospitals are

routinely running at high bed occupancy levels and demand continues to rise. It is not surprising that staff morale remains a key concern for finance directors.

Headlines

The King's Fund published its first quarterly monitoring report in April 2011 as part of its work to track, analyse and comment on the changes and challenges the health and care system is facing. This is the 22nd report and aims to take stock of what has happened over the past quarter and to assess the state of the health and care system. It provides an update on how the NHS is coping as it continues to grapple with productivity and reform challenges under continued financial pressure.

The quarterly monitoring report combines publicly available data on selected NHS performance measures with views from NHS trust finance directors and clinical commissioning group (CCG) finance leads. These were supplemented with interviews with four NHS leaders.

See the box below for further details of our methodology.

Survey of NHS trust finance directors and CCG finance leads

This report details the results of an online survey of NHS trust finance directors and clinical commissioning group (CCG) finance leads carried out between 18 January and 1 February 2017. We contacted 255 NHS trust finance directors to take part and 80 responded (31 per cent response rate). The sample included 39 acute trusts; 33 community and mental health trusts; 1 specialist trust; 1 ambulance trust and 6 unknown. In addition, we made contact with 155 CCG finance leads and 42 responded (27 per cent response rate). Between them these finance leads covered 51 CCGs (24 per cent of all 211 CCGs).

The new approach to NHS finances in 2016/17

After the £2.45 billion overspend by NHS providers in 2015/16, NHS Improvement and the other national NHS bodies have introduced a new approach to managing NHS finances. This approach has a number of key elements.

The Sustainability and Transformation Fund

Additional funding of £1.8 billion has been placed in the new Sustainability and Transformation Fund and is being allocated to trusts to help them manage deficits. This money will be paid out quarterly to NHS providers (overwhelmingly to acute providers), but only where they meet a set of finance and performance targets. Sustainability and Transformation Fund payments reduce an organisation's reported deficit. It was hoped that the £1.8 billion Sustainability and Transformation Fund would be sufficient to return the NHS provider sector as a whole to net balance. But this looks unlikely; NHS trusts now forecast a net deficit of £873 million for 2016/17. If a range of additional measures are taken NHS Improvement states that this net deficit may be reduced to between £750 million and £850 million (NHS Improvement 2017).

Control totals

Control totals are the financial targets for each organisation – they set the maximum deficit (or minimum surplus) an organisation is allowed to run. Each organisation has its own control total, which is agreed with NHS Improvement depending on its financial strength. The financial position reported by individual NHS trusts includes any Sustainability and Transformation Fund money they have received.

Meeting finance and performance targets

If providers fail to meet the finance and performance requirements that underpin their control totals, access to all or some of their planned payments from the Sustainability and Transformation Fund can be withheld. While withholding funding will increase deficits reported by individual providers, it will not alter the net provider

position as the Sustainability and Transformation Fund will be underspent by the equivalent amount and NHS Improvement counts this underspend against providers as a whole. This means deficits reported by individual organisations will overstate the overall provider deficit as NHS Improvement will have some offsetting unspent Sustainability and Transformation Fund money. By the third quarter of 2016/17, £356 million of sustainability funding was retained centrally by NHS Improvement and £994 million issued to providers (NHS Improvement 2017). If a provider cannot pay its bills – such as salaries for its staff – without Sustainability and Transformation Fund support, it may need to turn instead to the Department of Health for additional cash support usually provided as a loan.

Commissioners

In 2016/17 NHS commissioners have set aside 1 per cent of their total allocations (worth around £800 million) to offset risks to overall financial balance in the NHS. This creates an £800 million central risk reserve to set against potential overspends. If this reserve was not needed, the funding was to be released for investment in local priorities. NHS England has now confirmed that the reserve is required to meet deficits elsewhere in the NHS and will not be released for local investment.

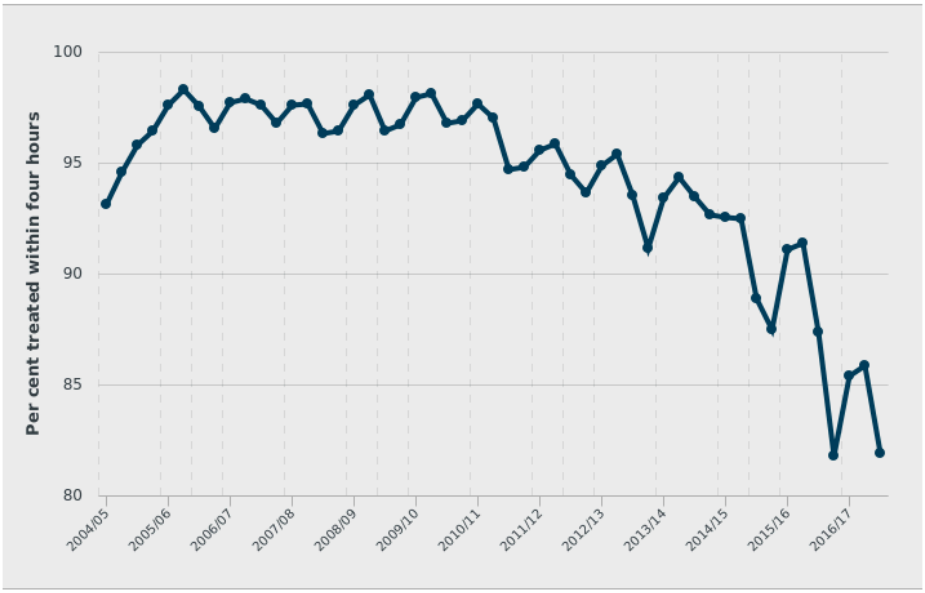
Latest forecasts

Without further action, at the end of the third quarter NHS providers forecast a full-year net provider deficit of £873 million for 2016/17 but are aiming to reduce this to a net deficit of between £750 million and £850 million. This includes the unspent Sustainability and Transformation Fund money still sitting with NHS Improvement. For commissioners, NHS England reported that clinical commissioning groups (CCGs) had overspent by £437.2 million, but are aiming to reduce this to a £370.4 million overspend by the end of the year. Against this, NHS England expects to underspend its own budgets and retain 'up to' £800 million of its reserve taking all commissioner budgets together.

How is the NHS performing?

- 2017 has not started well for the NHS. Performance against the four-hour A&E waiting time standard fell sharply in December and anecdotal reports of longer waits have increased in January and February. For type 1 A&E units, the decline in performance returns the NHS to waiting times not seen since before the four-hour target was first introduced. It is only five years ago that NHS type 1 A&E units could routinely admit, transfer or discharge more than 96 per cent of patients within four hours and where the winter declines in performance were at a level that would now be seen as unworthy of mention. Performance in other areas, including the 18-week referral-to-treatment standard, ambulance waits and delayed transfers of care, is also on a downward trend.
- Despite the focus on A&E in the media, trust finance directors' main concerns are delayed transfers of care, staff morale and high bed-occupancy rates. Since 2013 A&E performance has been one of the top three concerns in every QMR but one, and its disappearance from the top three now may suggest that finance directors are increasingly concerned about the underlying drivers of poor performance rather than the standard itself.

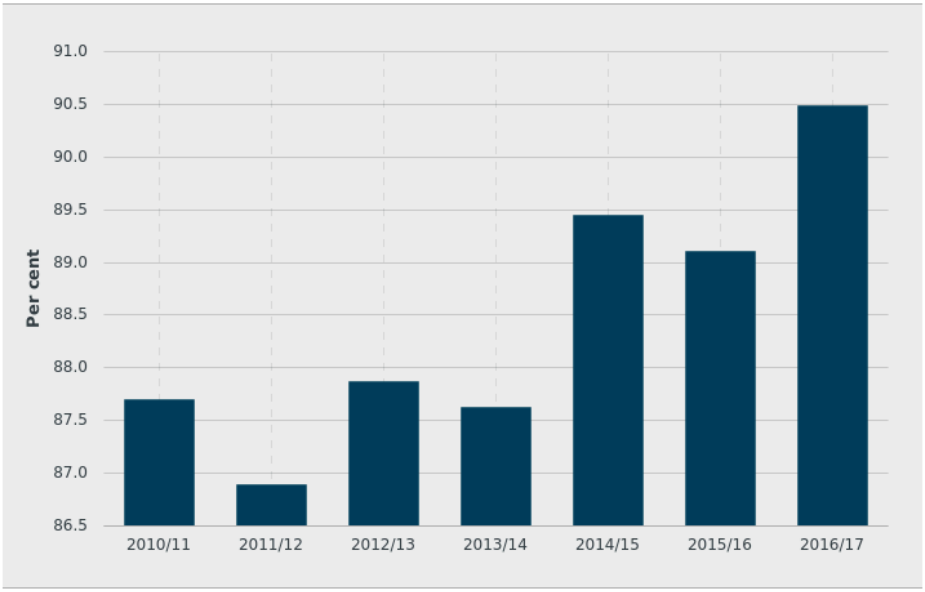
Figure 1: Performance against the four-hour A&E waiting time standard, type 1 unit 2004/05 to 2016/17, quarterly data



Data source: A&E attendances and emergency admissions www.england.nhs.uk

- What has caused this decline in performance? Public Health England's weekly monitoring reports on influenza (Public Health England 2017b) and norovirus (Public Health England 2017a) show neither are putting a significantly greater demand on health services than in previous years. Nor has it been a particularly cold winter. While emergency admissions rose by 2.1 per cent in December 2016 compared to December 2015, this growth is not particularly high by historical standards. Instead, the challenge for many NHS organisations was how to admit more patients when bed occupancy was already high. So high, in fact, that in the normally 'quiet' second quarter (July to September 2016) bed occupancy rates were above those of winter highs before 2012/13 and, unsurprisingly, bed occupancy rose again in quarter 3. Sustained increases in demand over many years, rising delayed transfers of care and seven years of low growth in NHS and social care spending have taken their toll. Unsurprisingly, more than half of finance directors from trusts and CCGs believe that the quality of care in their area has deteriorated over the past 12 months.

Figure 2: Bed occupancy at quarter 3, 2010/11 to 2016/17, general and acute beds



Data source: Bed availability and occupancy data www.england.nhs.uk

- From our survey it is also clear that the deterioration over winter was not due to any lack of effort by NHS providers, commissioners and their staff. In an attempt to pre-empt the winter pressures, more than 70 per cent of trusts increased the number of staff and/or opened more beds and more than half suspended some elective care. A wide range of other measures, including more step-down facilities, paying higher rates for agency staff or using more outsourcing for elective care, were all common. More than 70 per cent of CCGs invested in more primary care and more community services and established new care pathways to try to help manage demand. It is sobering to consider what would have happened to performance if the NHS had not pulled out all the stops in an effort to meet increased demand.

- Trust finance directors point to a number of causes of the difficulties in A&E. Eighty per cent noted rising numbers of patients with complex conditions or who are more acutely ill. Such patients are more likely to need admission to a hospital bed. Finance directors also identified delayed transfers of care as an issue – which means hospitals have fewer empty beds. Conversely, relatively few identified either poor access to general practice or shortages of clinical staff in A&E as key factors in increased pressure on A&E services.

- Winter may now leave an unpleasant hangover into spring. Breaking agency caps and outsourcing elective work will hit finances, while suspending elective activity will hit the 18-week referral-to-treatment standard. This pessimist outlook is supported by NHS trust finance directors. Three-quarters report that they are fairly or very concerned that they will not retrieve the A&E and 18-week referral-to-treatment standards by April (which was the original plan for most), with a clear re-balancing towards 'very concerned'. As a share of all trust finance directors, this 'very concerned' group has jumped from under half to nearly two-thirds. Spring usually brings some reduction in the pressures on A&E, so attention may soon shift towards 18-week referral-to-treatment standards and rising waiting times for routine treatment.

Financial prospects for 2016/17

- With quarter 3 results for NHS England and NHS Improvement now in the public domain, concerns over this year's finances have also risen. On the provider side, the latest results for quarter 3 show that trusts now forecast a net deficit for the year of £873 million. If a further set of actions are taken in quarter 4, NHS Improvement hopes to bring this down to between £750 million and £850 million. As the accumulated year-to-date deficit had already reached £886 million by the end of quarter 3, achieving any of these forecasts relies on NHS trusts running a surplus in quarter 4.

- A significant number of trusts we surveyed report that they are paying above the agency cap for temporary staff or are outsourcing elective work to the private sector to cope with increasing demand for emergency care over winter. This will make it more difficult to run a surplus in quarter 4 even once the last £450 million payment from the Sustainability and Transformation Fund is included. Thirty one per cent of trust finance directors report they will miss their control total but of those that are still reporting they will meet their financial targets, another 17 per cent say they remain fairly or very concerned that they may ultimately fail. This represents a substantial risk this late in the year.

- Our QMR in September identified risks that CCGs' financial performance could deteriorate. This risk has materialised as CCGs reported a year-to-date overspend of £437 million by quarter 3. This worsening position has been driven by difficulties in delivering the higher efficiency targets set by CCGs in 2016/17. Higher savings targets for commissioners were needed as 1 per cent of their budgets were held back to create the £800 million central risk reserve. While rising underspends in NHS England central budgets and direct commissioning (which includes spending on specialised services and primary care) have so far largely offset this slide in CCG finances, the NHS England quarter 3 finance report referred to 'up to an £800m managed underspend' (NHS England 2017) suggesting it is unlikely that NHS commissioners will be able to deliver any larger underspend. Indeed, CCGs, like their trust counterparts, may also find it hard to dramatically improve their financial performance in quarter 4 given the pressures of winter.

- This creates the risk that the provider deficit will be greater than the commissioner underspend. This happened in 2015/16 as well, but then the Department of Health found sufficient savings to (largely) offset the NHS net deficit. This year, the Department provided the resources to establish the £1.8 billion Sustainability and Transformation Fund and may well struggle to find significant additional savings. The risk that the Department will break its constitutional spending limits has grown materially greater.

Beyond 2016/17

- When asked about the future, trusts and CCGs remain very pessimistic about finances. Looking ahead, 53 per cent of trusts and 63 per cent of CCGs are fairly or very pessimistic about reaching financial balance in 2017/18. For CCGs, this has doubled from 30 per cent who were fairly or very pessimistic when they predicted their financial position for 2016/17 this time last year, underlining the spread of financial distress into the commissioning sector. Looking further ahead, when asked about whether they would achieve the efficiency gains underpinning the *NHS five year forward view*, 74 per cent of trust finance directors and 86 per cent of CCG finance leads say there is a high or very high risk of failure.
- Financial pressures mean some trusts are reducing their workforce, with 29 per cent of finance directors reporting that their organisations have plans to reduce permanent clinical headcount. Most organisations (74 per cent) also plan to reduce the number of agency staff that they use. However, it will be very challenging to reduce the clinical workforce at a time when many NHS hospitals are routinely running at high bed-occupancy levels and demand continues to rise. We have already witnessed this tension over winter, with 40 per cent of finance directors reporting that they have broken the spending caps on agency staff. It is not surprising that staff morale remains a key concern for finance directors.
- Previous QMRs have charted the rise and fall of provider deficits as money from the Sustainability and Transformation Fund has been released (or not), growing concerns over CCG finances and the (relatively) slow slide on performance. However, this slide in performance has clearly accelerated, at least in the acute sector, and the concerns expressed over both performance and quality of care by many finance directors are worrying not just in the long term, but for the next few months as well. With financial difficulties rising for providers and CCGs, the NHS may be facing the uncomfortable combination of missing both finance and performance standards.
- Meanwhile, although many agree that sustainability and transformation plans (STPs) may provide at least part of the answer to the underlying problems facing health and social care, very few think they can provide an answer quickly enough for there to be any optimism about the near future.

1. Health care surveys

This quarter's report is based on an online survey of 80 NHS trust finance directors and 42 clinical commissioning group (CCG) finance leads (covering 51 CCGs).

Respondents were asked about their organisation's financial situation and the financial outlook for their local health economy over the past and forthcoming financial year; the state of patient care in their area; the financial situation looking ahead to 2017/18; the key organisational challenges facing trusts and CCGs; and workforce issues. We also asked trusts about the actions they had taken to manage any winter pressures and what they felt was leading to any pressures felt in accident and emergency (A&E) departments.

2. Estimated end-of-year financial situation: 2016/17

- In our recent survey just under half of all trusts (46 per cent) forecast ending 2016/17 in deficit (Figure 3). More than 70 per cent of trust finance directors reported that their forecast position for 2016/17 would depend on significant financial support (Figure 5). Furthermore, 55 per cent of providers expecting to receive Sustainability and Transformation Fund monies still forecast a deficit by the end of the year.
- The total net deficit forecast for the end of 2016/17 for the 80 provider organisations surveyed amounts to £542 million. For acute providers the net deficit is £453 million. For organisations that have refused to agree control totals, or that have had Sustainability and Transformation Fund payments withheld, these deficits will be partially offset by unspent payments held by NHS Improvement.
- We also asked trusts to provide details of their agreed control totals for 2016/17. Of the 74 trusts that have agreed control totals (or that are in the process of agreeing control totals), 31 per cent forecast a worse end-of-year position against their control total. Furthermore, 34 per cent of trusts are either fairly or very concerned about meeting their agreed control totals in 2016/17 (Figure 7). Perhaps more alarming at this late stage of the year, 17 per cent of trusts are still forecasting that they will hit their control total but also remain fairly or very concerned that they may ultimately fail.
- More than half (57 per cent) of all CCGs forecast a surplus for 2016/17, and 25 per cent are expecting to overspend, up from 10 per cent last quarter (Figure 4). Forty per cent of CCGs have had to delay or cancel spending plans to support their finances (Figure 6). The potential threat to the £800 million central risk reserve is underlined by the fact that 18 per cent of CCGs are relying on their share being returned to them, rather than being used to support provider deficits.

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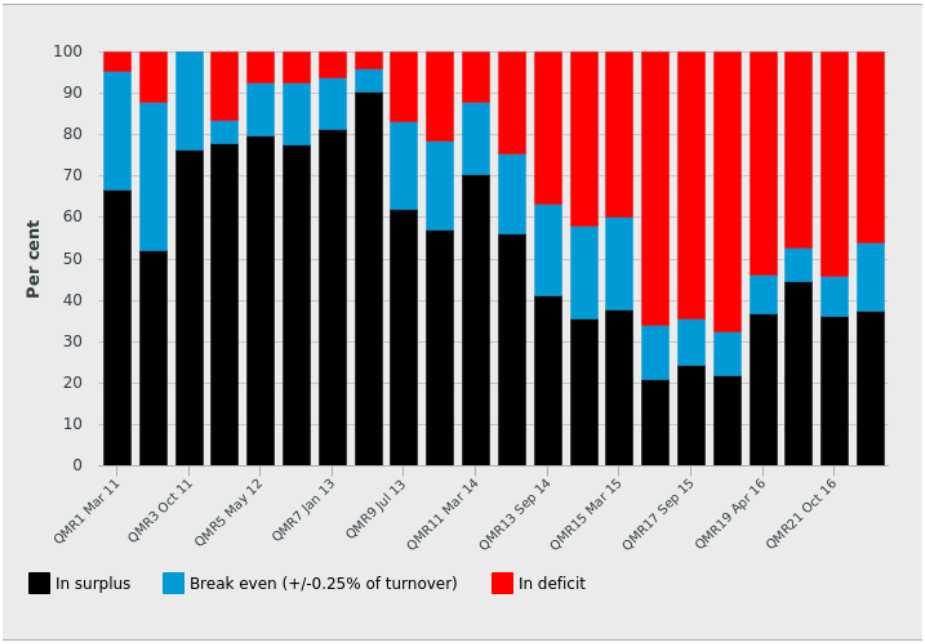
Figure 3: What is your organisation's forecast end-of-year financial situation?



QMR 1-4 based on a panel of 50 trust finance directors.

Respondent comments

"After deficit support funding and STF [Sustainability and Transformation Fund]."

– In surplus, Acute

"Contingencies/one-off benefits offsetting an underlying deficit."

– In surplus, Teaching hospital (with community services)

"We are still forecasting to hit the control total before STF [Sustainability and Transformation Fund]. However, won't get all the performance elements of the STF funding."

– Break even, Acute teaching

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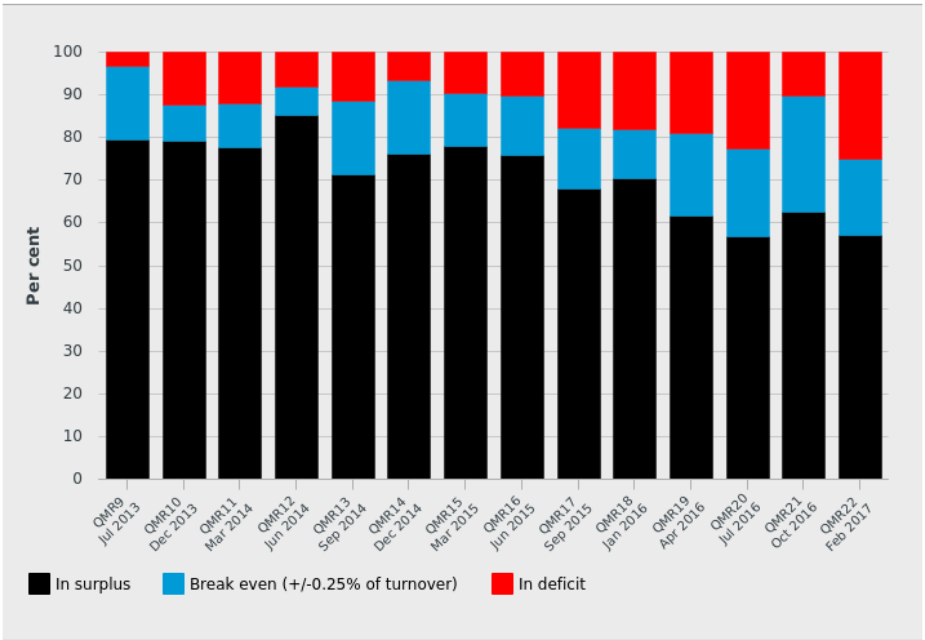
Figure 4: What is your organisation's forecast end-of-year financial situation?



42 CCG finance leads answered this question for the 51 CCGs they cover collectively; CCGs only surveyed since their establishment in April 2013.

Respondent comments

"In surplus as a result of mandated 1 per cent reserve requirements."

– In surplus

"Meeting our control total for 1 per cent surplus, but very tight."

– In surplus

"[In surplus due to] cumulative surplus being brought forward – in-year position is otherwise break even."

– In surplus

"Note that risks to forecast are not easy to report to NHS England without significant challenge and encourage organisations to under-play the risks."

– Break even

"CCG requirement for 1 per cent control total surplus to be met. Plus further 1 per cent non-recurrent reserve MUST be forecast as committed although CCG not permitted to spend it."

– Break even

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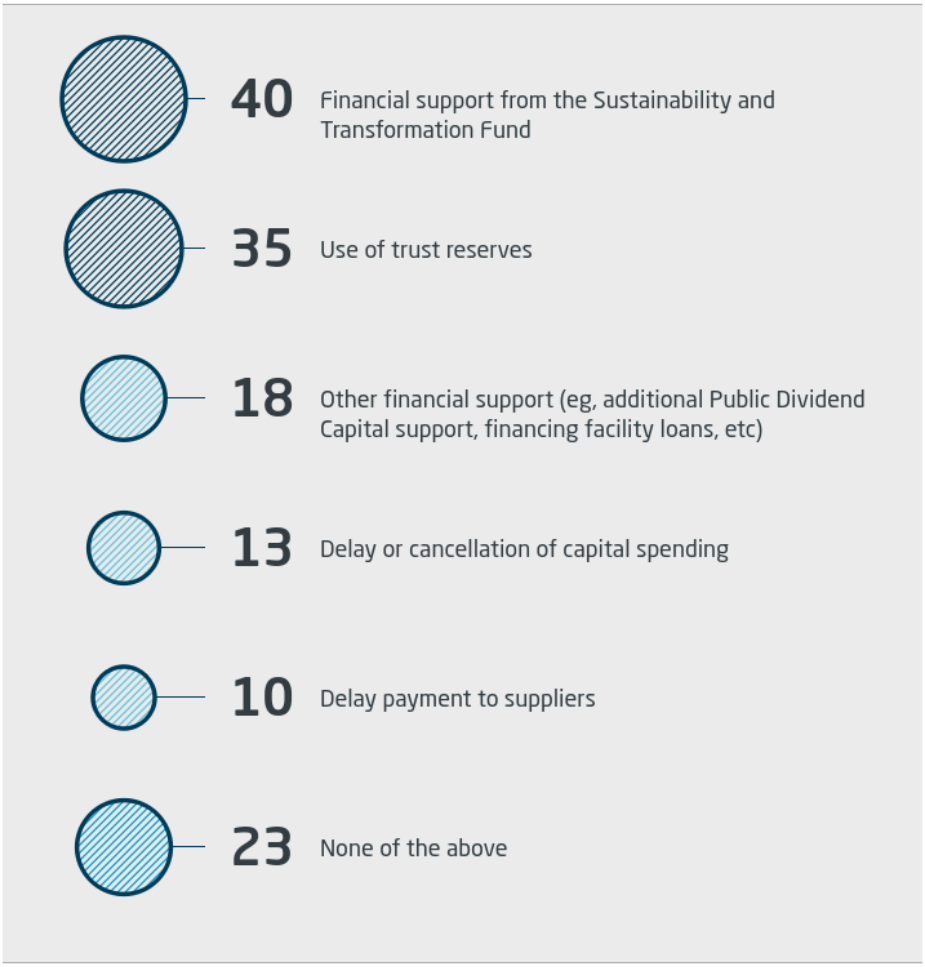
Figure 5: What is your forecast 2016/17 end-of-year outturn likely to depend on?



Only foundation trusts are allowed to retain surpluses. Respondents were allowed to select more than one form of additional financial support.

Respondent comments

"The main risks are cost of winter emergency care pressures and CCG income challenges."

"Bringing forward CIPs, discretionary expenditure freeze, asset lives review, ban on annual leave carry over, non-clinical vacancy controls, non-clinical agency ban."

"Our outturn will depend on the outcome of the dispute process with the CCG."

"Multiplier effect of STF [Sustainability and Transformation Fund] getting quite frightening."

"Winter pressures are derailing elective activity causing income reduction."

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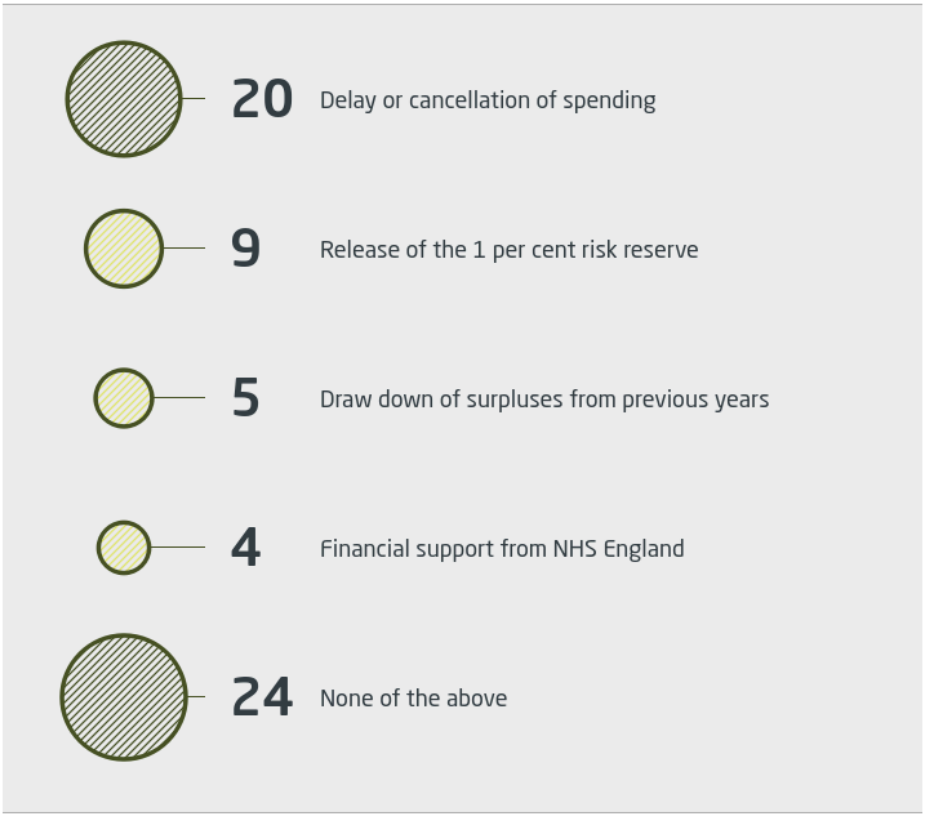
Figure 6: What is your forecast 2016/17 end-of-year outturn likely to depend on?



Respondents were allowed to select more than one form of additional financial support. 42 CCG finance leads answered this question for the 51 CCGs they cover collectively.

Respondent comments

"Planned investment in primary and community care services during 2016/17 has been abandoned."

"Acute trust over-forecasting/rejection of agreed risk share."

"Our surplus does not include release of 1 per cent reserve. Not clear whether this will be released to the bottom line or the allocation removed from the CCG."

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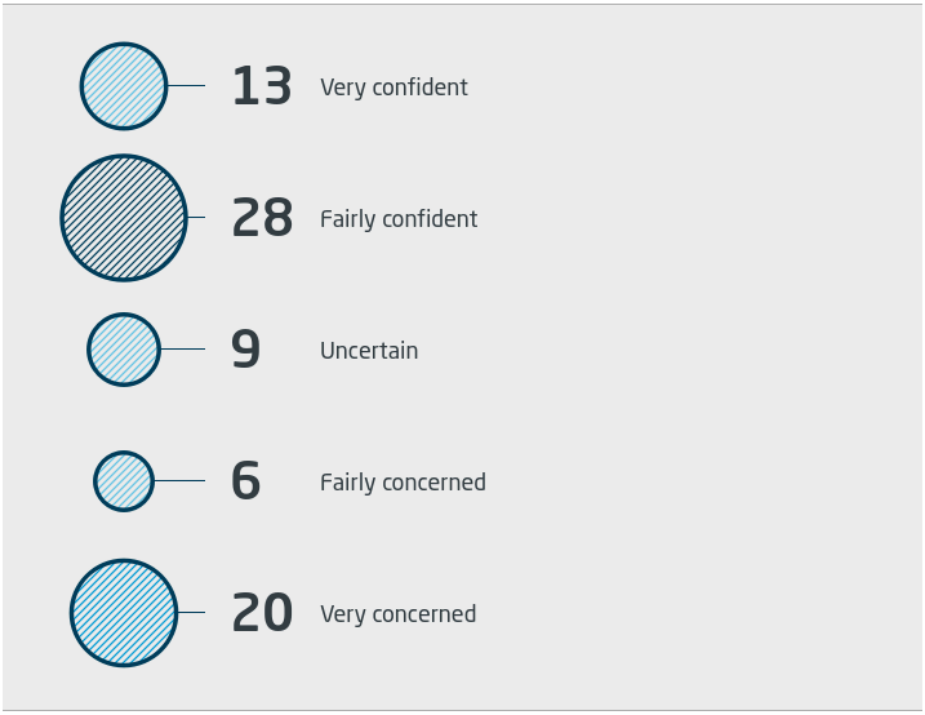
Figure 7: How confident are you that your organisation can meet its control total for 2016/17?



76 respondents (for whom this question was applicable). Includes a few providers who have not yet agreed a control total.

Respondent comments

"Taking the control total to be the delivery of the underlying deficit before STF. We have lost STF money for non-delivery of standards (eg, AED), but these are discounted when assessing financial performance."

– Fairly confident

"Impact of winter with no funding is a risk, ability of commissioners to pay for activity and therefore seek ways to not pay also an issue, agency costs continue to be a concern."

– Uncertain

"We are on track to hit the control total, however, CCG affordability a key constraint with challenge on activity classification and subsequent charging currently at arbitration. If this is adverse to the trust the control total will not be hit. The trust however believes its case to be robust."

– Uncertain

"Will definitely not meet performance standards (A&E) - underlying finance plan achievement is touch and go."

– Fairly concerned

"Not likely to secure sustainability and transformation funding linked to operational performance in quarters 3 or 4."

– Very concerned

"With three months to go we are 'on a knife edge' with our forecast outturn. We are very close and if we miss it, it will only be by £1 million or less."

– Uncertain

"We have had a massive miss on income targets which has resulted in this variance. This means that we miss STF funding which has compounded the issue."

– Very concerned

3. Cost improvement and quality, innovation, productivity and prevention (QIPP) programmes (2016/17)

- The average cost improvement programme (CIP) target for trusts for 2016/17 is 4.1 per cent, ranging from 1 per cent to 9 per cent of turnover (Figure 8).
- The average quality, innovation, productivity and prevention (QIPP) target for CCGs for 2016/17 is 3.3 per cent, ranging from 0.9 per cent to 7.1 per cent of allocation (Figure 8).
- More than a third (37 per cent) of all NHS trust finance directors are either fairly or very concerned about achieving their savings plans this year (Figure 9). This represents a lower level of concern than that reported at the same time in 2015/16 or 2014/15.
- Nearly two-thirds (59 per cent) of all CCG finance leads are fairly or very concerned about achieving their plans this year (Figure 10). High levels of concern among CCGs reflect the higher efficiency savings that were built into 2016/17 plans. These higher savings were necessary to generate the £800 million central risk reserve among NHS commissioners.

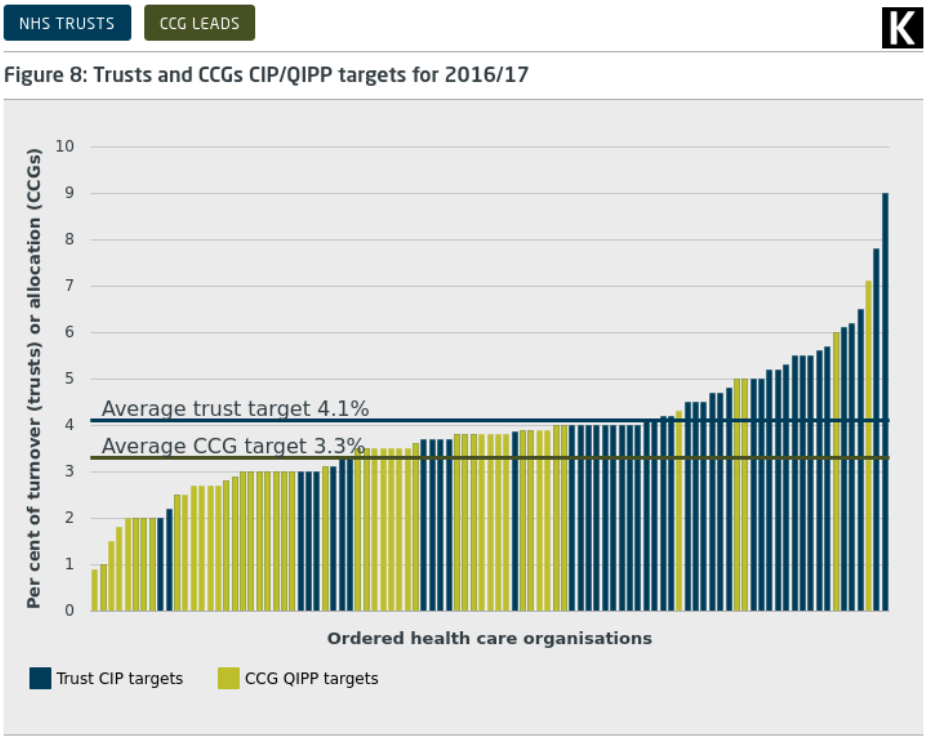


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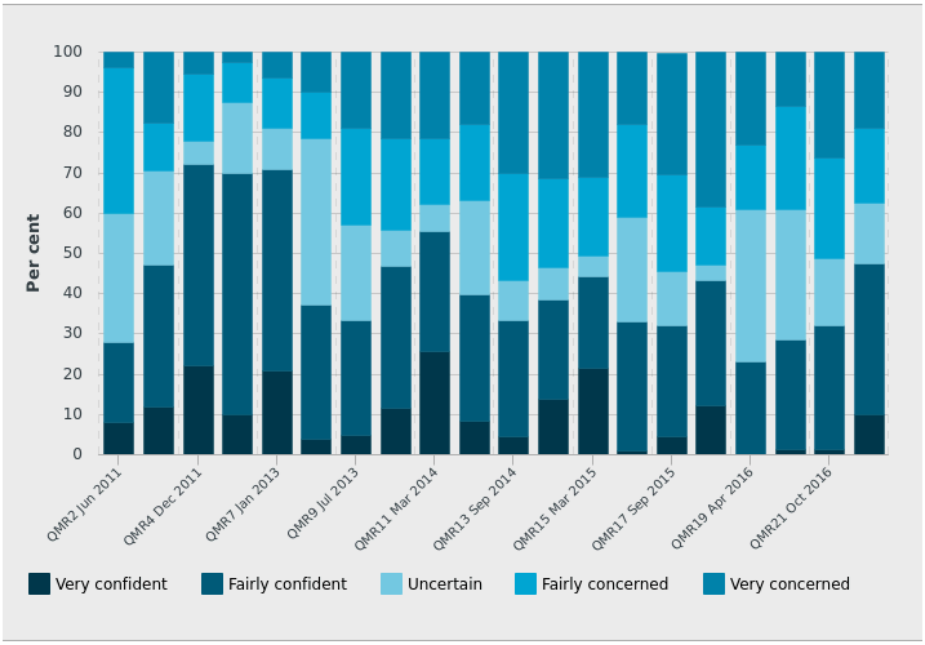
Figure 9: How confident are you of achieving your CIP target?



QMR 1-4 based on a panel of 50 finance directors. QMR1 and QMR5 excluded as wording of responses not compatible with other quarters' data.

Respondent comments

"Will achieve high proportion but not necessarily all, shortfall circa 6 per cent and not necessarily all in year, though action to attain CIP will have been taken savings may fall in next year, with non-recurrent savings making up shortfall."

– Uncertain

"We will not make savings to meet the full target."

– Very concerned

"We won't deliver it, but some non-recurrent pay savings, our contingency fund and some financial/technical solutions are offsetting the failure to achieve."

– Very concerned

"Loads of agency cost pressure."

– Very concerned

"We'll achieve about 80 per cent of cost savings and none of the service developments."

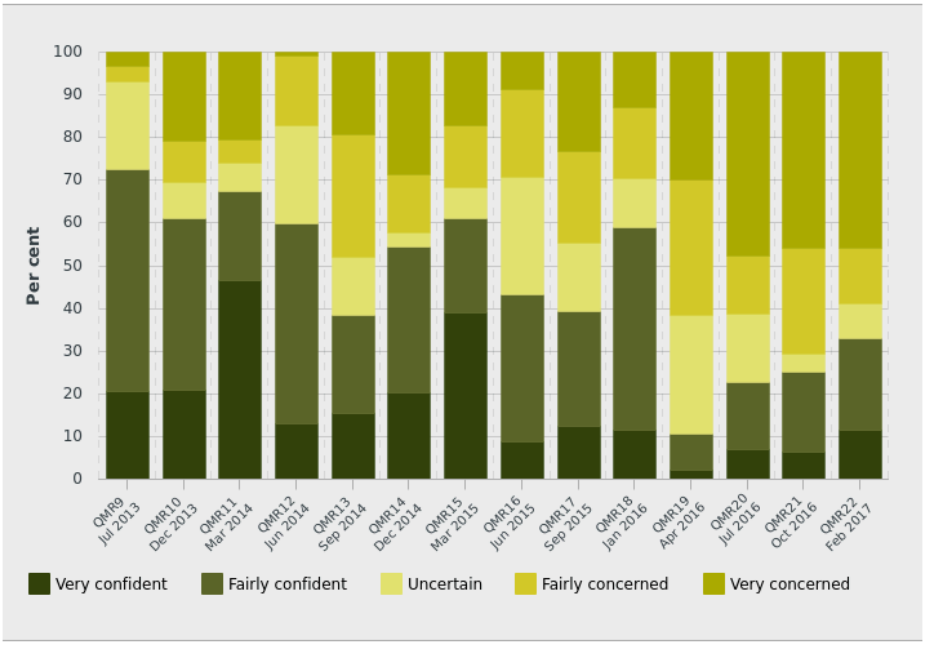
– Uncertain

"It is hard to demonstrate efficiency in concrete terms. The budget is often achieved via vacancy management reducing activity."

– Fairly concerned

CCG LEADS

Figure 10: How confident are you of achieving your QIPP target?



42 CCG finance leads answered this question for the 51 CCGs they cover collectively; CCGs only surveyed since their establishment in April 2013.

Respondent comments

"Relying on non-recurrent solutions to offset slippage on recurrent savings schemes."

– Very confident

"Some of this has been achieved but via non-recurrent fortuitous savings such as Cat M [generic medicine reimbursement] price reductions."

– Uncertain

"We have done well this year on QIPP as we have focused our efforts on a 3-4 big ticket items."

– Very confident

"Most of the QIPP target related to transactional contract agreements and therefore is more certain than transformational schemes."

– Fairly confident

"Expecting to deliver 91 per cent but have non-rec flexibilities that mean we can absorb this and still deliver our planned control total deficit."

– Fairly confident

"While we are planning to hit our planned position, we are behind in terms of the delivery of QIPP areas that we need recurrently to support our rapidly deteriorating underlying financial position."

– Fairly concerned

4. The state of patient care

- Just under two-thirds of trust finance directors (63 per cent) feel that patient care has worsened in their local area in the past year (Figure 11).
- For CCGs, more than half (56 per cent) of all CCG finance leads feel that patient care has worsened in their local area in the past year (Figure 12).
- The number of trust finance directors and CCG finance leads reporting that patient care has worsened in their local area in the past year has remained consistently high throughout 2016/17, when compared to earlier years.

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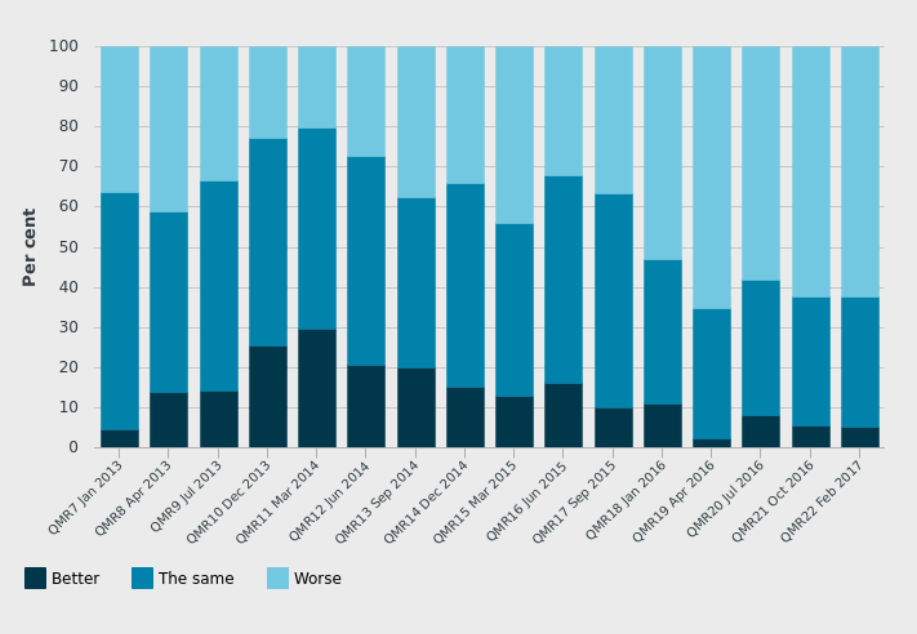
Figure 11: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



Question not asked before QMR6.

Respondent comments

"CCGs now moving into deficit alongside providers."

– *Worse*

"Wait times for treatment and in A&E have worsened significantly."

– *Worse*

"Demand has grown, eg, elective MSK [musculoskeletal] and emergency, but we can't get staff to cover the growth."

– *Worse*

"The impact of financial pressures over a number of years is now having a dramatic impact on patient care."

– *Worse*

"This is the start of the breakdown, it's starting to happen (as Tears for Fears once said)."

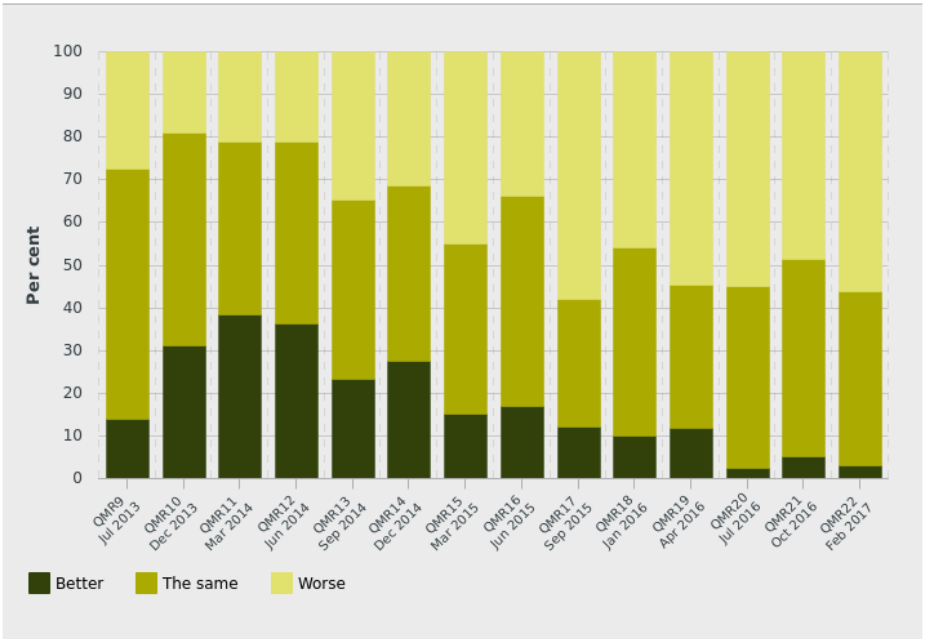
– *Worse*

"Pressures in A&E in other trusts, increased demand across our services being supported by agency spend, increases in private beds."

– *Worse*

CCG LEADS

Figure 12: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



CCGs only surveyed since their establishment in April 2013.

Respondent comments

"Additional service restrictions agreed within some parts of the STP footprint."

– *Worse*

"Deterioration in A&E, cancellation of electives, increase in waiting lists, access to GPs insufficient."

– *Worse*

"Availability of reserves has meant we have little room to absorb cost pressures."

– *Worse*

"Waiting times are longer; less staff in the community; commissioning thresholds raised."

– *Worse*

"Greater collaboration across STP footprint."

– *Better*

"Significantly worse. Four local CCGs delivered planned surpluses last year, three now forecasting real deficits for 16/17."

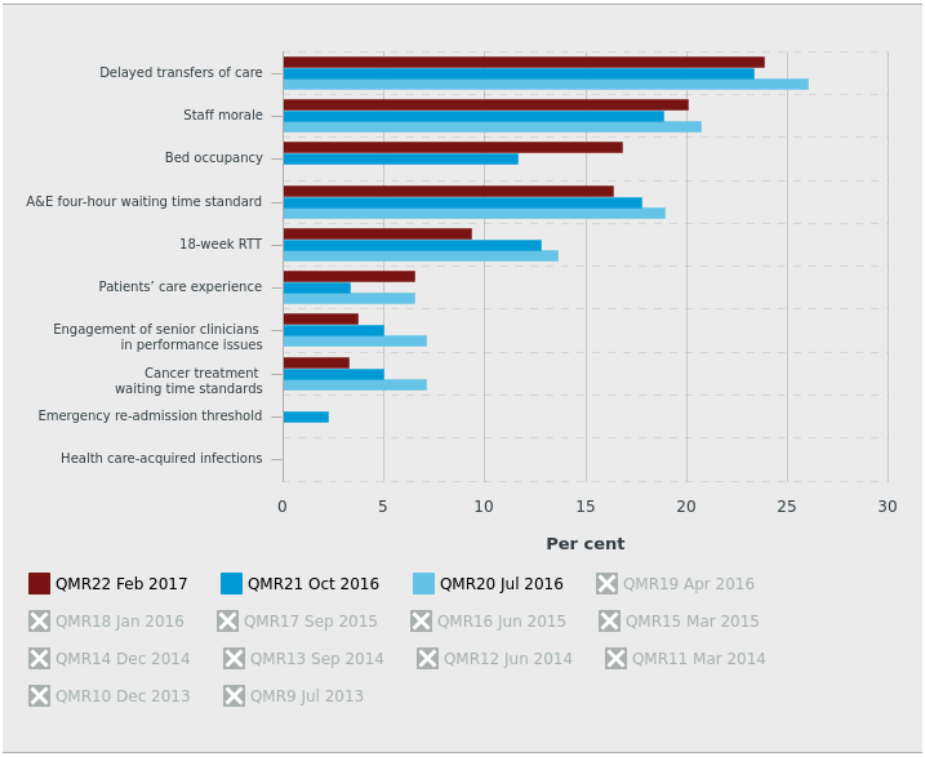
– *Worse*

5. Organisational challenges

- For trust finance directors, delayed transfers of care continues to be their main concern. As in the previous QMR, staff morale is their second highest concern. Bed occupancy is now the third major concern for trust finance directors. Since 2013 A&E has been one of the top three concerns in every QMR but one, and its disappearance from the top three now may suggest that finance directors are increasingly concerned about the underlying drivers of poor performance rather than the standard itself (Figure 13).
- For CCG finance leads the four-hour A&E waiting time standard continues to be their main concern for a second time in a row, followed by the 18-week referral-to-treatment standard. They also continue to be concerned about delayed transfers of care and the cancer treatment waiting times standards (Figure 14).

NHS TRUSTS

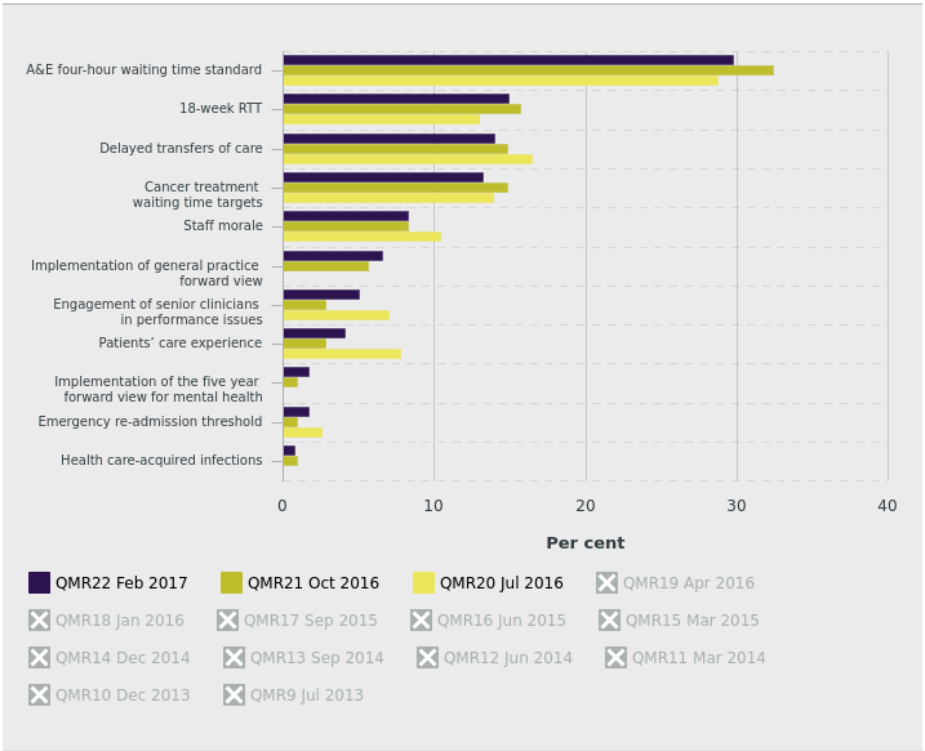
Figure 13: Which aspects of your organisation's performance are giving you most cause for concern at the moment?



Respondents asked to choose their top three concerns. Figures expressed as a percentage of the total number of concerns in each survey. A new option 'bed occupancy' was introduced in QMR21.

CCG LEADS

Figure 14: Which aspects of the performance of the organisations with which you contract with are giving you most cause for concern at the moment?



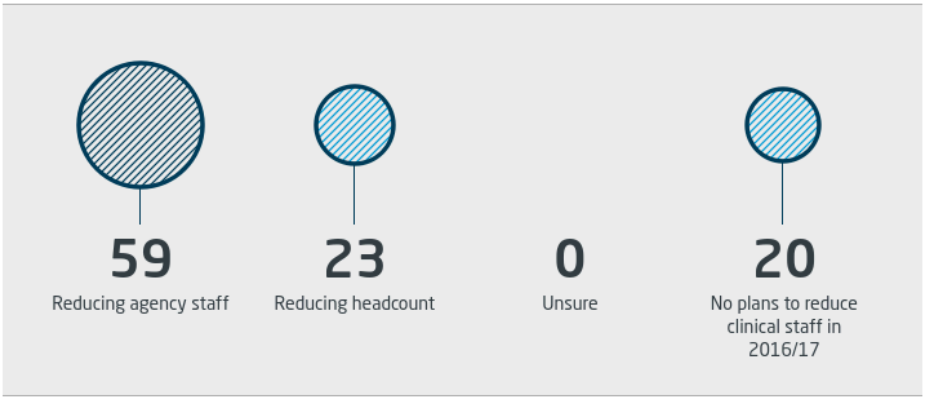
Respondents asked to choose their top three concerns. Figures expressed as a percentage of the total number of concerns in each survey. Two new options, implementation of general practice forward view and implementation of the five year forward view for mental health, were introduced in QMR21.

6. Workforce

- As providers continue to operate within an extremely challenging financial situation, a number of measures are available to them to improve their financial position. As clinical staff account for a high proportion of overall NHS costs, one of the most direct ways to make savings is to reduce the number of clinical staff employed. Alongside potential changes to permanent clinical headcount, the NHS has also been engaged in a major effort to reduce spending on agency staff, with some success (NHS Improvement 2017). NHS providers now forecast a £771 million reduction in spending on agency staff in 2016/17 compared to 2015/16, after three years in which spending had risen at 25 per cent per annum.
- Seventy-four per cent of trusts plan to reduce their use of clinical agency staff in 2016/17, and 29 per cent plan to reduce permanent clinical headcount (Figure 15). Twenty-five per cent of trusts plan to reduce both use of clinical agency staff and permanent clinical headcount. As in recent QMRs, the percentage of mental health and community health services trusts saying they plan to reduce headcount (36 per cent) is higher than the proportion of acute trusts planning to reduce headcount (21 per cent).

NHS TRUSTS

Figure 15: Does your organisation have plans for reducing clinical staff in 2016/17 through:



Respondents allowed to select more than one option.

Respondent comments

"Will continue to reduce agency spend but by further recruitment of substantive staff."

"Cost improvement plans must remove cost which includes clinical staff."

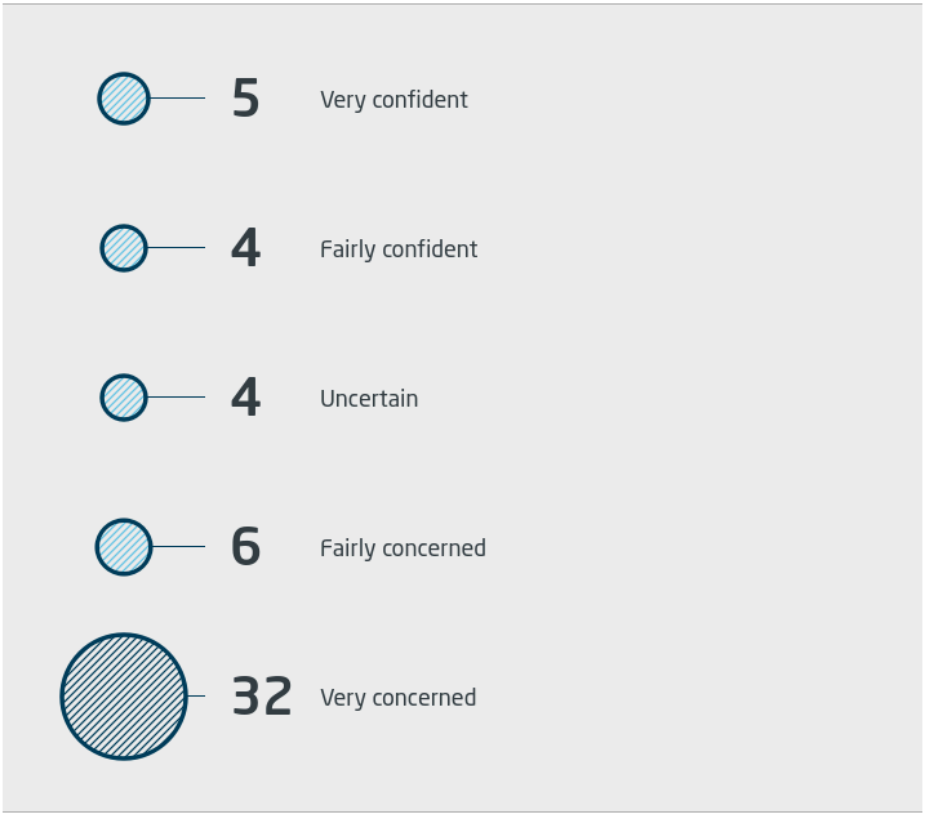
"Limited plans to reduce clinical headcount – mainly by consolidating clinical support services. Most headcount reduction via back office consolidation."

7. Waiting time standards

- As a condition of receiving sustainability and transformation funding, trusts are expected to develop credible plans for maintaining delivery of core standards for patients, including the four-hour A&E waiting time and the 18-week referral-to-treatment standards.
- We asked trust finance directors how confident they were in their organisation's ability to deliver on these standards by the end of 2016/17. Worryingly, three-quarters (75 per cent) are either fairly or very concerned that their organisation will not be able to deliver these operational standards by the end of 2016/17 (Figure 16). Since the last QMR, the proportion who are very concerned that their organisation will not meet these standards has risen from under half to nearly two-thirds, underlining the rise in pessimism over winter. Despite this, as noted above, neither A&E waiting times nor 18-week waiting times are within the top three organisational concerns for trust finance directors.

NHS TRUSTS

Figure 16: How confident are you that your organisation will meet the A&E four-hour and 18-week waiting time targets by the end of this financial year (2016/17)?



51 respondents (for whom this question was applicable).

Respondent comments

"Will deliver 18 weeks but the A&E target remains very challenged."

– Very concerned

"We will not meet these."

– Very concerned

"A&E will fail."

– Very concerned

"The year was lost in April..."

– Very concerned

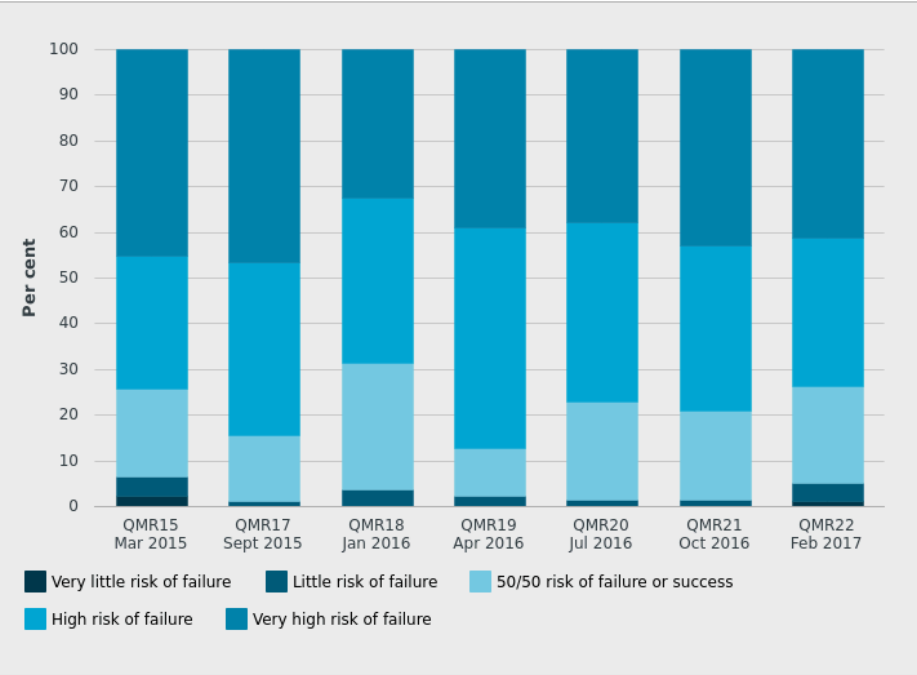
8. NHS five year forward view

- Previous surveys have revealed a high degree of scepticism about the achievability of the productivity challenge as set out by the Forward View.

- This survey shows that 74 per cent of trust finance directors and 84 per cent of CCG finance leads think there is a high or very high risk of failing to achieve the productivity gains suggested by the Forward View (Figures 17 and 18).

NHS TRUSTS

Figure 17: The NHS five year forward view sets out a challenge to the NHS to achieve an average of 2 to 3 per cent of productivity gains per year from 2015/16 to 2020/21. What is your estimate of the risk involved in achieving these productivity gains?



Question not asked in QMR16.

Respondent comments

"Risk of double counting of additional pressures from CCGs and Councils of savings on providers."

– 50/50

"We could achieve 2 per cent savings but as all NHS savings work their way down to providers and due to NHS Improvement setting control totals our target savings for the next two years are 5.5-6 per cent. These are unlikely to be achieved."

– Very high risk of failure

"The amount of saving is higher than envisaged in Forward View, and the levers available for change are being clogged up by cuts in social care."

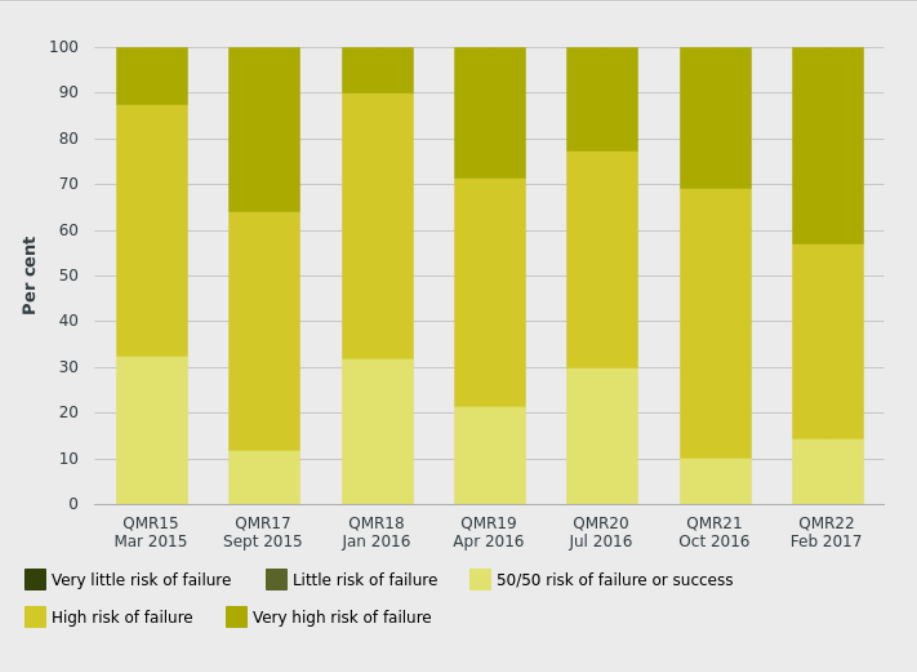
– Very high risk of failure

"It will be strategies that underpin the change that can do this and at present the investment in health is being used to prop up the financial position and STF [Sustainability and Transformation Fund] cannot be sued to make the transformational change we had thought it would facilitate."

– High risk of failure

CCG LEADS

Figure 18: The NHS five year forward view sets out a challenge to the NHS to achieve an average of 2 to 3 per cent productivity gains per year from 2015/16 to 2020/21. What is your estimate of the risk involved in achieving these productivity gains?



Question not asked in QMR16.

Respondent comments

"Trusts are continually firefighting with capacity and high levels of activity and this will only add further pressure at a time of immense pressure to deliver the basics."

– High risk of failure

"We have delivered efficiencies consistently over many years now and I think there is becoming less opportunity to identify more areas unless we make structural changes but this will require more capacity and resource in the short term, which will cost more and is unlikely to deliver the size of productivity gains required."

– High risk of failure

"Local economy is beyond productivity – now into closing services and redesigning where possible."

– High risk of failure

9. Winter pressures

- In order to manage the seasonal increase in demand seen over winter, 75 per cent of trusts in our survey increased the number of staff available, 73 per cent opened additional beds, and 55 per cent suspended/cancelled elective activity in order to free up capacity (Figure 19). Turning to CCGs, 81 per cent invested in additional primary care capacity and 78 per cent of CCGs have also invested in additional capacity in

the community (Figure 20). These responses underline just how widespread the contingency planning for winter was, across both trusts and CCGs.

- When asked what was having the most impact on A&E pressures, 80 per cent of trust finance directors say higher levels of patients with more complex conditions or who were more acutely ill, 70 per cent say delayed transfers of care and 61 per cent point to rising demand (Figure 21). This indicates a high degree of agreement among finance directors over the underlying cause of rising waiting times in A&E and the associated winter pressures on the NHS. Significantly fewer finance directors point to either access to general practice or a shortage of clinical staff in A&E as key factors.

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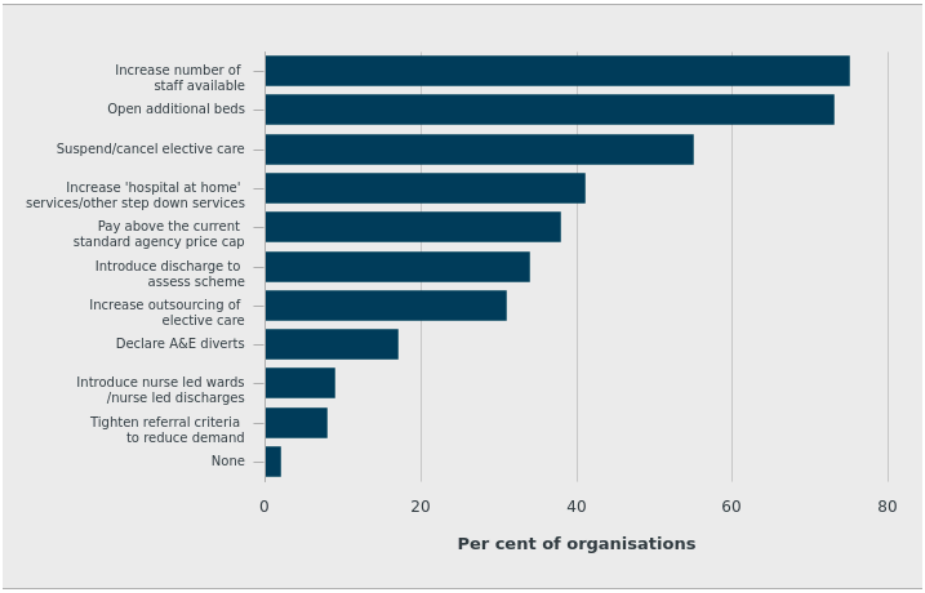
Figure 19: What actions has your organisation taken to manage winter pressures?



64 respondents (for whom this question was applicable). Respondents were allowed to select as many options as applicable.

Respondent comments

"Less system resilience funding provided by CCG than for previous winter and further social care cuts."

– Teaching hospital with community services

"Increased use of private ambulance services, clinical managers diverted to frontline responding."

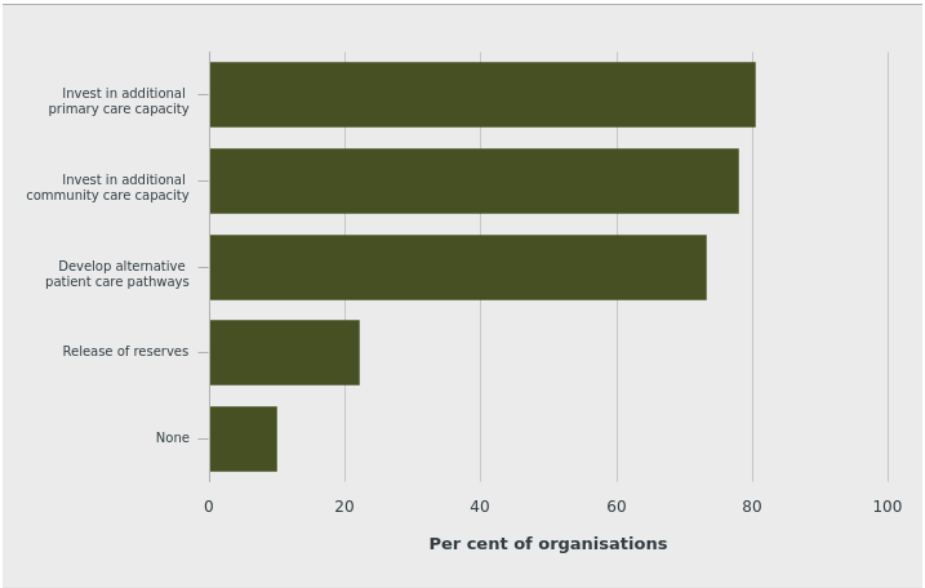
– Ambulance trust

"Most of the above is linked to the acute sector and all funding has been focused here."

– Mental health and community trust

CCG LEADS

Figure 20: What actions has your organisation taken to manage winter pressures?



41 CCG finance leads answered this question for 50 CCGs they cover collectively. Respondents were allowed to select as many options as applicable.

Respondent comments

"We have had to look at using CQUIN and existing funds to invest in additional support."

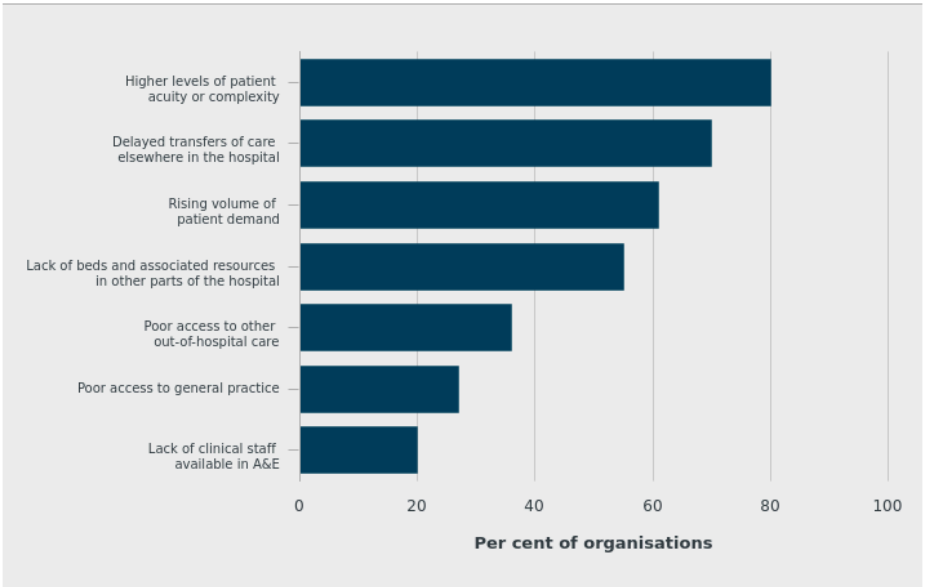
"Resilience funding fully allocated across system, included additional acute beds."

"No funds available for investment. Pressures managed through A&E delivery boards but without funding."

"Part-funded additional adult social care resources."

NHS TRUSTS

Figure 21: Which of the following are having the most impact in increasing the pressures on your A&E department?



44 respondents (for whom this question was applicable). Respondents asked to choose their top three.

Respondent comments

"As a mental health trust we are focusing on enhancing A&E liaison services."

– Mental health trust

"We do have a lack of beds but it is caused by DTOCs [delayed transfers of care]."

– Acute trust

"While we do not have an A&E we have mental health emergency services and we are seeing increasing demand and challenges in delayed transfers of care."

– Mental health trust

"DTOCs [delayed transfers of care] much higher this winter (due to social care cuts)."

– Teaching hospital (with community services)

10. Looking ahead...

- When asked for their views about the financial state of their wider local health and care economy over the next 12 months, 96 per cent of trust finance directors and 81 per cent CCG finance leads are fairly or very pessimistic (Figures 22 and 23).
- More than half (59 per cent) of NHS trust finance directors are very or fairly pessimistic about balancing their books in 2017/18 (Figure 24).
- Just under two-thirds (61 per cent) of CCG finance leads are very or fairly pessimistic about achieving financial balance in 2017/18 (Figure 25).

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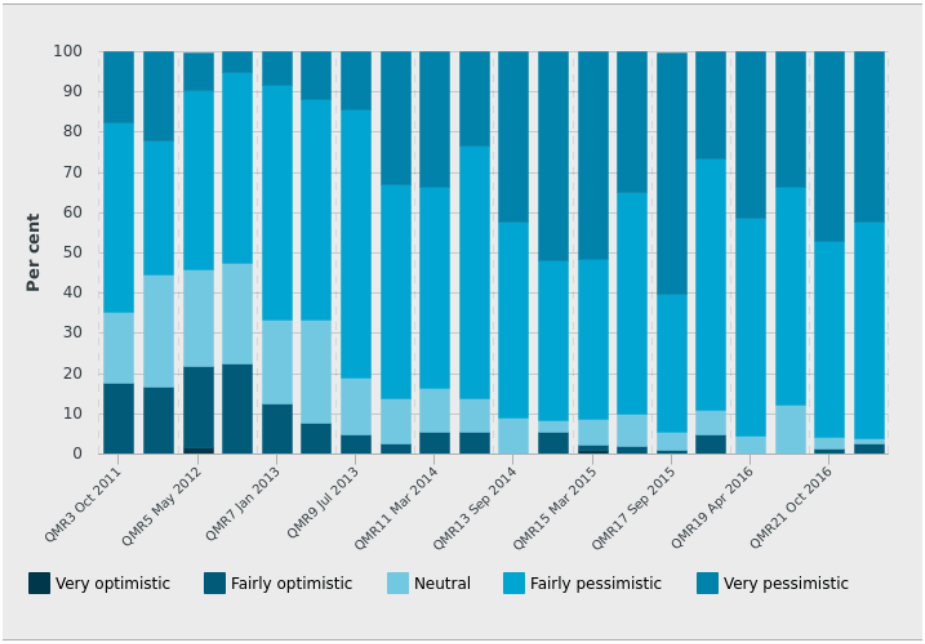
Figure 22: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next 12 months?



Question not asked before QMR3; QMR 1-4 based on a panel of 50 finance directors.

Respondent comments

"The control total for our sector is unachievable, the plans for demand reduction are over optimistic and lacking credible detail however there are encouraging signs of joint working and more honest recognition of the real problems."

– Fairly pessimistic

"With no additional funds the economy is not sustainable even allowing for STP plans."

– Very pessimistic

"Social care, public health and local authority budget pressures really ramp up from April and the position is already very challenging."

– Very pessimistic

"Three acute trusts in the patch with large overspends continuing into 2017/18."

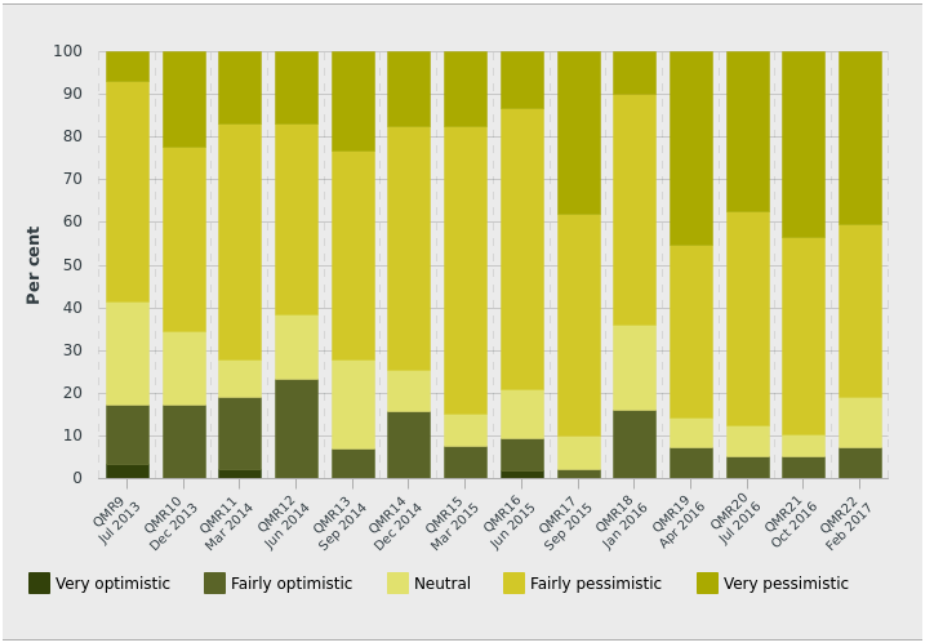
– Very pessimistic

"We are staring down the barrel of greater demand, increased acuity and pressure to achieve all targets with an even lower deficit. Harry Houdini probably wouldn't take on this trick."

– Very pessimistic

CCG LEADS

Figure 23: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next 12 months?



CCGs only surveyed since their establishment in April 2013.

Respondent comments

"Local acute trusts declined to support STP initiatives when it came to contract agreement."

– Very pessimistic

"Everyone talks of shared ownership but acute providers still looking to maximise income while CCG need to spend less. And no financial headroom to pump-prime change/manage stranded costs in the transition."

– Fairly pessimistic

"Further cuts to social care will impact on ability to deliver NHS services."

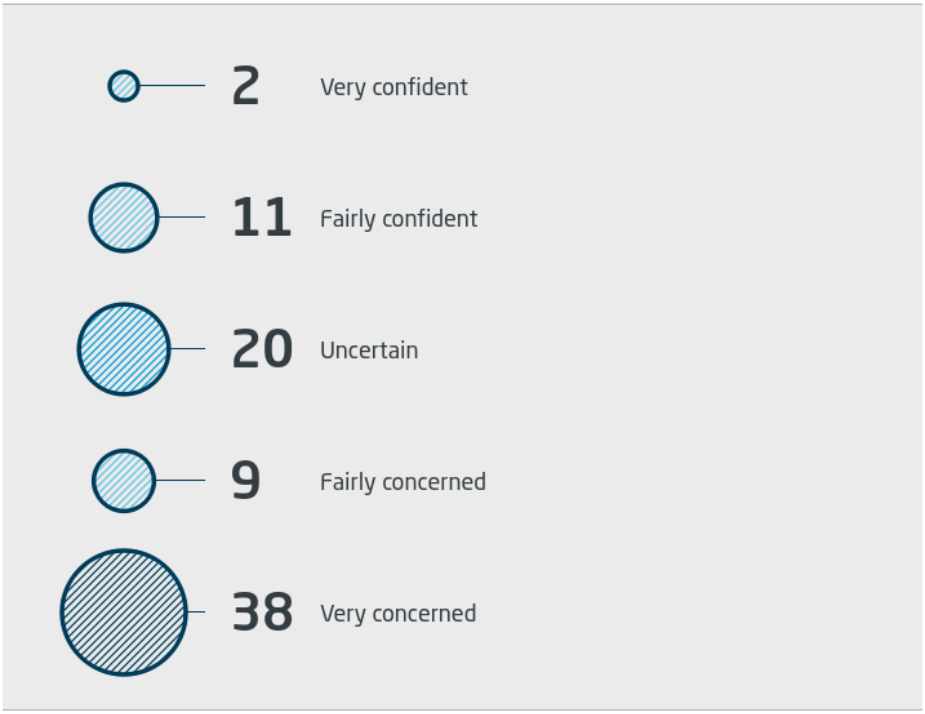
– Very pessimistic

"A combination of further extreme reductions in social care together with extremely tight NHS financial positions."

– Very pessimistic

NHS TRUSTS

Figure 24: Looking ahead, how confident are you that your organisation will achieve financial balance in 2017/18?



Respondent comments

"Control total trajectory of improvement would not achieve financial balance."

– Very concerned

"We won't, we will continue to run at a deficit similar to this year."

– Very concerned

"Contract not yet agreed for 2017/18."

– Fairly concerned

"A combination of an underlying deficit brought-forward from 16/17, 2 per cent efficiency, Health Education England funding reductions, losses on tariff, contracting losses and pressures around junior doctors (gaps and new contract), IT and emergency care pathways give a £40 million gap to address."

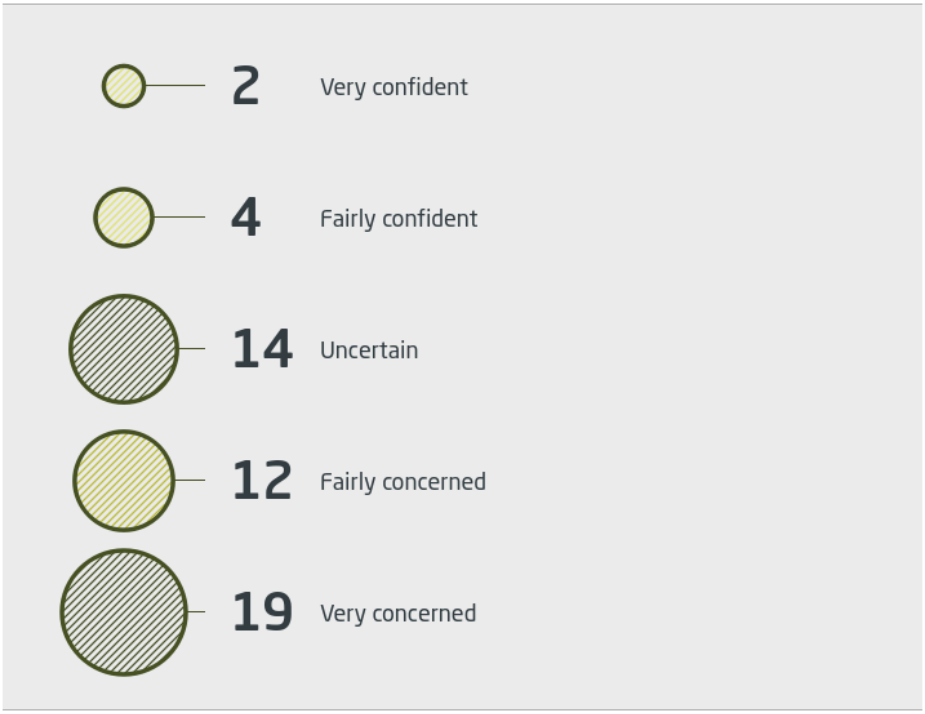
– Very concerned

"We won't achieve balance – our underlying deficit is significant."

– Very concerned

CCG LEADS

Figure 25: Looking ahead, how confident are you that your organisation will achieve financial balance in 2017/18?



42 CCG finance leads answered this question for the 51 CCGs they cover collectively.

Respondent comments

"Depends on STP-wide commitment to new models of care. Acute trusts unsupportive."

– Very concerned

"My CCG has submitted a deficit financial plan with very high levels of risk (over and above planned deficit)."

– Very concerned

"No possibility whatsoever."

– Very concerned

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11. Discussions with NHS leaders

12. Finance director, mental health and community services trust

STPs have attracted a lot of attention. How have they worked for your organisation and area?

We are engaged well in the STP and in the circumstances it's gone quite well. It's making people talk together, which is good, but the reality is, for us certainly, that we need to be pragmatic about how to go about creating a plan. We needed solid plans for different parts of our geography and then we need to see what synergies there are in joining those plans together. To go from nothing to a single integrated STP in our area is clearly not achievable.

When we modelled the growth in activity and revenue through to 2021, we ended up with a [financial] gap. So the way we viewed this gap is: this is not about taking cash out of the system or just reducing cost. What we have to do is be more productive and cover the increased activity with the same amount of money. The issue for us – and I think for many areas – is that the revenue increases pretty much cover the inflation assumptions. After that what you have to do is absorb all the activity growth within the same real-terms resource and so it's all about productivity. If you take that view it focuses the mind on what needs to be done and not just cost reduction. So what we have to look at is how we treat x per cent more patients in the urgent care pathway and you have to re-design the urgent care pathway. This is quite constructive but will take a bit of time to actually bear fruit.

Has the STP given priority to mental health and community services?

Directionally, yes. But what we have to avoid is this strategic winner thing. If you think in terms of organisational entities there will be natural barriers to doing anything. You have to look at it as a complete patient flow. So it's all about the patient: how are they going to be better treated and are we going to treat all of those patients and are we going to re-arrange the resources that we have to be able to meet the demand?

Typically, what it does mean is that you have to get people in and out of the acute side of things more quickly and obviously avoid [people] going in if you can, which means you need to do certain things elsewhere. I don't think community services need to increase. Community just has to be a lot more efficient and slicker and then it does come down to primary care; ultimately it must do more. There are difficulties with that because there's a shortage of GPs. So on paper it can look good but actually delivering it is going to be difficult. But I think that is true across the country.

Has the Mental Health Taskforce and its implementation led to more money for mental health?

This year we probably got the right growth from one CCG but from the other we didn't.

Was more money on offer in the 2017/18 and 2018/19 contracting round?

No. Nobody offers you anything – you have to fight for it. The fact is that for commissioners, their priority when they are negotiating contracts and tidying up risk is always the acute sector because PbR [payment by results] is activity based. So their goal is to sort out the acutes before coming to our block contract.

On parity of esteem, this needs to be watched. It's quite remarkable that we don't have, ready to hand, statistics by CCG on spending per head of population on mental health and this would really help get to grips on what's happening in mental health and we need this transparency.

What has your experience been with agency controls?

Well the agency controls are quite helpful. The fact that there is some consistency across the patch with them, that's quite useful. We've put in place all the things you need to do, with e-rostering, tight controls, generating your own bank and these sort of things.

Implementation has been pretty good. All of this has been done and this is helpful as it's held a lid on the prices. But is hasn't actually changed our need to use agency [staff] because we can't recruit readily. For us as a trust one of our biggest concerns is recruitment: being able to recruit the skills we need.

What gives you optimism for the future?

A couple of things. I think the collaborative discussions that the STP process has established is a good start in trying to break down the barriers of traditional organisational protection and actually trying to look at the patient and trying to get the best for them is really good and important and should continue.

There is a lot of potential in technology. The question is how to harness it and use it effectively to support implementation. If you track the patient meticulously from when someone first feels an ache or pain, you should be able to work out which technology will help support them getting the right help at the right time.

13. Chief executive, acute trust

What are your biggest challenges?

Number one is the level of demand that we are experiencing within the acute sector at the moment. Our staff do an amazing job every day but the system is very stretched at the moment and it's stretched to the point that it is becoming incredibly inefficient because of the levels of occupancy that we are running at.

The second thing, which is perhaps more specific to us, is the state of our estate. We really do need a sustainable solution to rebuild our infrastructure which is very inefficient, keeps breaking down and is past the end of its useful life.

What is driving the increase in demand?

I've not seen any specific analysis that's been done to get to the root cause, but I think none of us are terribly surprised by the rising demand. We've all known about the ageing baby boomers and the rising numbers of people who have multiple chronic conditions and I think that is part of the underlying cause.

The other part of the underlying increase is that support services within the community are overstretched, and so are not able to provide sufficient support to people needing care at home. This means they turn up at our A&E. We have had about a 10 per cent increase year-on-year in attendances at the emergency department and a 6 per cent increase in emergency admissions. These are people who actually do need to be in hospital but we're not able to turn them around and discharge them as quickly as we might because of the constraints within the community sector. Also these people are deteriorating in the first place, perhaps, because they are not getting the support that they might otherwise have received at home.

This means that this winter has been far worse than last year. With this significant increase in demand, if we had a whole lot of spare capacity that would be one thing, but we were already operating at a really high level of occupancy. People who have worked here for many years say it's the hardest winter they've seen.

Where are you financially?

It's incredibly tight. We haven't signed up to a control total yet and that's despite performing well financially in 2016/17 where we did sign up and we are on budget nine months into the year. So on all accounts we have managed very well financially in 2016/17 but 2017/18 looks an incredibly difficult financial challenge. It's hard for us to see at this stage how we could sign up and how we could make ends meet.

There's no doubt that an injection of funds from a March budget into social care would improve things considerably. I think we would all say the same thing but whether it would close that financial gap? I doubt it would. I think that there

is a question which is a question for the community about how much does the UK want to spend on its health care system and if that's the budget that's been given, then I think the question is: what is truly achievable within that budget. I don't hear us having that discussion.

Will the STP help?

Getting people round the table and forming those relationships between health and social care is absolutely the right solution. I suppose what concerns me about it is that it takes a long time to create those relationships and to then effect change.

Is it the solution? Well, it depends what problem you're trying to solve. So it's absolutely part of the solution to get health and social care working together, shifting resources between these two buckets of money, so you can distribute the money to the areas that will have the most impact. Breaking down the barriers between health and social care, between physical health and mental health, between acute and community, this is absolutely what we should be doing.

But when you get 20 people or 40 people sitting around a table it's an incredibly slow process to get decisions made and there is a question in my mind: I am a big fan of accountable care and having an organisation responsible for the health of a catchment population. The process we're going through within the UK is a sort of accountable care partnership route and the concern I would have about the partnership route compared to the accountable care organisation (ACO)* route is it takes a lot longer to get consensus decision-making and have we got time to build those partnerships, to get the consensus, to get the change?

I'm not a big believer in letting a 1,000 flowers bloom. I do believe in setting and implementing a strategy, making some tough decisions up front and getting on with it. The Lansley reforms have not moved the NHS forward. If we know that why don't we do something about it rather than tiptoeing around the edges? And do it now as there is no time to waste.

** An ACO is a formal organisation. An accountable care partnership is a looser structure, with weaker formal accountability and structure, and represents voluntary co-operation between independent organisations.*

14. Chair, clinical commissioning group

What are your greatest concerns at the moment?

Number one is the balance between trying to manage a two-year contract financially and, at the same time, support innovation locally.

Number two is the effect of an STP [sustainability and transformation plan] process that hasn't yet started to talk about clinical engagement, as I come from the perspective of clinical commissioning.

Number three would be the balance between larger commissioning organisations being the right thing to do versus member-based organisations trying to keep their members on board as that is important as well.

What are your financial prospects for the years ahead?

The objectives for the planning round are all about financial balance. That's what we were told to achieve. We have not agreed contracts yet. It's completely understandable when you see the other side's point of view. Either something gives them problems or it gives us problems. We want to agree this, they don't want to agree that.

To make the books balance to 2021 we needed a five-year transformational plan which had to include some fairly big things that were bound to affect the first years. Where does the money come from for this? It comes from the resources that we have, which means from the providers. But then we were told to guarantee the amount of money for providers for the next two years. Where's the logic?

Has the STP helped?

First, in our particular case, the STP footprint is an odd footprint given what it needs to do.

Second, the STP was a planning process, therefore in a planning process what you do is make a plan and then make that plan a reality. There's no vehicle by which to make that plan a reality, no accountable body, so it's basically done on goodwill. Therefore we've got many different organisations in an STP that's the wrong size trying to work in a collegiate way where they have no authority. That's not a planning process, that's something else. I think there is a question about who they [national bodies] put in charge of STPs and whether they [national bodies] make them viable bodies to make a difference. And actually they've got to do one thing or the other. Either we give them the power or we don't give them the power.

Though not a planning process, I'd say it's still been helpful, definitely. I'd say that people are definitely working together more closely as a consequence. I think it has been bizarrely helpful to expose the many further weaknesses – not in a negative way – but it's become more obvious where people have to own how much money they actually have rather than, for example, hide behind the fact that they've got their own board. So [the process has led to] shared collective understanding of the challenges, an ability to build a shared vision, possibly, between commissioners and providers. That alone would be a good reason to do it. Interacting with social care and local authorities – no one thinks that's the wrong thing to do. Getting that as an agenda item is important – I'm not saying it's got the relationship right yet – but it is now an agenda item.

What gives you optimism for the future?

If I'm honest we've always had big questions all over the place. So we're quite excited by the fact that we can solve them and get on with it. The tension will be what do people actually want to get done and how will we actually make good care happen at the same time as all that other stuff that's going on. That's the real question and that's what we have prided ourselves on trying to deliver.

I think the job of a good leader is to make it all work despite the circumstances. The way you start is to have a good understanding of what the issues are and I think I understand well what the issues are and how they sit. So that's actually a much better place than being deludedly happy about changing things when they face big problems that haven't been dealt with.

Therefore I feel quite positive because we actually have a good grasp of what is going on. And if you have that then you can start saying ok, in that case what are we going to do? You need to think about how we put big decisions in front of the public saying, we have to make these decisions about where we are going to spend our money, what we're going to do and how we're going to transform health care.

15. Chief executive, mental health trust

What are your greatest concerns?

First, that the government seems to believe that the NHS has been adequately resourced and fails to recognise that the NHS has its worst financial settlement ever.

Second, I am very worried about the narrative that all we need to do is give social care more money. Yet a very significant proportion of delays in hospital are still mainly down to delays in waiting for NHS care. We are at risk of falling into the trap of the government putting a reasonable amount of extra money into social care with the not unreasonable expectation that the NHS will then deliver because we been telling them that social care is the only problem, and then [the NHS] actually failing to deliver.

Of course I understand the call for more social care money. We are having a number of services decommissioned which is causing some of our service users to stay longer in hospital or, worse, come into hospital when they would not have otherwise needed to.

Are STPs helping?

Ours started as a pretty frustrating process as it did for most people. But we got beyond that. We had already done some work in the patch, so we knew we'd not gone far enough on acute reconfiguration. [So far] there have been very few firm 'we're going to close this, we're going to close that' decisions but at least there's discussion between clinicians, chief executives and boards about doing a proper job on acute services.

Another workstream looks at delivering services in a more 'wrapped around' way in communities and still saving money. There is very little evidence that a significant increase in community services necessarily reduces the demand into the acute system but even if it doesn't, from a quality and co-ordination point of view, from a patient and service user point of view, it has to be absolutely the right thing to do. But I have no confidence that it will deliver the financial bottom line.

Finally, it took a lot of effort, but we have managed to establish a mental health and learning disability workstream. This is doing three things: it's helping with the implementation of the *Five year forward view for mental health*; it's looking at the lessons from how we've reduced our reliance on beds in mental health and learning disability; and it's genuinely looking to integrate physical health and mental health.

Financial prospects

We are a bastion of PbR [Payment by Results]. The PbR problem guarantees that the share of the pie going into mental health and community services will continue to decrease.

We have looked at how much our income has changed from the local CCGs [clinical commissioning groups] over the past five years and it has changed by pennies: just 1 per cent cash uplift and our contract values will fall in 2017/18. Our share has gone massively backwards and I'm sure we're not alone in that. Somebody else has hoovered up the money and there's only really two places: prescribing and acute hospital services.

Forget parity of esteem, forget the mental health Forward View: while demand in the acute sector goes up and there is a guarantee it's paid for, the share for mental health and community will go down. To be clear, I don't blame the CCGs: they don't have the money unless they take it out of the acutes or cut prescribing.

How are you managing?

We did start, some years ago, benchmarked as over-bedded and we probably were. So we have had a process of transformation where we have managed to close lots of wards but we re-invested a significant chunk of that back into community services such as guaranteed 24/7 crisis resolution home treatment. However, we've just about reached the end of the track on closing beds.

Our main strategy is on the informatics side, where we have a very clear, very ambitious strategy. We're also doing skill-mix reviews to see if we can reduce the use of expensive staff, starting at the bottom looking at the competences required. We also have some other proven initiatives to roll-out across the patch.

However, there is an imbalance between demand and capacity in CAMHS [child and adolescent mental health services] and problems in prison health. But if we received the Mental Health Investment Standard I am confident we would be able to deliver the mental health Forward View. Others areas may not be in the same position.

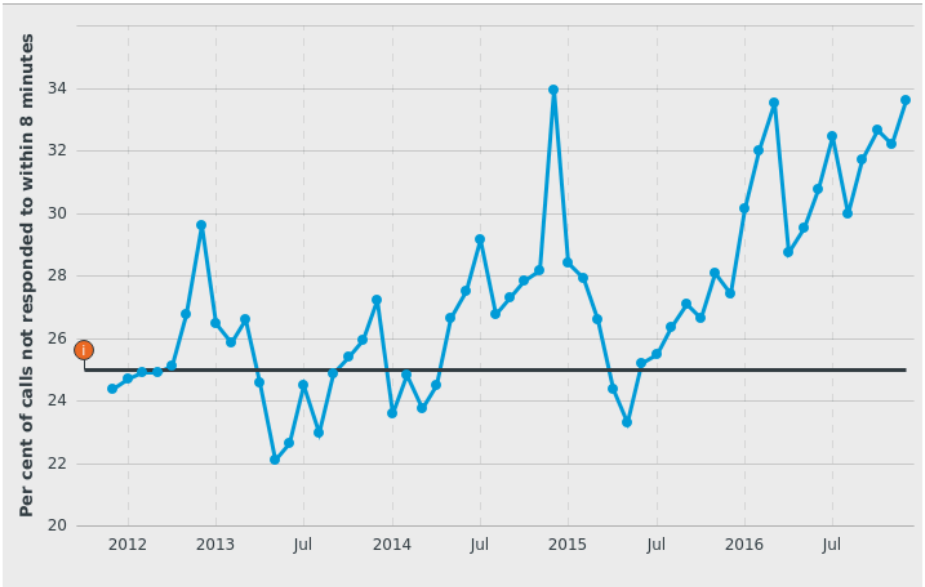
1. NHS performance dashboard

2. Urgent care

Ambulance services

- Since June 2012 ambulance trusts have been given eight minutes to respond to the most urgent cases and nationally no more than 25 per cent of these calls should be responded to outside of this time.
- This standard was met until 2013/14 but for all subsequent years has been missed. The most recent data shows performance remains poor; in six of the past seven months more than 30 per cent of calls were responded to after eight minutes (Figure 26). This is the worst run in performance since this target was introduced.

Figure 26: Monthly performance of ambulance trusts in England for Red 1 calls

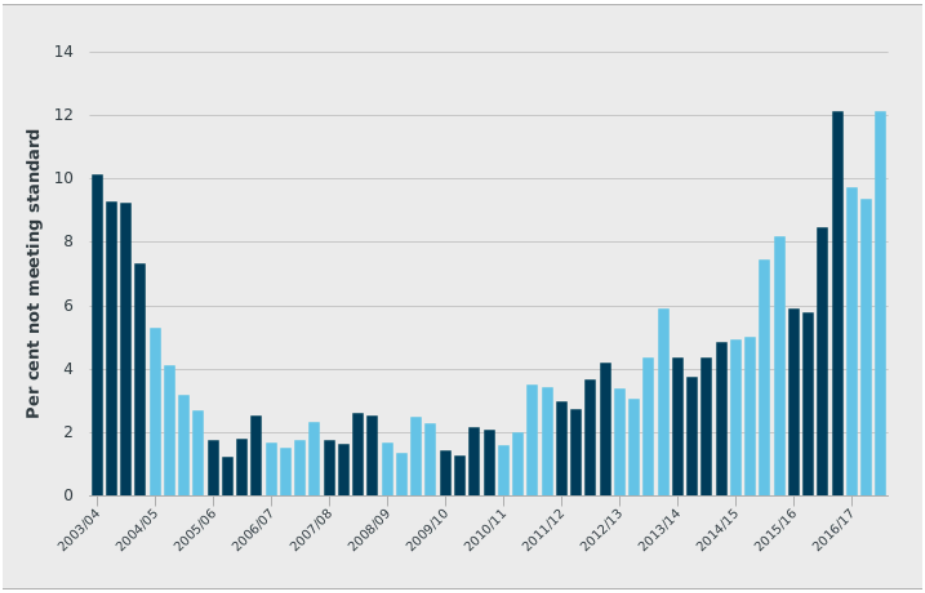


Data source: Ambulance quality indicators www.england.nhs.uk

Accident and emergency

- In quarter 3 2016/17 the proportion of patients waiting more than four hours from arrival to discharge, admission or transfer in all A&E departments was 12.1 per cent (more than 709,600 patients in total). This is the highest proportion in the third quarter of the year since 2003/4 (Figure 27).

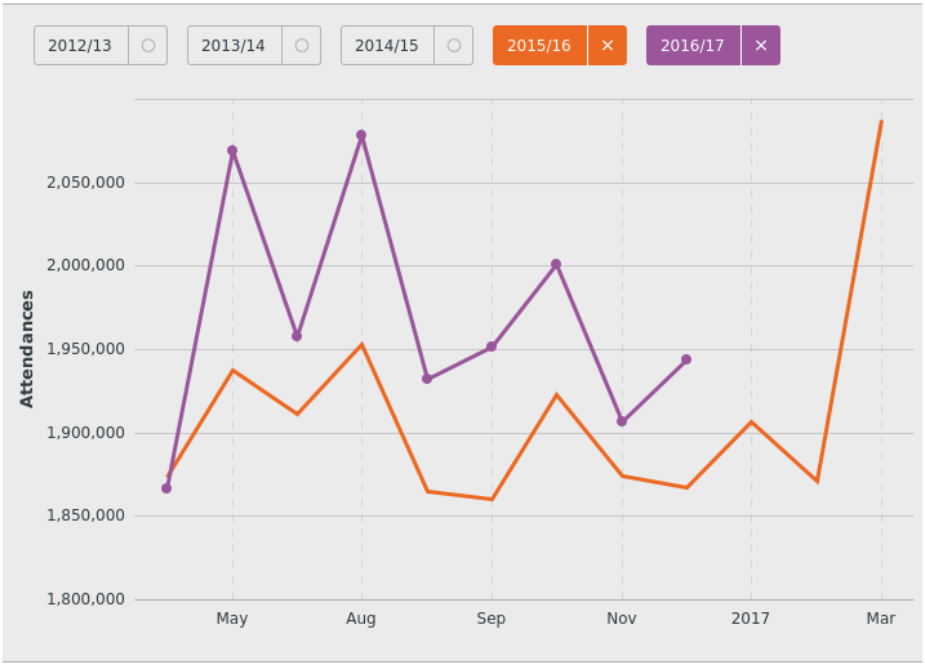
Figure 27: Percentage spending more than four hours in A&E from arrival to admission, transfer or discharge; quarterly data



Data source: A&E attendances and emergency admissions www.england.nhs.uk

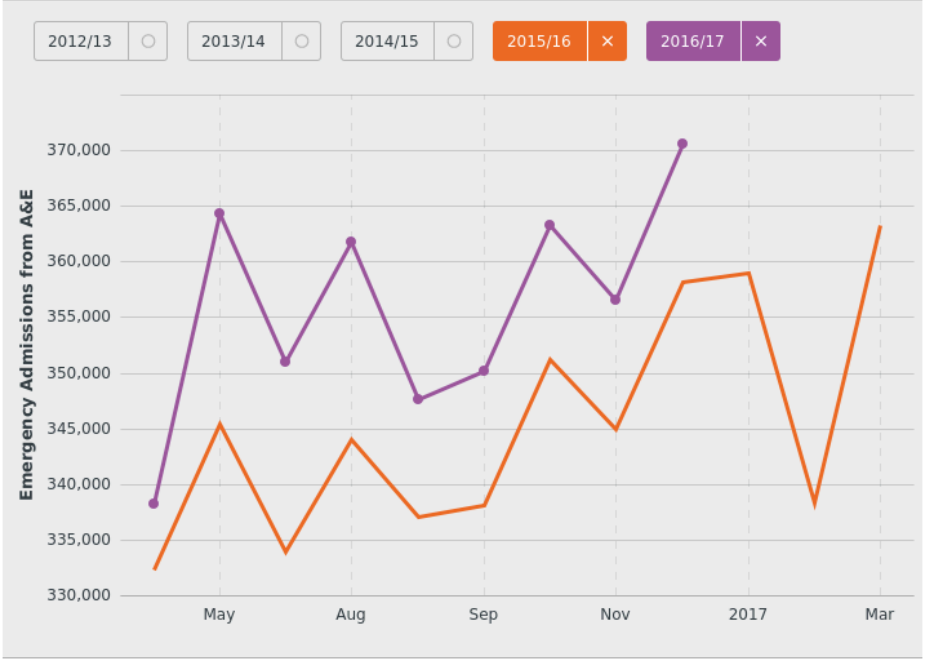
- Pressures to admit more patients continued to impact performance against the four-hour standard in the third quarter of the year (Figure 27). Compared to the same quarter last year, A&E attendances are 3 per cent higher this year (Figure 28) and emergency hospital admissions from A&E have also increased by 3 per cent (Figure 29).
- These small percentages represent large numbers. The increase equates to more than 186,300 additional attendances and 36,180 additional admissions to hospital in the third quarter of 2016/17 compared to 2015/16.
- Over the year, for each month so far in 2016/17 this is the equivalent of an additional 71,300 attendances at A&E departments and 13,161 admissions from A&E compared to the previous year.

Figure 28: Total attendances at accident and emergency departments, monthly data



Data source: A&E attendances and emergency admissions www.england.nhs.uk

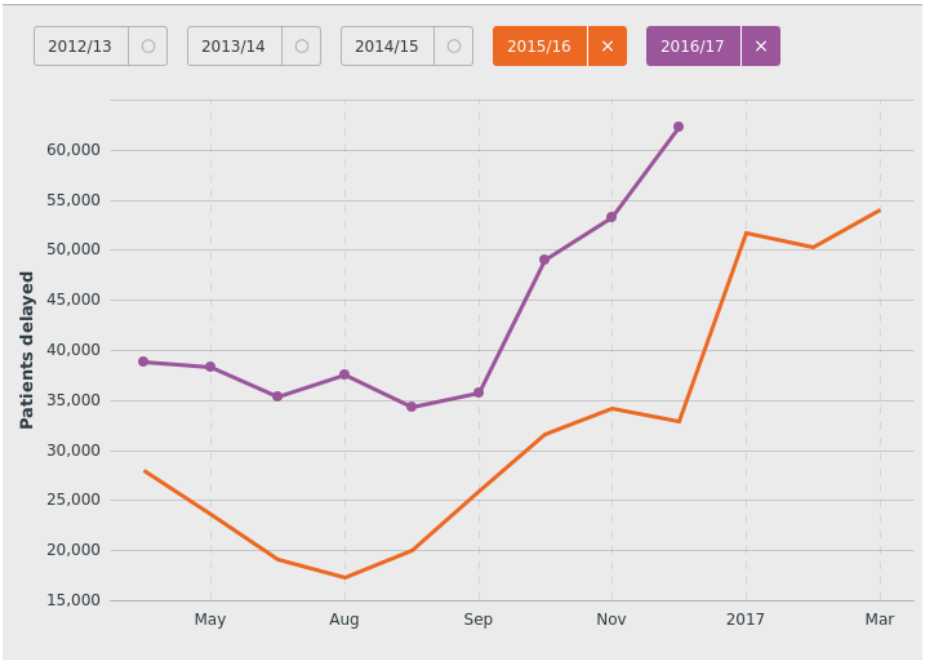
Figure 29: Emergency admissions from accident and emergency departments, monthly data



Data source: A&E attendances and emergency admissions www.england.nhs.uk

- There has been an increase in the number of patients waiting more than four hours from decision to admit from A&E to admission to a hospital bed on a ward ('trolley waits') to 163,311 in quarter 3 2016/17, which is 64,620 patients (65 per cent) more than in the same quarter in 2015/16 (Figure 30).

Figure 30: Patients waiting more than four hours in A&E from decision to admit to admission, monthly data

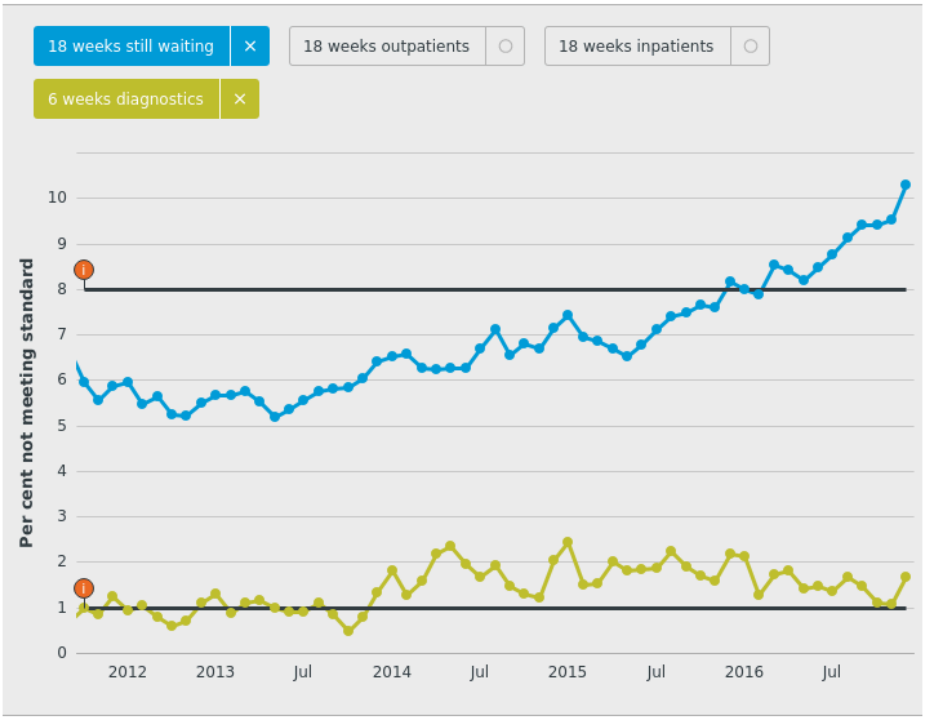


Data source: A&E attendances and emergency admissions www.england.nhs.uk

3. Waiting times

- The proportion of patients waiting more than 18 weeks to begin their treatment increased to more than 10 per cent in December 2016 (Figure 31). This is the worst performance, and the first time that performance has breached 10 per cent, since this definition of the standard was introduced in April 2012. It is also the tenth month in a row that the standard (8 per cent) has been breached. In total, there were 376,877 patients still waiting to begin their treatment after 18 weeks at the end of December 2016, and 1,228 of these patients have been waiting for more than a year.
- For the standards that were dropped last year, latest figures show that the proportion of admitted patients treated after having waited more than 18 weeks has remained above 20 per cent for the past seven months. The proportion of non-admitted patients waiting more than 18 weeks has remained above 9 per cent for the past four months in a row.

Figure 31: Per cent still waiting 18 weeks to begin treatment / having waited more than six weeks for diagnostics

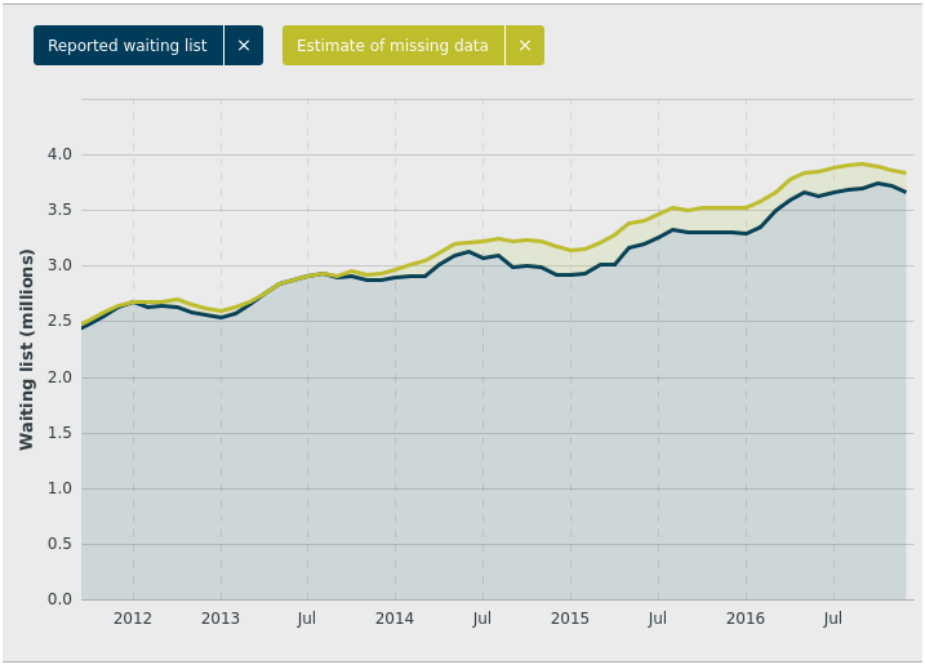


Data source: Referral-to-treatment waiting times statistics www.england.nhs.uk

Diagnostic waiting times statistics www.england.nhs.uk

- The total elective waiting list grew to 3.75 million in October 2016, but fell to 3.66 million in December. Though falling, this is still 367,387 more patients than in January 2016.
- Furthermore, this total does not include several trusts that have not been reporting their waiting lists. Including these trusts, NHS England estimates that the true waiting list in December 2016 was more than 3.8 million patients (Figure 32).

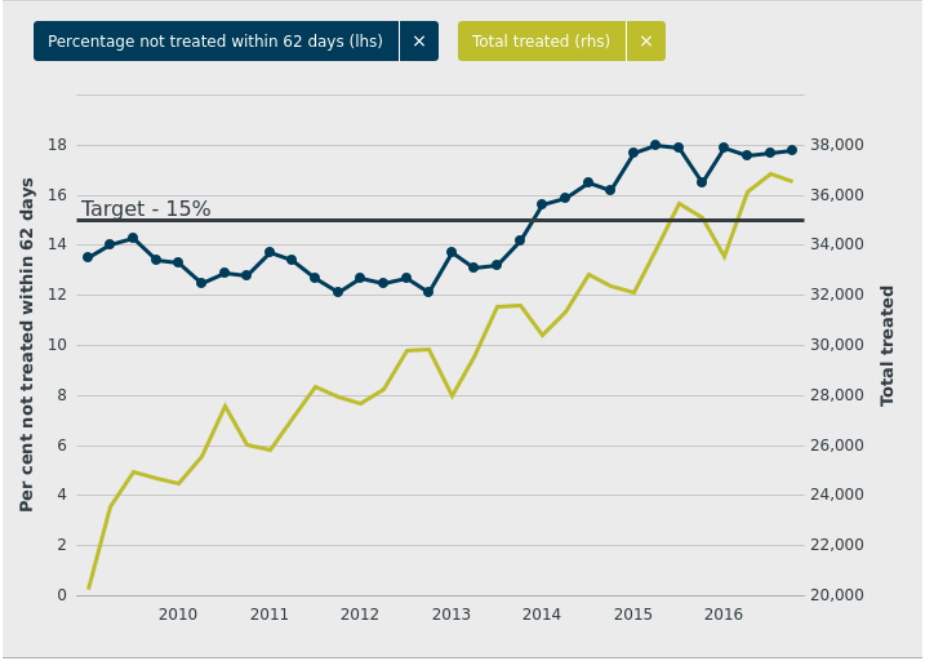
Figure 32: Referral-to-treatment total waiting list size in millions, England



Data source: Referral-to-treatment waiting times statistics www.england.nhs.uk

- The proportion of patients waiting more than six weeks for a diagnostic test has now missed its target (1 per cent) for the past 37 months in a row.
- The overall waiting time standard for cancer treatment is that no more than 15 per cent of patients should wait more than 62 days from an urgent referral from their GP to receiving treatment for their cancer. This standard was met from quarter 4 2008/9 until quarter 4 2013/14, when it was missed (15.6 per cent). In quarter 3 2016/17 (October to December 2016) performance was again below the standard. The trend over the previous two years shows increasing numbers of total patients treated, while the proportion of patients waiting more than 62 days to treatment remains around 17.5 per cent (Figure 33).

Figure 33: Maximum 62-day wait for first treatment: all cancers (urgent GP referral to treatment)



Data source: Provider-based cancer waiting times www.england.nhs.uk

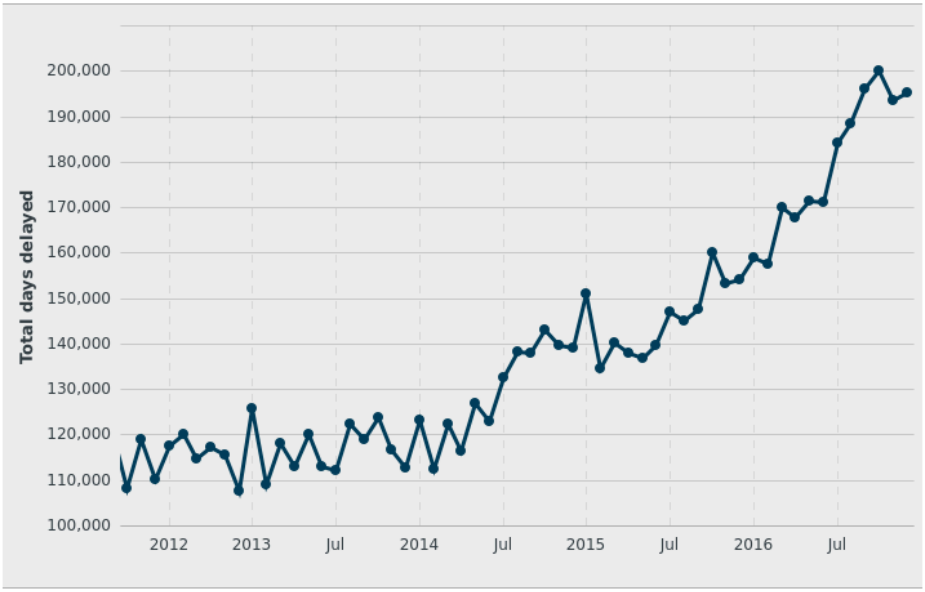
4. Delayed transfers of care

- At the end of December 2016, 6,191 patients were delayed in hospitals. This is the highest number for this time of year since the data began and is an increase of 24 per cent since December 2015 (Figure 34).
- The number of total days delayed increased to more than 195,000 in December 2016, the highest ever recorded for this month (Figure 35) and 27 per cent higher than December 2015.

Figure 34: Delayed transfers of care: number of patients delayed on last day of month

Data source: Acute and non-acute delayed transfers of care, patient snapshot, 2016/17 www.england.nhs.uk

Figure 35: Delayed transfers of care: total number of days delayed each month

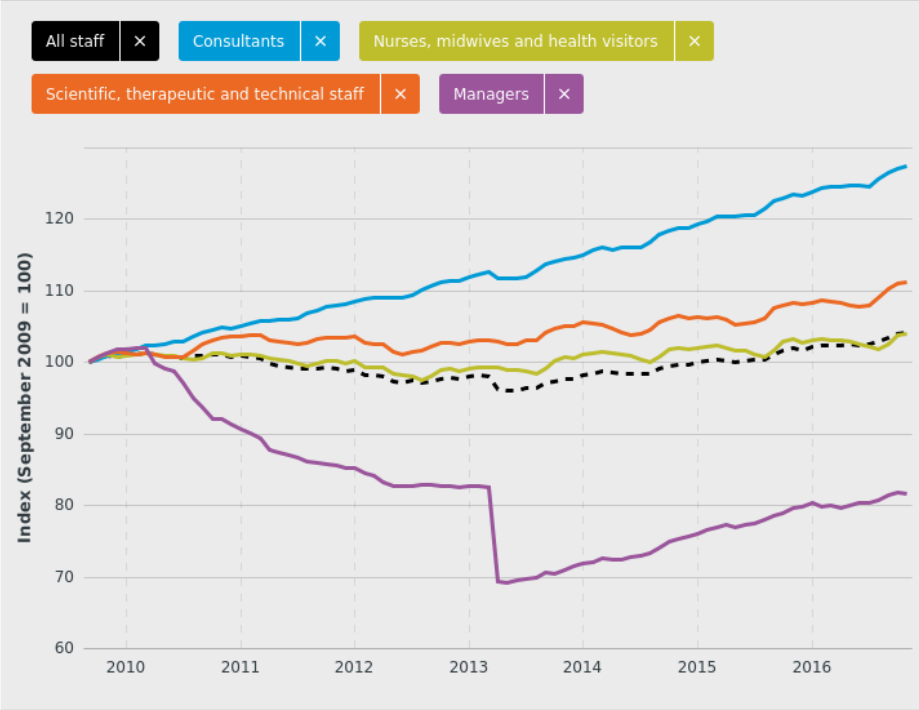


Data source: Acute and non-acute delayed transfers of care, total days delayed, 2016/17 www.england.nhs.uk

5. Workforce

- In November 2016 the total number of full-time equivalent (FTE) staff working in hospital and community health services (excluding, for example, general practitioners) was more than 1.044 million (Figure 36).
- Compared to November 2015, there has been an increase in all staff of 21,346 FTE posts (2.1 per cent). This has been across all staff groups: consultant numbers have increased by 3.3 per cent; managers by 2.5 per cent; scientific, therapeutic and technical staff by 2.7 per cent; nurses, midwives and health visitors by 0.6 per cent.

Figure 36: Index change in NHS full-time equivalent staff: September 2009 - November 2016

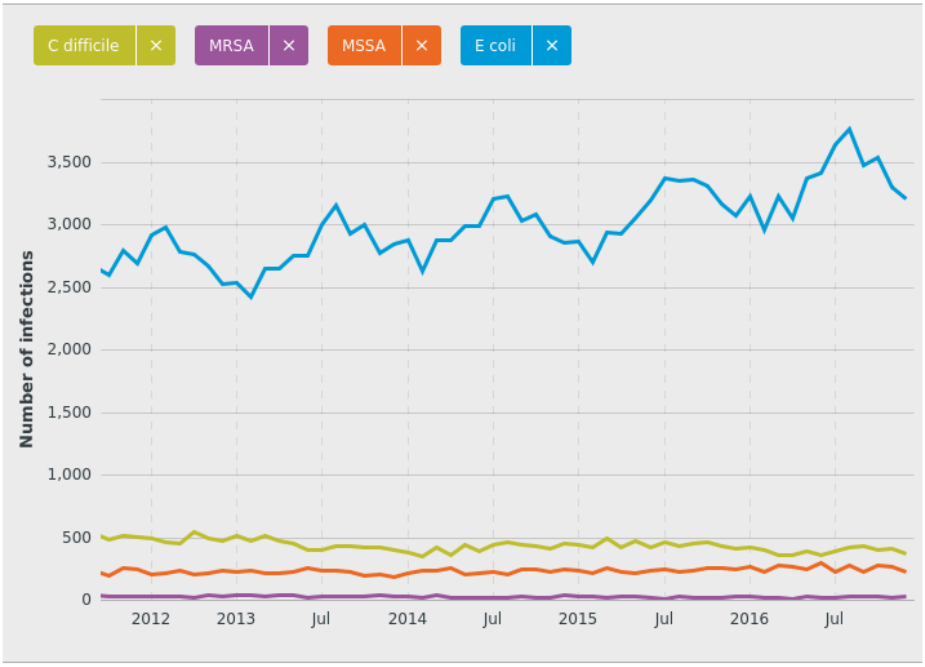


Data source: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England - November 2016, Provisional statistics www.digital.nhs.uk

6. Health care-acquired infections

- *C difficile* infections increased to more than 400 cases a month between August and November 2016 but reduced to 370 in December 2016. The number of methicillin-resistant *Staphylococcus aureus* (MRSA) infections remains low - a total of 27 in December across England (Figure 37).
- The number of reported methicillin-susceptible *Staphylococcus aureus* (MSSA) infections in December 2016 has decreased to 229. Similarly, numbers of *E coli* infections decreased.

Figure 37: Monthly counts of selected health care-acquired infections



Data source: *Clostridium difficile* infection: monthly data by NHS acute trust www.gov.uk

Monthly counts of methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia by post infection review (PIR) assignment www.gov.uk

Monthly counts of trust apportioned methicillin susceptible *Staphylococcus aureus* (MSSA) bacteraemia by NHS acute trust www.gov.uk

Monthly counts of *Escherichia coli* (*E coli*) bacteraemia by NHS acute trust www.gov.uk

About the QMR

What is The King's Fund's quarterly monitoring report?

Our quarterly monitoring report (QMR) reveals the views of NHS trust finance directors and clinical commissioning group finance leads on the productivity challenges they face, and examines some key performance data for the NHS in England.

It provides a regular update on how the NHS is coping as it grapples with the evolving reform agenda and the more significant challenge of making radical improvements in productivity.

What is different about the digital QMR?

Our first nine issues were produced as longer PDF documents and can be found on The King's Fund website at kingsfund.org.uk/qmrproject. The new QMR features digital versions of the survey results and interactive performance data charts showing the key findings for this quarter.

Where does the data come from?

The quarterly monitoring report combines publicly available data on selected NHS performance measures with views from NHS trust finance directors and clinical commissioning group finance leads. These views are collated through a survey run by The King's Fund data team.

Making the most of the digital QMR

- **Filtering the survey by respondents**

  Filter the survey results by respondent group (financial directors of NHS trusts, financial directors of clinical commissioning groups, and financial directors in social care in applicable quarters) by clicking them on or off at the top of the survey page.

- **Comments from survey respondents**

  Read selected comments from the survey respondents by clicking on the speech bubble

- **Survey charts**

  The area of the bubble in the survey charts represents the value shown. The sizes of the bubbles are comparable between the charts.

- **Sharing and saving charts**

  Share charts on social media sites by clicking on the share logo
  You can also download the charts as images by clicking on the save logo

- **Changing the date range of the NHS performance data charts**

  See the data in a different date range by moving the sliders on the x-axis.

- **Printing the QMR**

  Print the report by clicking on the print icon