QMR 23 JUNE 2017

NHS areas planning to cancel or delay spending due to financial pressures

ABOUT THIS REPORT

The underlying reality is that demand for services is continuing to outstrip the rate at which the NHS budget is growing.

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Survey responses were more optimistic than this time least year, possibly due to *Next steps on the NHS five year forward view* providing greater certainty on immediate priorities, and expected impact of extra social care funding.
The final quarter of 2016/17 also saw a sharp improvement in A&E performance.

The underlying financial position remains gloomy, with many trusts having relied on one-off actions such as land sales and STF payments to improve their position.

43%

of trust finance directors expect to overspend their budget in this financial year.

50%

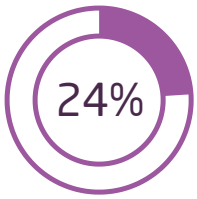
of CCG finance leads say that achieving this year's financial forecast is likely to depend on delaying or cancelling spending.

2.5 million

patients spent longer than four hours in A&E, an increase of over 685,000 on the year before.

362,000

patients waited longer than 18 weeks for hospital treatment in March 2017, an increase of almost 64,000 on the previous year.



increase in bed days lost as a result of delayed transfers of care, compared to the previous year.

Despite some improvement in outlook, NHS finance directors remain very concerned about finance and subsequent performance, whether in A&E, mental health or general practice.
With little real-terms growth in funding, the NHS continues to experience year-on-year growth in demand.

69%

of trust finance directors (and 72% of CCG finance leads) think there is a high or very high risk of failing to achieve productivity gains suggested by the Forward View.

"Local NHS leaders will be forced to make tough decisions about priorities and this is likely to have a direct impact on what care patients can access and how long they have to wait for it."

Richard Murray, Director of Policy

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 23rd 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.

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 carried out between 13 April and 4 May 2017. We contacted 256 NHS trust finance directors to take part, and 84 responded (33 per cent response rate). The sample included 41 acute trusts; 34 community and mental health trusts; 3 specialist trusts; 2 ambulance trusts and 4 unknown. In addition, we contacted 160 clinical commissioning group (CCG) finance leads, and 42 responded (26 per cent response rate). Between them these finance leads covered 50 CCGs (24 per cent of all 209 CCGs).

General practice monitoring

This report includes results from our monitoring of general practice. This is based on data from a sample of 202 practices (around 2.7 per cent of all practices in England) held by ResearchOne, a database created using records from TPP's SystmOne, one of the main clinical information systems used in general practice in England. In addition, we surveyed a panel of GP partners and practice managers in England and received 68 responses, which provides a snapshot of opinion in the GP community. This is not designed to be a representative sample of general practice, but instead to provide a qualitative assessment of the priorities and challenges in general practice and how these change over time.

Managing NHS finances in 2017/18

In 2016/17 NHS Improvement and NHS England introduced a new approach to NHS finances, designed to reduce the significant deficits that had grown over previous years. NHS planning guidance made clear that many features of this new approach would be retained in 2017/18 and 2018/19 along with a small number of changes. The key elements of this approach are set out below.

The Sustainability and Transformation Fund

In 2017/18 and in 2018/19, the NHS will again place £1.8 billion into the Sustainability and Transformation Fund. This will be paid out to mainly acute trusts as long as they meet targets on finance and A&E. Payments from this Fund reduce an organisation's reported deficit.

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 position across the provider sector as a whole as the Sustainability and Transformation Fund will be underspent by the equivalent amount and NHS Improvement counts this underspend against the overall position. 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. The ambition at the outset of the planning round in the autumn was that NHS providers as a whole would be in net financial balance in 2017/18.

Commissioners

CCGs also have financial targets. In 2017/18, 1 per cent of the total commissioning budget (worth around £830 million) has been set aside to offset risks to overall financial balance in the NHS. Unlike in 2016/17, when CCGs were required to set aside the full 1 per cent from their budgets, this year CCGs have been asked to hold only half of their share (£360 million) uncommitted at the start of the year to which NHS England has added £200 million from its own resources. The remaining £270 million will come from Commissioning for Quality and Innovation (CQUIN), which makes a proportion of NHS providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

Sustainability and transformation partnerships (STPs)

In 2016, the NHS developed new sustainability and transformation plans covering the years to 2020. To do this, England was divided into 44 geographical areas – the 'footprints' for the STPs. The detailed operational plans for each organisation in 2017/18 and 2018/19 are intended to be consistent with these more strategic STPs. In addition, NHS Improvement and NHS England have introduced system control totals: for each STP area (now renamed sustainability and transformation partnerships), these represent the sum of control totals of the organisations contained within the STP's geography. STPs can apply to NHS Improvement and NHS England to alter organisations' control totals, as long as they do not alter the system control total and are consistent with net financial balance in both providers and commissioners.

How is the NHS performing?

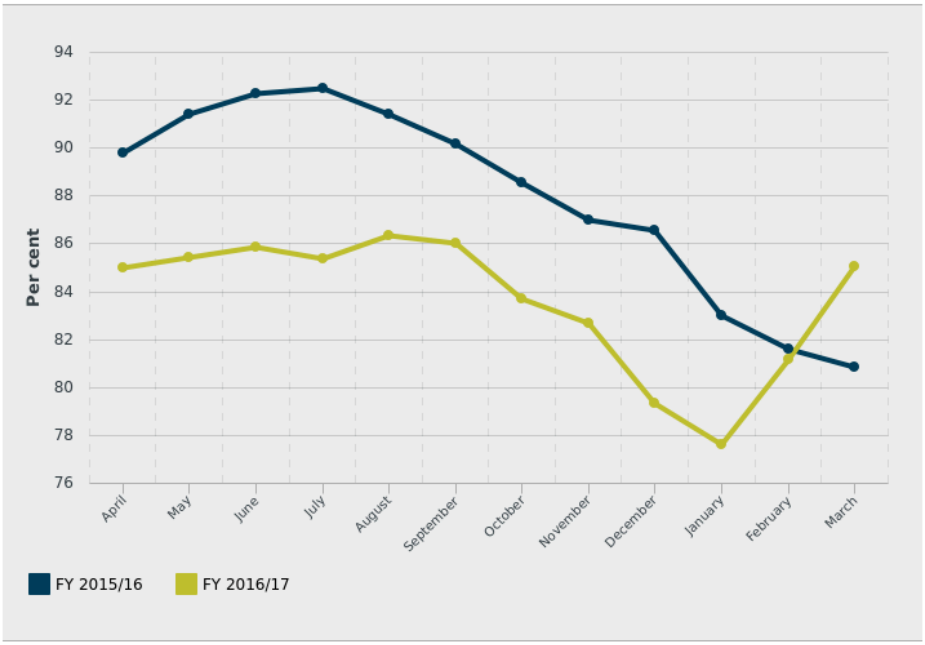
- Spring has arrived, bringing the usual seasonal upturn in performance in A&E. As January 2017 saw the worst performance on waiting times for a decade, the upturn could not come too soon. Compared to last year it was a relatively strong recovery, and waiting times in A&E (though still a long way off the target) were better in March 2017 than they were in March 2016 (Figure 1). The NHS as a whole (including walk-in centres and minor injuries units) managed to reach 90 per cent of patients admitted, transferred or discharged within four hours (although performance in major A&E departments was lower than this at 85.1 per cent). This is important given that *Next steps on the NHS five year forward view* committed the NHS to the standard of more than 90 per cent by September. If the NHS can maintain its March performance then this first milestone is already in the bag. However, our survey shows many are not confident that this will happen: 49 per cent of trust finance directors and 60 per cent of CCG finance leads were fairly or very concerned about the meeting this commitment by September. For some, this concern appeared to relate to uncertainties about the state of social care and its impact on delayed transfers of care. The 90 per cent standard is still some way short of the 95 per cent standard, which *Next steps* commits the NHS to reaching within 2018.
- On the wider set of waiting times standards, 2016/17 maintained the trend seen in recent years: a slow but steady worsening in performance across the board for the most prominent standards, as set out in Table 1. While *Next steps* set out a trajectory for the NHS to recover the A&E standard and also set out the measures to restore the 62-day cancer waiting time target, it gave notice that the planned levels of elective activity would not be enough to maintain the 18-week referral-to-treatment standard, effectively downgrading it temporarily. Following this announcement, a small number of commissioners are re-considering their plans for 2017/18 and may try to cut back on elective activity. The recognition that the NHS cannot do everything in the face of continued pressures on finance and workforce is requiring leaders – both national and local – to make difficult

prioritisation decisions. In our survey, the percentage of CCGs stating that they cancelled or cut back spending plans to balance the 2016/17 position jumped to more than 50 per cent.

- Along with emergency care and cancer, *Next steps* reconfirmed plans to improve primary care and mental health; however, the wider financial challenge facing the NHS along with workforce shortages will make the plans difficult to achieve. CCG finance leads rated pressures on general practice as their second highest operational concern (below A&E). This concern may be well placed; despite commitments to increase the number of GPs by 5,000 by 2020, the number of full-time equivalent GPs actually fell slightly over the past year (although the number of other staff, particularly those providing direct care, did rise). On mental health, just under two-thirds of mental health trust finance directors were fairly or very concerned about commissioners' ability to meet the funding commitment for mental health (the mental health investment standard*) in 2017/18. CCG finance leads were much more confident about this issue (only 16 per cent were fairly or very concerned) although a substantial group (just under a third) remained uncertain, which is worrying as contracts for the year should have been signed by now.

*The mental health investment standard requires CCGs to increase mental health funding by at least the same percentage as their overall budgets increase.

Figure 1: Performance against the four-hour A&E waiting time standard in type 1 (major consultant-led) units; 2016/17 compared to 2015/16



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

Table 1: Waiting times performance since 2012/13

	Performance for the full year				
	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)
Ambulance red 1 calls (standard: 75 per cent responded to within 8 minutes)	74	76	72	73	69
A&E waits (standard: 95 per cent treated, admitted or discharged within four hours, all units)	96	96	94	92	89
Elective treatment waits (standard: 92 per cent begin treatment within 18 weeks)	94	94	93	92	91
Cancer waiting time (standard: 85 per cent of patients receive first treatment within 62 days following urgent referral from GP)	87	86	83	82	82

Financial prospects

- The general election has delayed the release of the full-year financial numbers from NHS Improvement and NHS England. For the commissioning sector at the last update, covering the first 11 months of the year, NHS England forecast it would deliver the £800 million risk reserve, to be set against provider deficits. This impressive performance was slightly clouded by the evidence of imbalances between different parts of the commissioning sector with substantial CCG deficits (£550 million) being offset by underspends within NHS England's budgets.
- At quarter three, NHS Improvement announced the year-to-date provider overspend had hit £886 million but that it had measures in place to bring this down to £750–£850 million by the end of the year. To reduce the overspend by the end of the year providers would have had to run a surplus in the final quarter, a challenge given how difficult the winter period was. However, recent estimates of the 2016/17 provider deficit are compatible with the £750 million to £850 million range expected by NHS Improvement.
- Our survey does provide some grounds for optimism that the last quarter was indeed rather better. Compared to the last QMR, trusts were more sanguine about their end-of-year position, with the percentage forecasting a surplus rising from 38 per cent in February to 54 per cent now. While there was also a similar jump in the proportion of trusts receiving support from the Sustainability and Transformation Fund (which will not alter the net provider position as NHS Improvement sets any unspent Sustainability and Transformation Fund money against the overall deficit), comments from finance directors make clear this does not explain all the improvement. While no doubt welcome when trying to manage the 2016/17 outturn for providers, it is clear that the actions – such as sale of land – reported in QMR were overwhelmingly non-recurrent; they do not reflect underlying improvements in efficiency and as such will not help the 2017/18 position. Any improvement, however welcome, must also be set against the initial ambition for the Sustainability and Transformation Fund, which was to reduce the overall provider deficit to zero.
- For 2017/18, the broad objective for the provider sector was again to reduce the overall deficit to zero. Though the quarterly update on finance and performance has been postponed due to the general election, Jim Mackey, Chief Executive of NHS Improvement, said suggestions that the forecast provider deficit for 2017/18 was between £500 and £600 million (as of April) were 'not miles out'. In our survey, 43 per cent of trust finance directors were still forecasting a deficit for the end of 2017/18, although this is a slightly lower proportion than at the same point last year.
- Finance leads in trusts and CCGs remain very pessimistic about the future on any of the financial indicators we collect through QMR. However, it is important to note that on a range of measures they are not quite as gloomy as they were at the same time last year. If we set aside the improvement in trust finances that followed the introduction of the Sustainability and Transformation Fund, this is the first widespread reduction in pessimism QMR has recorded (Table 2).

Table 2: Finance leads sentiment about the future

Question	April 2016(%)	May 2017(%)
Productivity gains required by the NHS five year forward view: high or very high risk of failure (trust finance directors)	87.4	69.0

Productivity gains required by the NHS five year forward view: high or very high risk of failure (CCG finance directors)	79.0	71.4
Trust finance directors' confidence over next year's outturn: per cent very concerned	46.0	33.3
CCG finance directors' confidence over next year's outturn: per cent very concerned	31.0	24.0

- What might have caused this slight reduction in pessimism? Possibly two things. First, since the last QMR, NHS England published *Next steps*, thereby providing some greater certainty on the immediate priorities, and some organisations appear to be more confident that they will receive Sustainability and Transformation Fund payments. Second, with trust finance directors reporting delayed transfers of care as their top operational challenge (it ranked third highest for CCGs), the announcement in the Budget of an additional £2 billion for social care – half of which is to come in 2017/18 – may have provided some grounds for (relative) optimism. Particularly for trusts, lower delayed transfers may allow capacity to be switched to more profitable elective work. As this additional money begins to flow through the system, it will be important to see if this trend can be maintained.
- Despite this improvement in outlook, NHS finance directors clearly remain very concerned about finance and their ability to make good on performance, whether in A&E, mental health or general practice. With the NHS currently facing little real-terms growth in funding in the coming years, Figure 2 underlines the challenge – the NHS continues to experience year-on-year growth in demand. Given the nature of datasets in the NHS, this view of demand is necessarily focused on the acute sector. However, in this QMR we also report on activity levels seen in a sample of general practices, which shows growth in activity over and above the growth in the population, particularly in those aged over 85. We will continue to include updates on activity and outlook in general practice in future QMRs as we continue to expand the data in this area.

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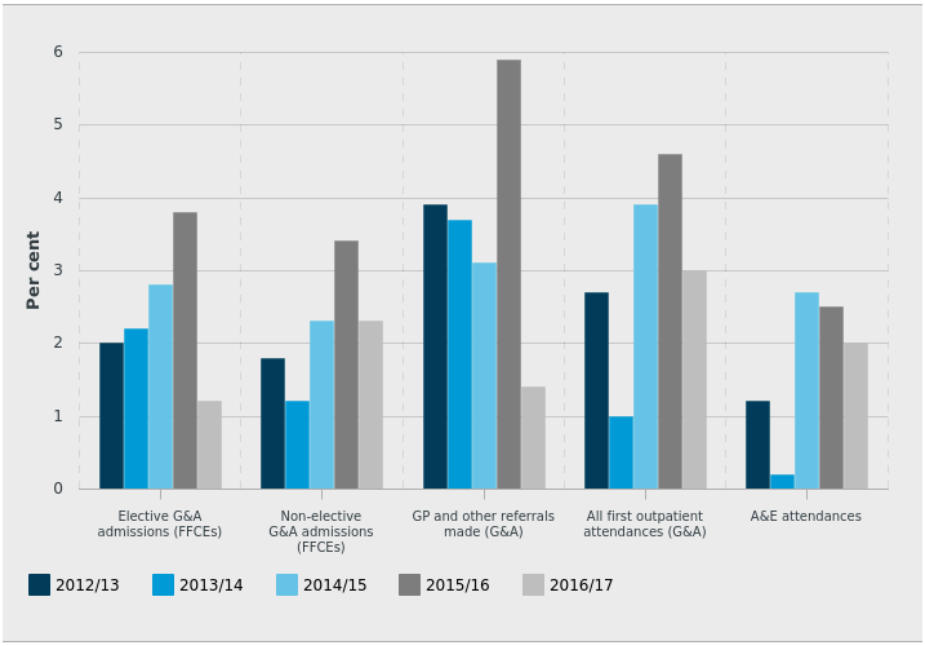
Figure 2: Growth rates in NHS activity



General and acute clinical specialties (G&A). First finished consultant episodes (FFCE)

1. Health care surveys

This quarter's report is based on an online survey of 84 NHS trust finance directors and 42 clinical commissioning group (CCG) finance leads (covering 50 CCGs).

Respondents were asked about their organisation's end-of-year financial situation for 2016/17 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 2018/19; the key organisational challenges facing trusts and CCGs; and workforce issues. We also asked respondents about the NHS's ability to meet A&E (accident and emergency) targets as set out in the *Next steps* document.

2. End-of-year financial position: 2016/17

- Just over a third (36 per cent) of all providers indicated that they ended 2016/17 in deficit. The situation was worse for acute providers, of whom 54 per cent ended last year in deficit (Figure 3). 82 per cent of trust finance directors reported that their year-end position for 2016/17 depended on significant financial support (Figure 5). The situation was worse for acute trusts where 95 per cent reported that their year-end position for 2016/17 depended upon significant financial support.
- A fifth of all CCGs ended 2016/17 in deficit (Figure 4). Two-thirds of all CCGs reported their year-end position for 2016/17 relied upon significant financial support. More than half (52 per cent) of all CCGs have delayed or cancelled spending plans, and just under a quarter (24 per cent) relied upon the release of the 1 per cent risk reserve in order to achieve their year-end position (Figure 6).

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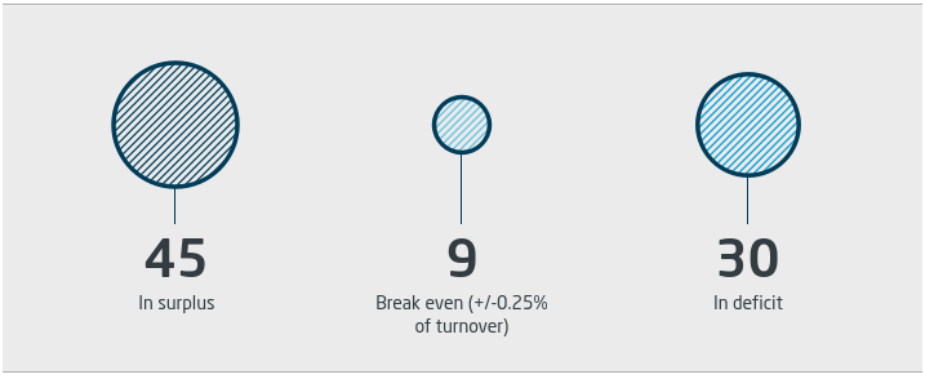
Figure 3: LOOKING BACK ON 2016/17: What was your organisation's end-of-year financial position?



Respondent comments

"Basically as a result of accounting for additional stocks and capitalising staff, neither of which generate cash."

– Acute - district general hospital and specialist, in surplus

"With help of land sale surplus."

– Unknown, in surplus

"Deficit £30.7 million normalised."

– Acute teaching provider, in deficit

"Deficit from plan driven by loss of quarter four sustainability and transformation funding due to non-achievement of economy-wide savings combined with above plan 'winter' costs."

– Acute, in deficit

"Breaking even sounds OK, but this is 1.2 per cent of turnover below our surplus control total, and the worst outturn performance the trust has ever posted since being established."

– Mental health trust, break even

"Owing principally to non-recurring, non-operational accounting entries."

– Specialist foundation trust, in surplus

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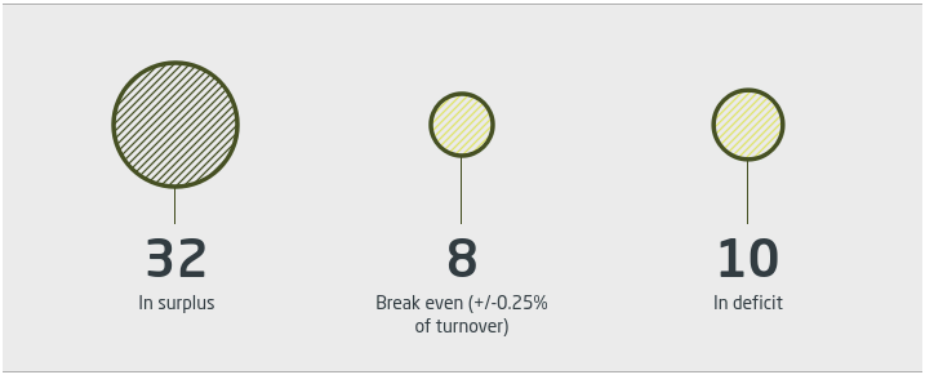
Figure 4: LOOKING BACK ON 2016/17: What was your organisation's end-of-year financial position?



42 CCG finance leads answered this question for the 50 CCGs they cover collectively.

Respondent comments

"In surplus, but only with the fallout of the 1 per cent national risk pool."

– In surplus

"Position confused by year-end release of 1 per cent reserve on NHS England rules."

– In surplus

"CCG planned break-even plus 1 per cent non-recurrent reserve (in accordance with instructions) held as surplus to balance provider position nationally."

– In surplus

"However, we also had to utilise our 1 per cent risk reserve to improve our position (as mandated by NHS England), so technically, we achieved a 1 per cent surplus rather than our planned break-even position."

– Break even

"Surplus below planned control total and at the time of writing remains subject to the outcome of a dispute with principal acute provider, that has the potential to deteriorate this position further."

– In surplus

"Significant in-year shift from break even to 3.5 per cent deficit (including release of 1 per cent non-recurrent)."

– In deficit

"Excluding release of 1 per cent risk reserve – with risk reserve the position is 1 per cent surplus."

– Break even

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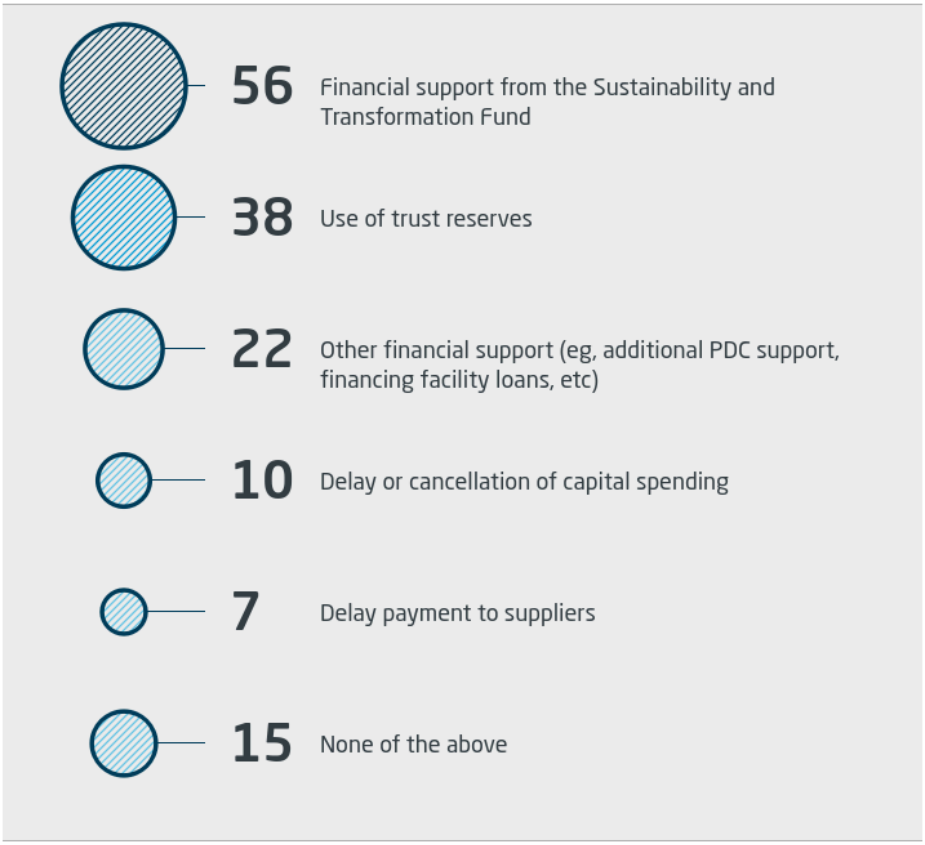
Figure 5: LOOKING BACK ON 2016/17: What did your end-of-year outturn depend on?



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

Respondent comments

"Sustainability and transformation funds increased the size of our surplus but nothing more."

– Mental health, in surplus

"As well as using all contingency reserves, we also relied on some non-recurrent technical adjustments, which mean the underlying run rate is a deficit position."

– Community trust, break even

"Stripping the balance sheet provided non-recurrent benefits."

– Specialist, in surplus

"Non-recurrent actions and asset lives/asset revaluation exercise conducted with support externally, non-recurrent and stringent non-clinical discretionary/agency/recruitment controls for past six months."

– Community and mental health foundation trust, in surplus

"Property gains. Charitable donations received."

– Specialist foundation trust, in surplus

"Balance sheet flexibilities such as deferred income have been used – which will deny R&D and some training funds for 2017/18."

– Medium-sized district general hospital, in deficit

"Significant land sales."

– Acute and specialist foundation trust, in surplus

CCG LEADS

Figure 6: LOOKING BACK ON 2016/17: What did your end-of-year outturn depend on?

42 CCG finance leads answered this question for the 50 CCGs they cover collectively. Respondents were allowed to select more than one form of additional financial support.

Respondent comments

"The CCG ended the year with an in-year deficit position, which included the release of the 1 per cent risk reserve. The CCG only reported a cumulative surplus with the inclusion of the brought-forward surplus position."

– In surplus

"It was made clear to us that the 1 per cent non-recurrent reserve would NOT be a legitimate means of achieving our target."

– In surplus

"Release of Continuing Health Care (CHC) accruals, referral management, use of non-recurrent support."

– In surplus

"No formal drawdown, but several £ million released from review of balance sheet/provisions... ie, non-recurrent things which can't be repeated."

– In surplus

3. Estimated end-of-year financial position: 2017/18

- In our recent survey just under half of all trusts (43 per cent) forecast ending 2017/18 in deficit (Figure 7). 81 per cent of trust finance directors reported that their forecast position for 2017/18 would depend on significant financial support (Figure 9). Furthermore, half of all providers expecting to receive Sustainability and Transformation Fund monies still forecast a deficit by the end of the year.
- We also asked trusts to provide details of their agreed control totals for 2017/18. Of the 78 trusts that have agreed control totals (or that are in the process of agreeing control totals), 8 per cent forecast a worse end-of-year position against their control total. Furthermore, just under half of all trusts (46 per cent) are either fairly or very concerned about meeting their agreed control totals in 2017/18 (Figure 11).
- Half of all CCGs forecast a surplus for 2017/18, and 18 per cent are expecting to overspend (Figure 8). Just under half (48 per cent) of all CCGs are fairly or very concerned about meeting their forecast end-of-year position for 2017/18 (Figure 12). Furthermore, 50 per cent of all CCGs expect to delay or cancel spending plans to support their finances in 2017/18 (Figure 10). The potential threat to the commissioner portion of the central risk reserve (£360 million) is underlined by the fact that 28 per cent of CCGs are relying on their share being returned to them, rather than being used to support provider deficits (Figure 10).

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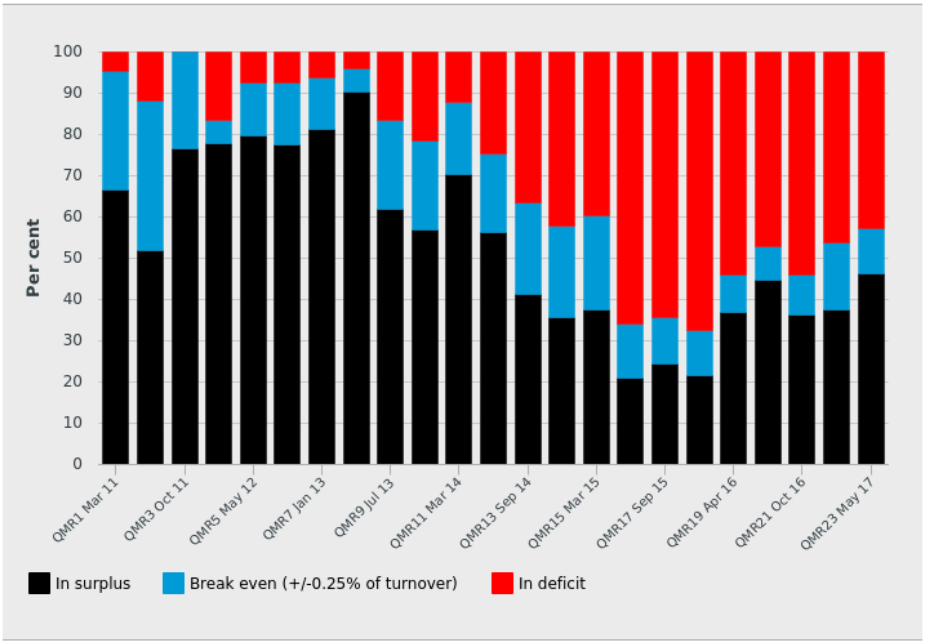
Figure 7: What is your organisation's forecast end-of-year financial position?



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

Respondent comments

"But a real challenge to achieve that particularly given STP financial position."

– Mental health provider, in surplus

"5.8 per cent CIP required to achieve this position including 1.7 per cent trust gap driven by public health grant cost reductions."

– Community and mental health foundation trust, in surplus

"Requires CIPs/QIPPs of nearly 6 per cent – high risk of non-achievement."

– Mental health provider, in surplus

"We are aiming to achieve 3.5 per cent savings, which will leave us with a £7 million deficit."

– Acute – district general hospital and specialist, in deficit

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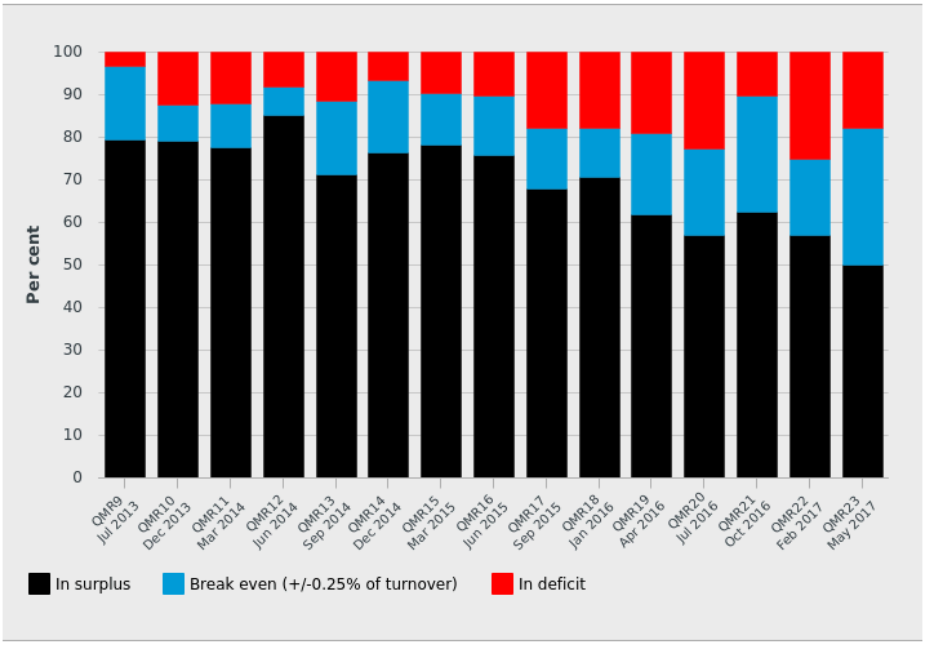
Figure 8: What is your organisation's forecast end-of-year financial position?



42 CCG finance leads answered this question for the 50 CCGs they cover collectively; CCGs only surveyed since their establishment in April 2013.

Respondent comments

"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

"Still aiming for surplus but reporting a high degree of net risk."

– In surplus

"Cumulative surplus brought forward is being maintained and therefore in-year position is break even."

– Break even

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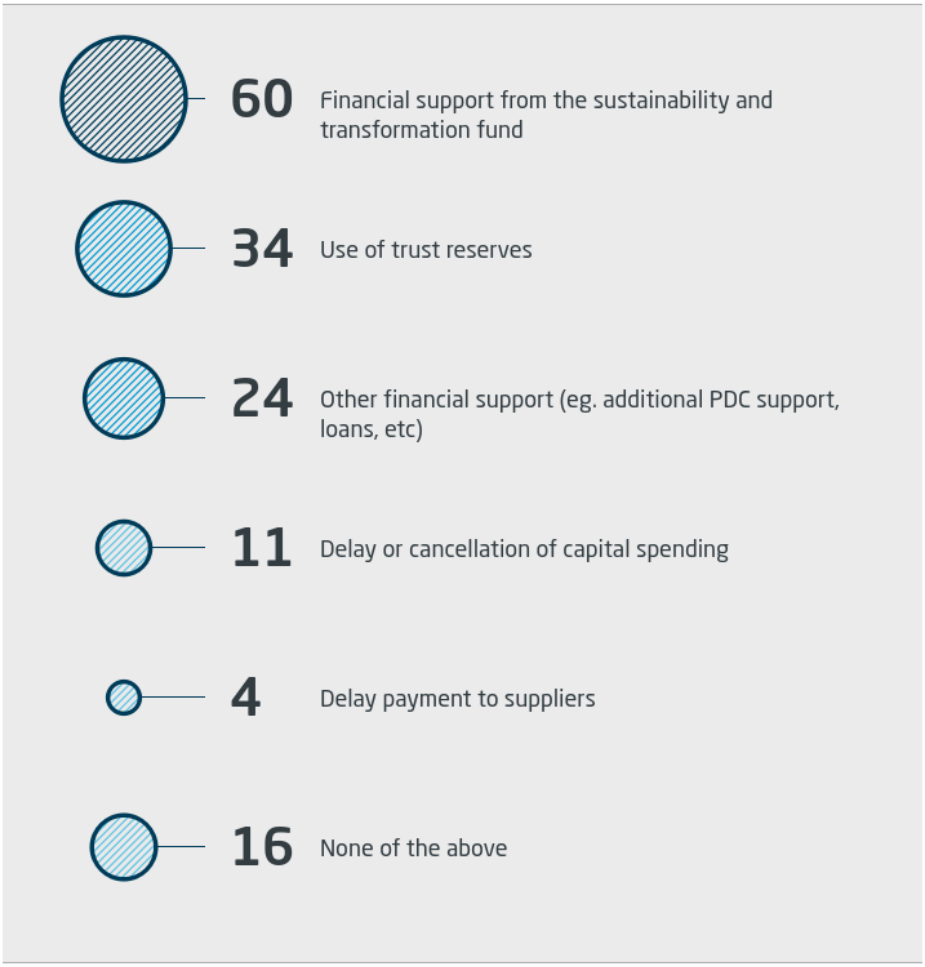
Figure 9: What is your forecast 2017/18 end-of-year outturn likely to depend on:



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

Respondent comments

"100 per cent Sustainability and Transformation Fund income, 4.7 per cent CIP and 0 per cent demand increase (funded by CCG on basis of flat cash for flat activity at 2016/17 outturn levels)."

– Acute

"Other land sales."

– Acute and specialist foundation trust

"Delivery of challenging CIPS and assistance from commissioners."

– Acute foundation trust

"Ability to recruit, operational performance, CCG plans, delivery of CIPS, etc, etc, etc."

– Acute trust

"Capital asset disposals, revenue to capital transfers."

– Acute

"It will need a bloody miracle."

– Medium sized district general hospital

"Need cash to cover deficit position."

– Acute

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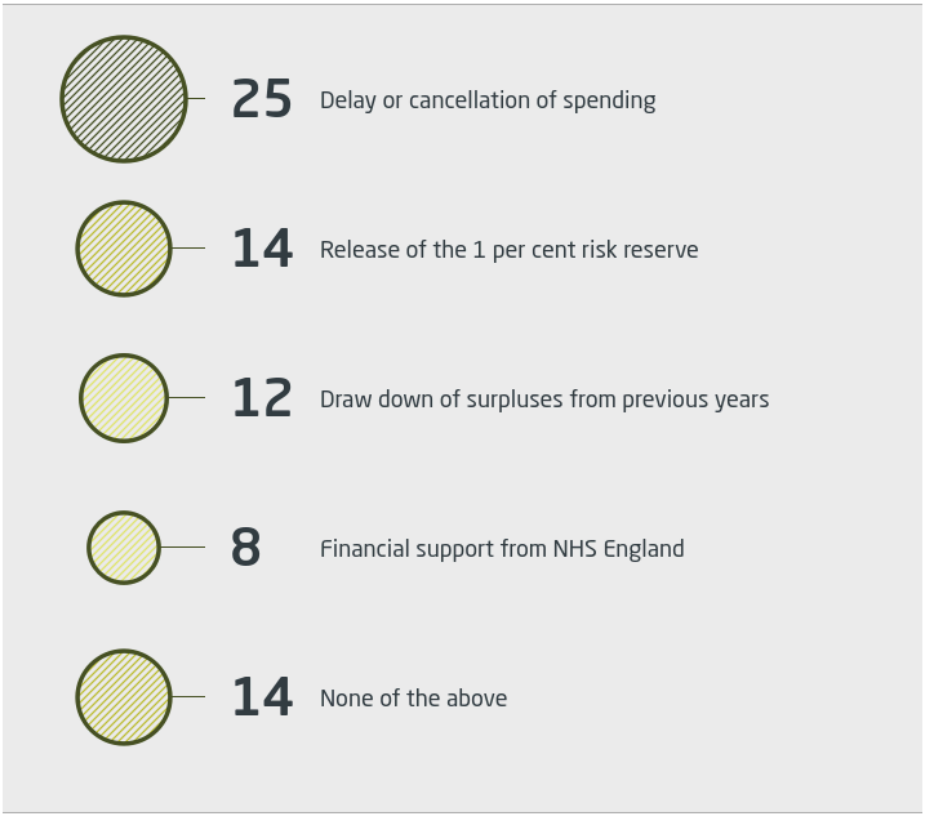
Figure 10: What is your forecast 2017/18 end-of-year outturn likely to depend on:



42 CCG finance leads answered this question for the 50 CCGs they cover collectively. Respondents were allowed to select more than one form of additional financial support.

Respondent comments

"Primary factor which will make a difference is a behaviour change by the local acute trust to take a system view rather than delivering their own bottom line at all costs."

"Have been allowed a modest drawdown of £700,000 against previous surpluses >1 per cent."

"Will need to make decisions to stop services classed as high-risk items."

"Delivery of increasingly high-risk reductions in spending."

"Good financial management and commissioning plus cost improvements as a result of system-based cost-reduction programmes."

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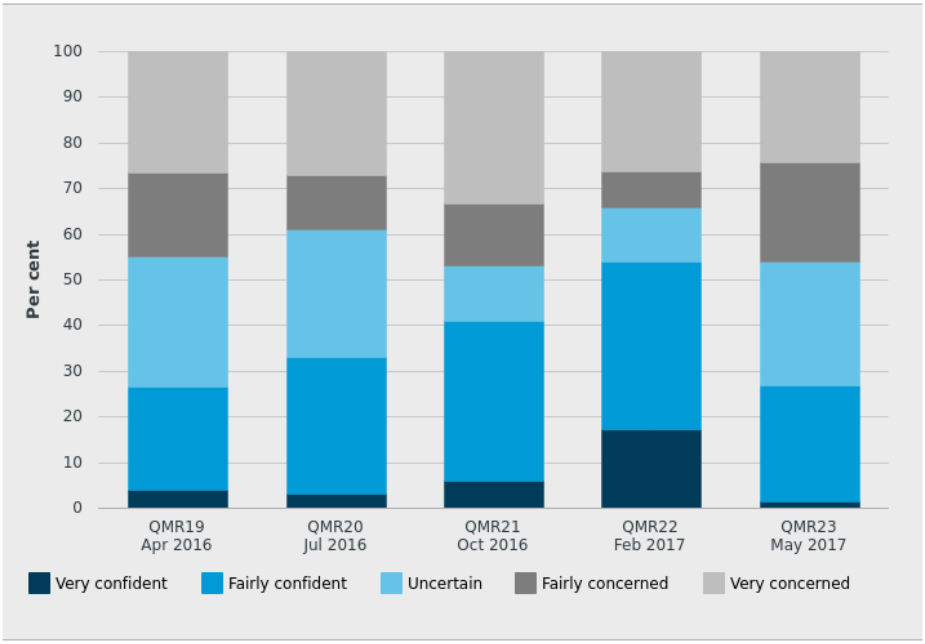
Figure 11: How confident are you that organisation can meet its control total for the year ahead?



78 respondents (for whom this question was applicable).

Respondent comments

"The impact of CCG financial positions make the risk of contract disagreements and dispute very high."

– Community trust, uncertain

"Main contract has moved from cost and volume to block for 2017/19."

– Ambulance, uncertain

"Interpreted the question as how confident am I that we will live inside the block contract income."

– Community provider (social enterprise), fairly confident

"Without a 'Harry Houdini accounting trick or two', the trust will likely record a significant deficit (pre-STF)."

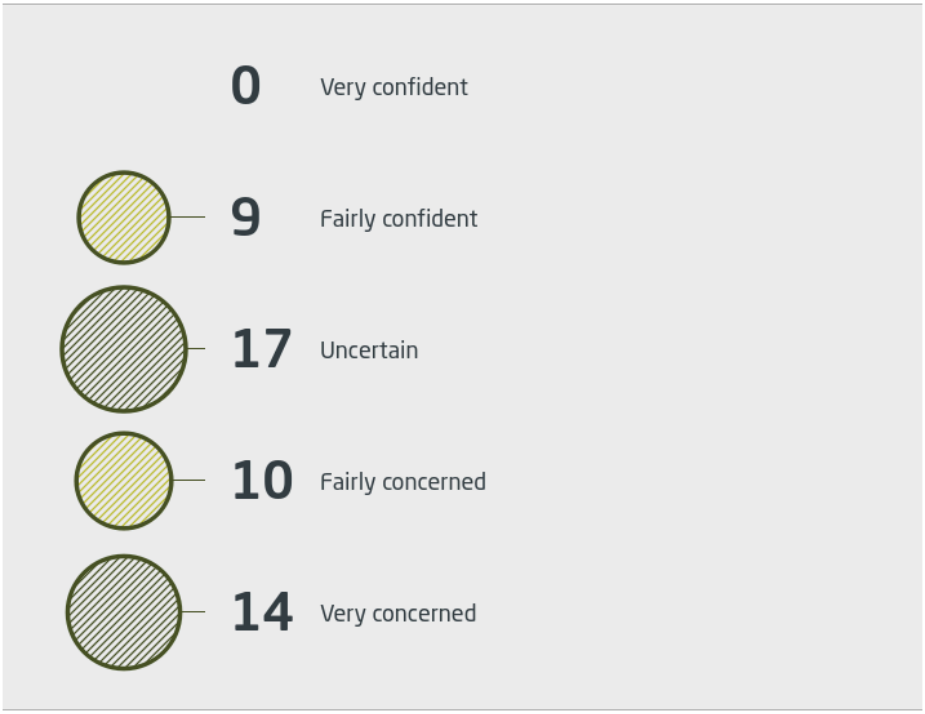
– Medium-sized district general hospital, very concerned

"Much hinges on a one-off gain which would contribute to the financial result."

– Specialist foundation trust, fairly confident

CCG LEADS

Figure 12: How confident are you that your organisation can meet its forecast end-of-year postion for 2017/18?



42 CCG finance leads answered this question for the 50 CCGs they cover collectively

Respondent comments

"Locally and county-wide there is insufficient pace of change to enable us to hit a 4 per cent QIPP. The massive allocation shifts and risks attached to Identification Rules changes and HRG4+ carry very high risk. There is little confidence in the accuracy of the calculations that underpin them."

– Break even, very concerned

"Highly dependent upon system-wide approach particularly from our acute provider (delivery of QIPP requires cultural changes and minimal up coding and counting)."

– In deficit, uncertain

"Without significant, radical and immediate system change (beyond anything currently planned) I fear that all commissioners locally will be managing significant deficit positions early in 2017/18."

– Break even, very concerned

"QIPP programme nearly double what we achieved, no risk shares in place with acute providers."

– In surplus, very concerned

4. Cost improvement (CIP) and quality, innovation, productivity and prevention (QIPP) programmes (2017/18)

- The average cost improvement programme (CIP) target for trusts for 2017/18 is 4.3 per cent, ranging from 2 per cent to 7.5 per cent of turnover (Figure 13).
- The average quality, innovation, productivity and prevention (QIPP) target for CCGs for 2017/18 is 4 per cent, ranging from 1 per cent to 8 per cent of allocation (Figure 13).
- Just under half (46 per cent) of all NHS trust finance directors are either fairly or very concerned about achieving their savings plans this year (Figure 14). This represents a higher level of concern than that reported at the same time in 2016/17 and 2015/16.
- Just over half (52 per cent) of all CCG finance leads are fairly or very concerned about achieving their plans this year (Figure 15).

NHS TRUSTS CCG LEADS

Figure 13: Trusts and CCGs CIP/QIPP targets for 2017/18

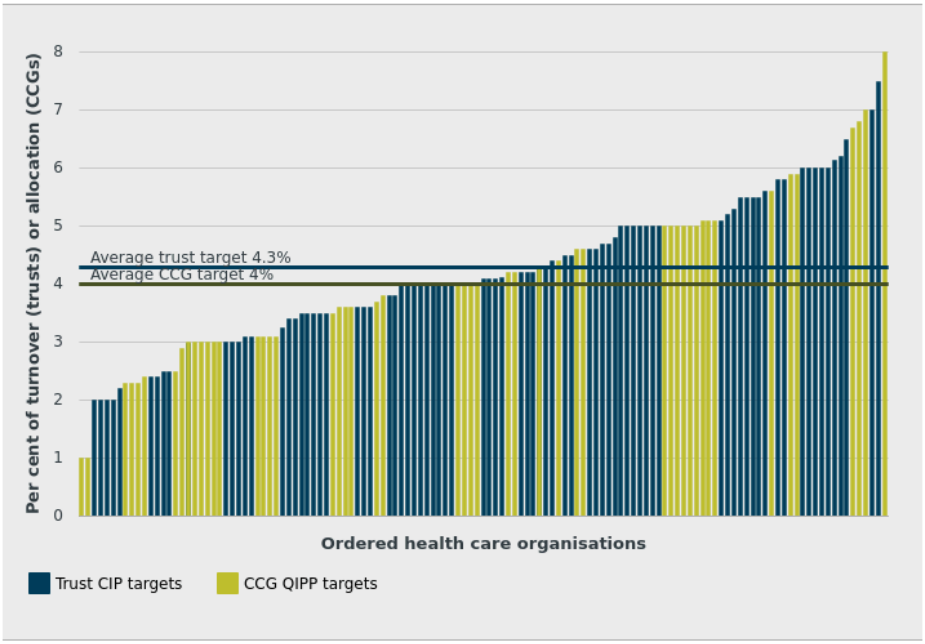


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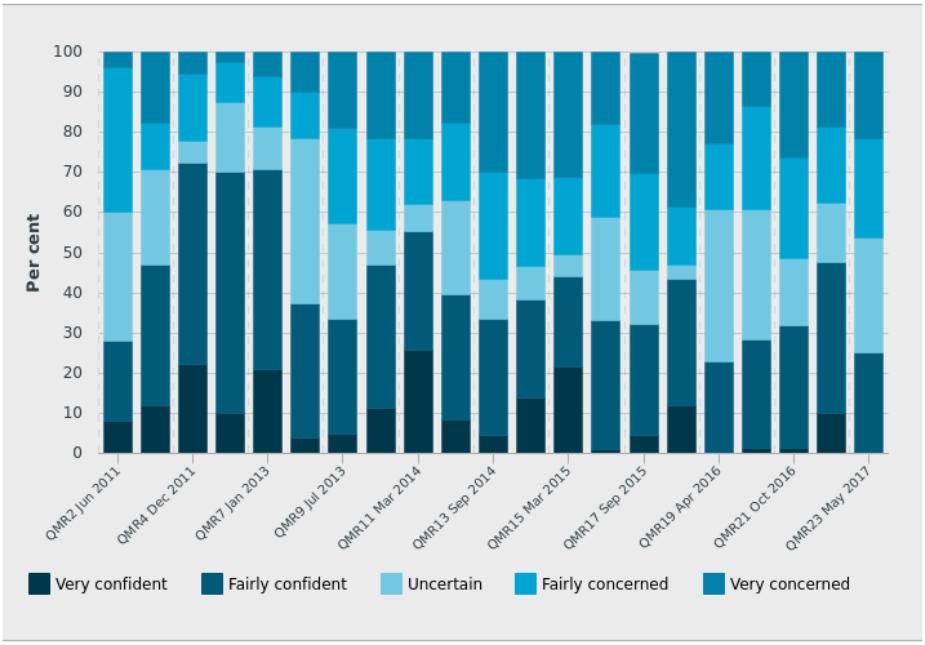
Figure 14: How confident are you of achieving your CIP target?



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

"We will deliver our cost improvement requirements, but the implications on (particularly) volumes of patients that we can treat concern me. We will not compromise patient safety, and the focus of savings on management areas will influence our ability to manage the agenda."

– Community provider (CIC), fairly concerned

"Significant cost reduction alongside the need to integrate with primary care while maintaining safety and quality will be a real challenge; the latter being essential for a sustainable health care system."

– Mental health provider, fairly concerned

"Low reference costs mean already efficient so improvements are more difficult."

– Community and mental health, uncertain

"The majority of our CIPs require savings from frontline resources - therefore high risk to achievement given patient safety concerns."

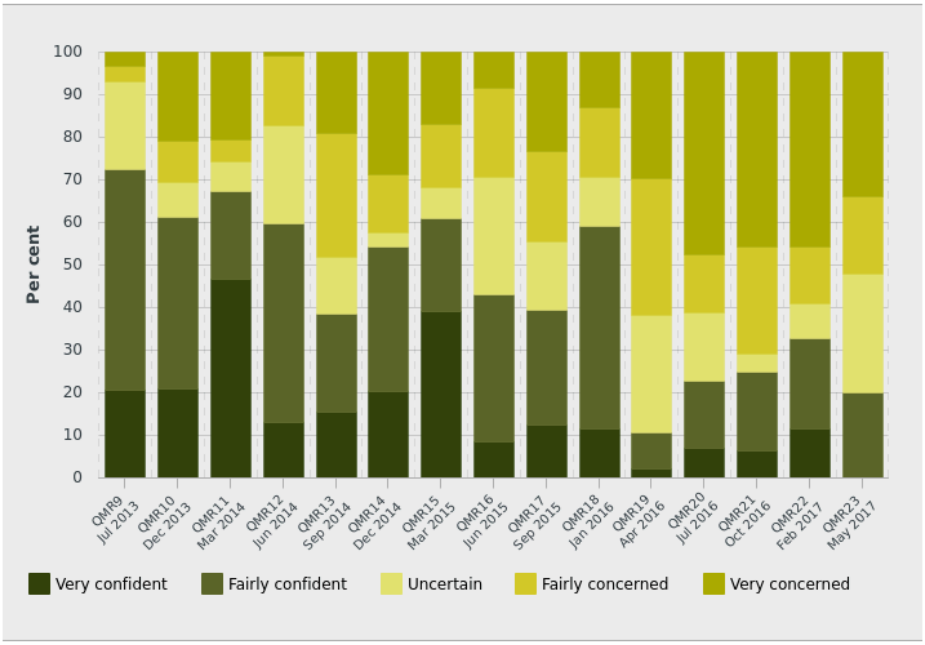
– Ambulance, very concerned

"About 50 per cent of the trust's CIP requirement has not yet been identified."

– Specialist foundation trust, uncertain

CCG LEADS

Figure 15: How confident are you of achieving your QIPP target?



42 CCG finance leads answered this question for the 50 CCGs they cover collectively; CCGs only surveyed since their establishment in April 2013.

Respondent comments

"Requires action from entire county-wide STP and acute trusts not engaged in not accepting of the need to reduce acute beds."

– Very concerned

"In financial terms my organisations QIPP target for 2017/18 is approximately 100 per cent above the highest value it has ever delivered before."

– Very concerned

"QIPP is very misleading. We are into dis-investment, de-commissioning, and stopping services."

– Very concerned

"Mitigating through use of non-recurrent flexibilities but very concerned re our ability to reduce acute spend and our local trust is not supporting our QIPP initiatives so uphill work."

– Fairly concerned

5. The state of patient care

- Just under half of trust finance directors and CCGs (49 and 48 per cent respectively) feel that patient care has worsened in their local area in the past year (Figures 16 and 17).
- The number of trust finance directors and CCG finance leads reporting that patient care has worsened in their local area in the past year remained high throughout 2016/17, and into 2017/18 when compared to previous

years.

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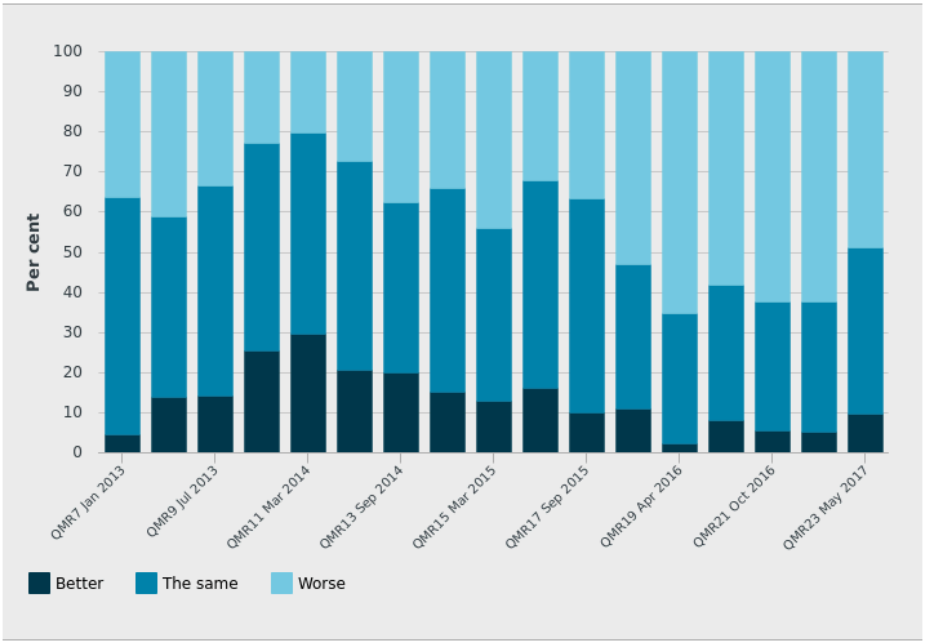
Figure 16: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



Question not asked before QMR6.

Respondent comments

"Lack of clarity about the impact of STP, particularly where the work on acute sector reconfiguration has an impact upon out-of-hospital care (primary and community)."

– Community provider (CIC), worse

"Increasing strain on waiting times and A&E performance but still outperforming rest of country."

– Mental health and disability, worse

"Much longer waits in hospitals which is detrimental to patient care."

– Ambulance, worse

"A&E and primary care access especially plus public health grant reductions in health visiting, substance misuse and school nursing."

– Community and mental health foundation trust, worse

"The hospital has been extremely busy and been badly affected by the social care cuts. DTOCs have been very high and lots of 'green-to-go' patients. Waiting lists have grown, more interventions are no longer funded by CCGs, ambulance service struggling etc."

– Acute - district general hospital and specialist, worse

"CCGs have taken the Forward View refresh as a green light to not fund RTT backlogs."

– Acute teaching provider, worse

"My concerns are not about the 'broad brush' of local services but a realisation that certain services - especially those being impacted by QIPPs enforced by commissioners - are now being so reduced in scope that there is an inevitable impact upon quality."

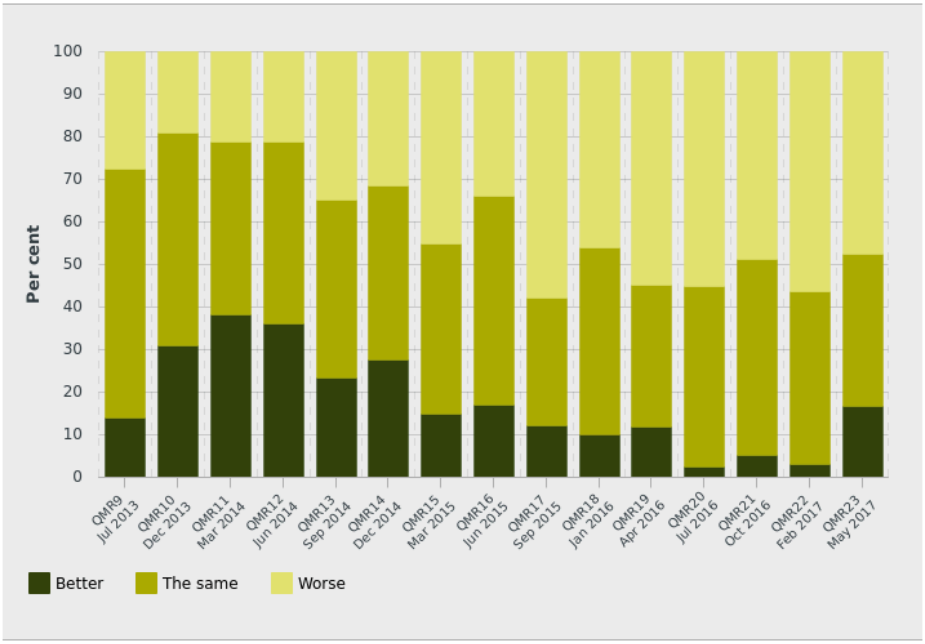
– Mental health provider, worse

"Worse RTT performance and significantly worse DTOC position."

— Acute foundation trust, worse

CCG LEADS

Figure 17: 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

"RTT problems at local trust being one such issue."

– Worse

"Although we have taken actions to re-prioritise and decommission patient services in the year, the impact will start to come across more in 2017/18."

– The same

"We have struggled to ensure patients are treated within the 4 hours at A&E and have had a number of 12-hour breaches. This has had a knock-on effect on elective care with operations being cancelled. We have also suffered from delays in patients leaving the hospital so they are kept in longer than required because we cannot source domiciliary care."

– Worse

"Earlier part of the year it was worse but improved towards the end of the year, main areas of concern being A&E waiting times, delayed transfers of care, ambulance response times."

– The same

"Main provider trust (acute, community, mental health and ambulance provider) has just been placed in special measures, following CQC inadequate rating."

– Worse

"No actual evidence of poorer clinical quality but waiting times have gone out and know that our community provider is managing its own finance by holding vacancies which must have an impact on services."

– Worse

"Local acute trust is managing a significant annual and historic financial deficit, is in special measures and is overly reliant upon agency staff – for which IR35 changes have had a worrying impact."

– Worse

6. Organisational challenges

- For trust finance directors, delayed transfers of care continue to be their main concern. As in the previous QMR, staff morale is the second highest concern for finance directors, and bed occupancy continues as the third major concern for trust finance directors for the second QMR in a row. 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 four-hour waiting time standard itself (Figure 18).
- For CCG finance leads the four-hour A&E waiting time standard continues to be their main concern for a third QMR in a row. Their second biggest concern is pressures on general practice, introduced as an option for the first time in this QMR. They also continue to be concerned about delayed transfers of care and the cancer treatment waiting times standards (Figure 19).

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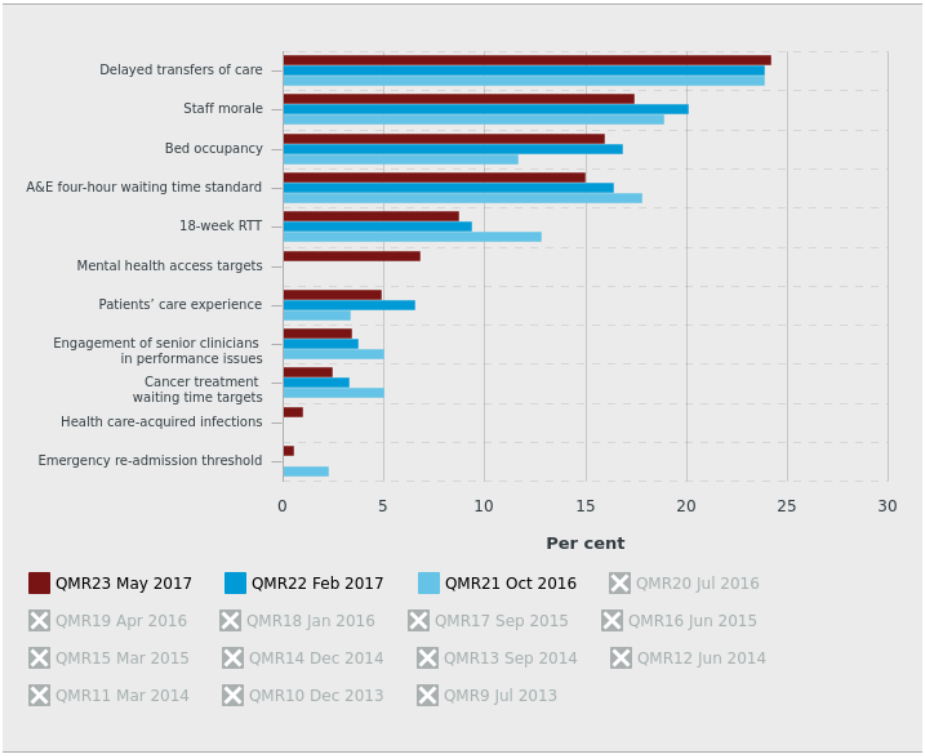
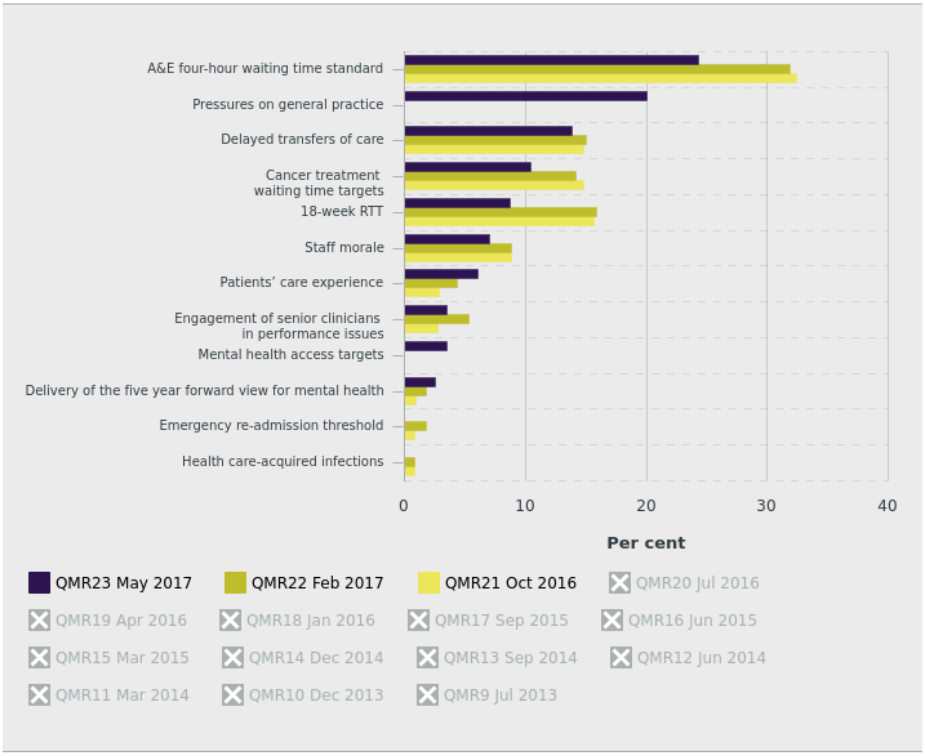
Figure 18: Which aspects of your organisation's performance are giving you most cause for concern at the moment?



CCG LEADS

Figure 19: Which aspects of your organisation's performance are giving you most cause for concern at the moment?



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

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 A&E four-hour performance standard.
- We asked trust finance directors how confident they were in the NHS's ability to deliver on the A&E four-hour performance standard by September 2017. Worryingly, just under half (49 per cent) of all trust finance directors (Figure 20) and three-fifths (60 per cent) of CCG finance leads (Figure 21) are either fairly or very concerned that the NHS will not be able to deliver this performance standard by September 2017.
- The *Next steps* document also gave notice that the planned levels of elective activity would not be enough to maintain the 18-week referral-to-treatment standard. As a result, the standard was downgraded. Following this announcement just under 70 per cent of trust finance directors said they had no plans to reduce elective activity (Figure 22), while a small number commissioners (15 per cent) were re-considering their plans and may seek to reduce the level of elective activity contracted for (Figure 23).

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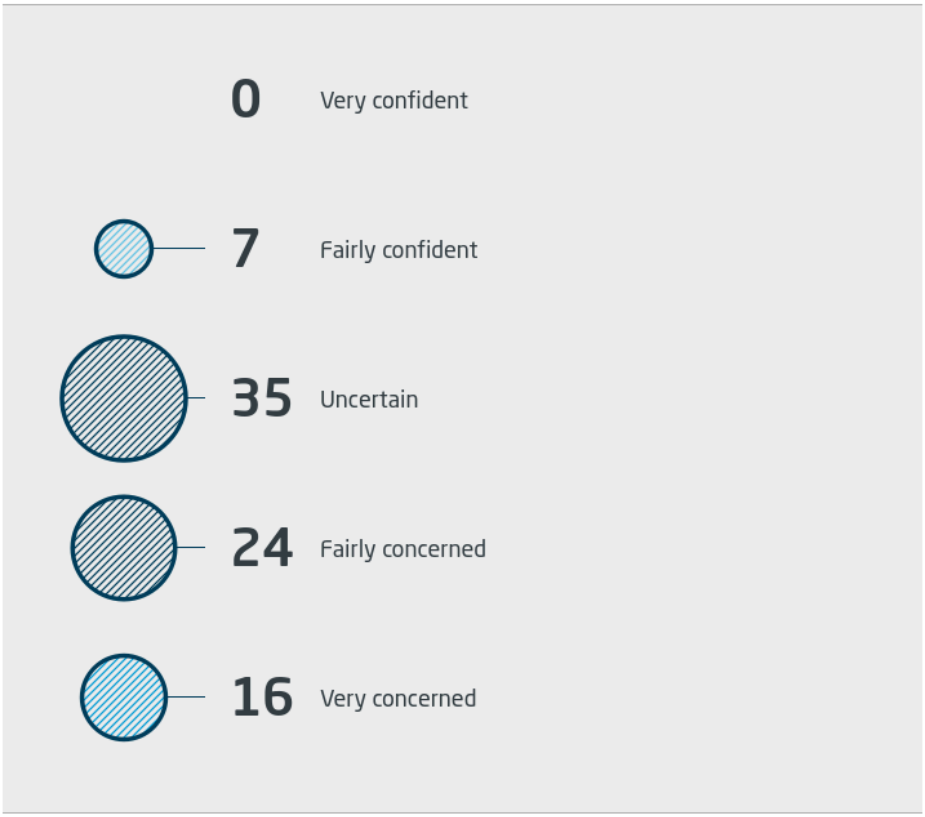
Figure 20: How confident are you that the NHS will meet the 90 per cent A&E four-hour performance standard by September 2017, as set out in the 'Next steps on the NHS five year forward view'?



82 respondents

Respondent comments

"If demand keeps growing at the same rate, achievement of the target will be extremely difficult. Social care services and ability to discharge patients in a timely manner remains a real concern."

– Acute provider, uncertain

"A&E medical staff are like hens' teeth."

– Acute trust, very concerned

"Hopeful but depends on how new social care funding is invested."

– Teaching hospital with community services, uncertain

"Locally we will achieve it, but not sure nationally."

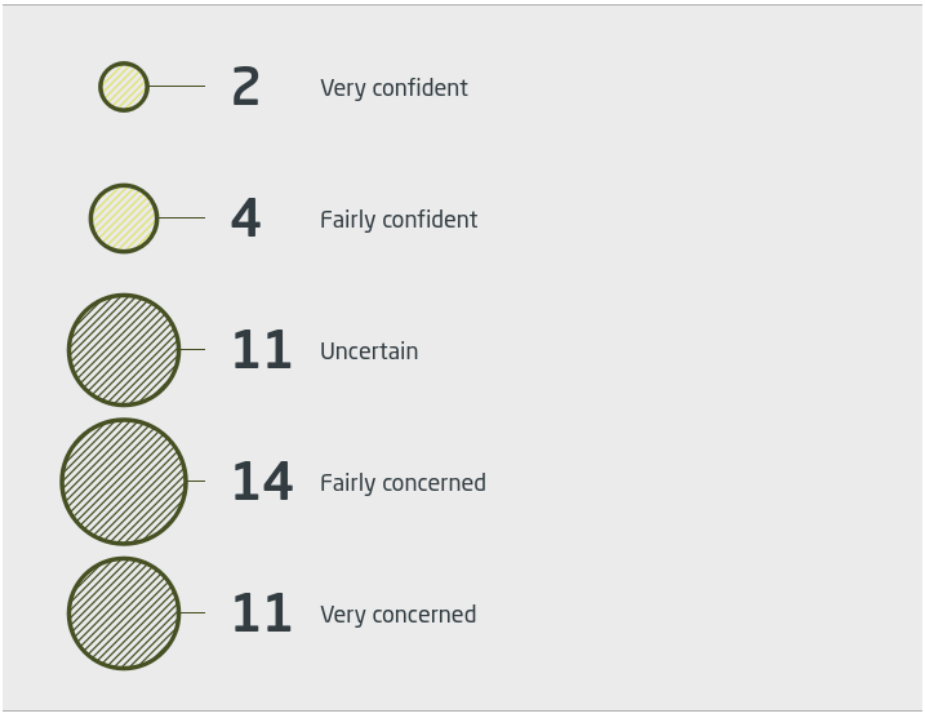
– Acute and community foundation trust, uncertain

"Key as noted above on patient flow, etc, will be use of Better Care Fund, change in culture from admit to assess to assess to discharge."

– Acute, fairly concerned

CCG LEADS

Figure 21: How confident are you that the NHS will meet the 90 per cent A&E four-hour performance standard by September 2017, as set out in the 'Next steps on the NHS five year forward view'?



Respondent comments

"We have received national capital funds to enable infrastructure changes required to stream more minors. We need to ensure we can source the primary care staff to manage these patients and this extra capacity will be sufficient to cover off increases in demand."

– Fairly concerned

"Concerned about the unintended consequences, in 2016/17 in order to meet the target there was a change in clinical practice which included significant increase in short stay admissions, which created additional cost for commissioners."

– Very confident

"Again, this is reliant on being able to recruit appropriately skilled resilient staff and at the moment this is not the case. The impact of IR35 is already a factor in not being able to fill all medical staff gaps."

– Uncertain

"Fairly concerned for September deadline, very concerned for next winter."

– Fairly concerned

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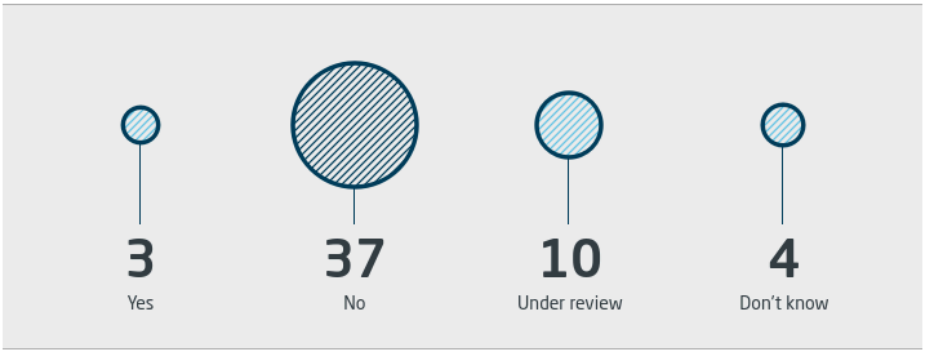
Figure 22: The 'Next steps on the NHS five year forward view' stated that the growth in elective activity was unlikely to be sufficient to maintain the 92 per cent 18 week standard. In light of this, will your organisation now reduce the planned level of activity in 2017/18?



54 respondents (for whom the question was applicable)

Respondent comments

"Will try to maintain performance so long as it does not undermine finance."

– Acute, no

"May choose not to incur premium rate costs to maintain 18 weeks."

– Acute foundation trust, no

"We will be increasing as backlog was not in signed-off plan and contract."

– Acute, no

"It doesn't take long to lose RTT performance but years to recover. Our board remains committed to ensuring that patients referred to us are treated in a timely manner."

– Acute teaching provider, no

"Demand already outstrips supply."

– Acute foundation trust, no

CCG LEADS

Figure 23: The 'Next steps on the NHS five year forward view' stated that the growth in elective activity was unlikely to be sufficient to maintain the 92 per cent 18 week standard. In light of this, will your organisation now plan to contract for a reduced level of activity in 2017/18?

41 CCG finance leads answered this question for the 48 CCGs they cover collectively

Respondent comments

"2016/17 RTT performance above target. Full programme of referral and elective prioritisation QIPP schemes to reduce referrals, no plan to reduce RTT. Delivered RTT and A&E, but moved into deficit in year."

– No

"We have notified NHS England that we will not be able to achieve 92 per cent target."

– Yes

"As a commissioner, elective activity is one of the key areas in which we are able – at least theoretically – to influence referral patterns and therefore reduce expenditure."

– Yes

"Plans already agreed with providers who want/need to get the patients in and treated to support their organisational positions, PbR [Payment by Results] at work."

– No

"From a financial perspective this would certainly be beneficial to the CCG but our local acute trust is unlikely to agree to a reduced plan as this would negatively impact upon its own finances."

– Under review

"This will only work if the permission to not meet the standard is supported by commissioner ability to enforce contracted levels with providers."

– Yes

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 69 per cent of trust finance directors and 72 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 24 and 25).

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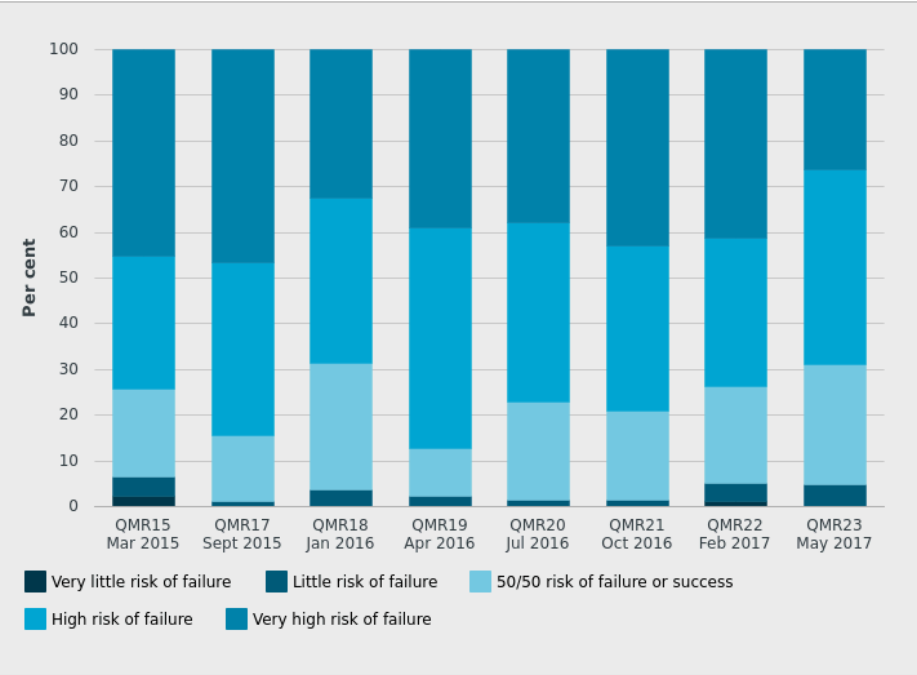
Figure 24: The 'NHS five year forward view' sets out a challenge to the NHS to achieve an average of 2 to 3 per cent of productivity gains per year from 2015/16 to 2020/21. What is your estimate of the risk involved in achieving these productivity gains?



Question not asked in QMR16.

Respondent comments

"This is hilarious, if we were being asked to achieve 2-3 per cent we'd be laughing! We need to deliver double the top end of this. 1 per cent national cost pressures this year (CNST, CQC, NHSLA, Apprenticeship levy, etc, etc) 1.7 per cent public health grant, 2 per cent tariff, balance local unfunded pressures, eg, Microsoft, IM&T, safer staffing, etc"

– Community and mental health foundation trust, little risk of failure

"The 2-3 per cent is a headline and does not recognise the true challenge we face as additional cost are put on providers centrally (IR35, pension costs, CNST, NI contributions) and all commissioner QIPPs roll down to providers in the end."

– Acute foundation trust, very high risk of failure

"Efficiency gains can be found to offset cost increases of approx 2 per cent annually. Managing demand pressures on top of this is unlikely to result in the flat line income streams demanded."

– Community provider (social enterprise), high risk of failure

"If the British economy as a whole struggles to secure 2-3 per cent productivity growth annually - I can't see how a service industry such as the NHS can expect to match that level of growth!"

– Mental health provider, little risk of failure

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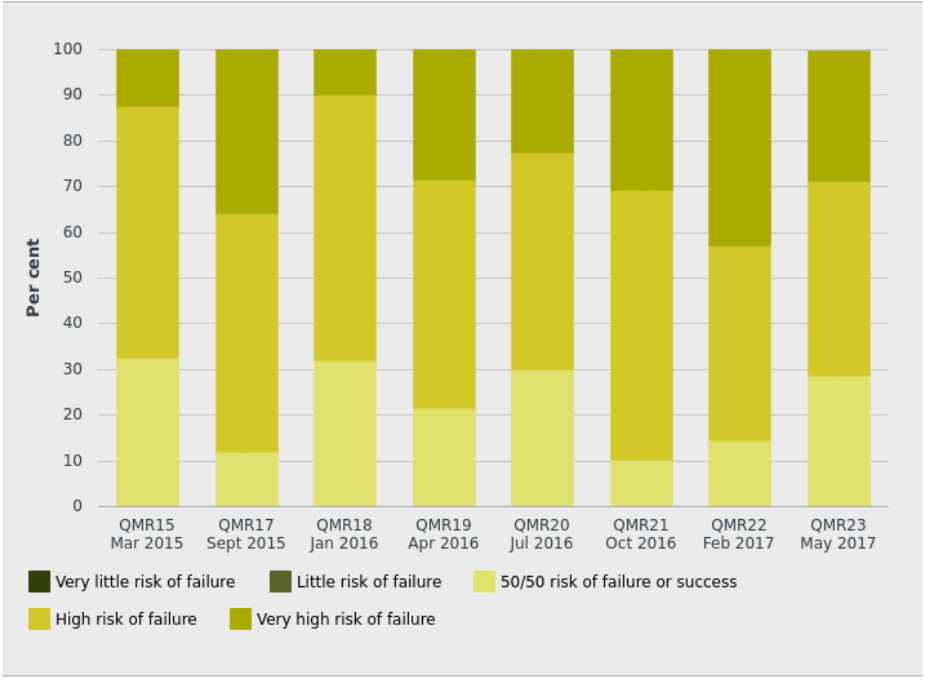
Figure 25: The 'NHS five year forward view' sets out a challenge to the NHS to achieve an average of 2 to 3 per cent productivity gains per year from 2015/16 to 2020/21. What is your estimate of the risk involved in achieving these productivity gains?



Question not asked in QMR16.

Respondent comments

"I think we are now dependent upon large-scale system-wide changes such as the development of an accountable care system to achieve such gains which is not a quick fix."

– High risk of failure

"Concerned that we are reaching the limit of improvement and funding for stepped/transformational change is now limited."

– Very high risk of failure

"With inflation running in excess of allocation uplifts, a deficit of substantive medical and nursing staff locally and slippage on STP implementation plans, I am concerned that productivity will not improve without organisational change."

– Very high risk of failure

"Year-on-year savings get harder to deliver and the actual number required to offset the demographic growth, acuity impact and patient demand is considerably higher than 2-3 per cent."

– High risk of failure

"Current system does not incentivise commissioners and providers to pull in the same direction, despite the fine words spouted by STP boards."

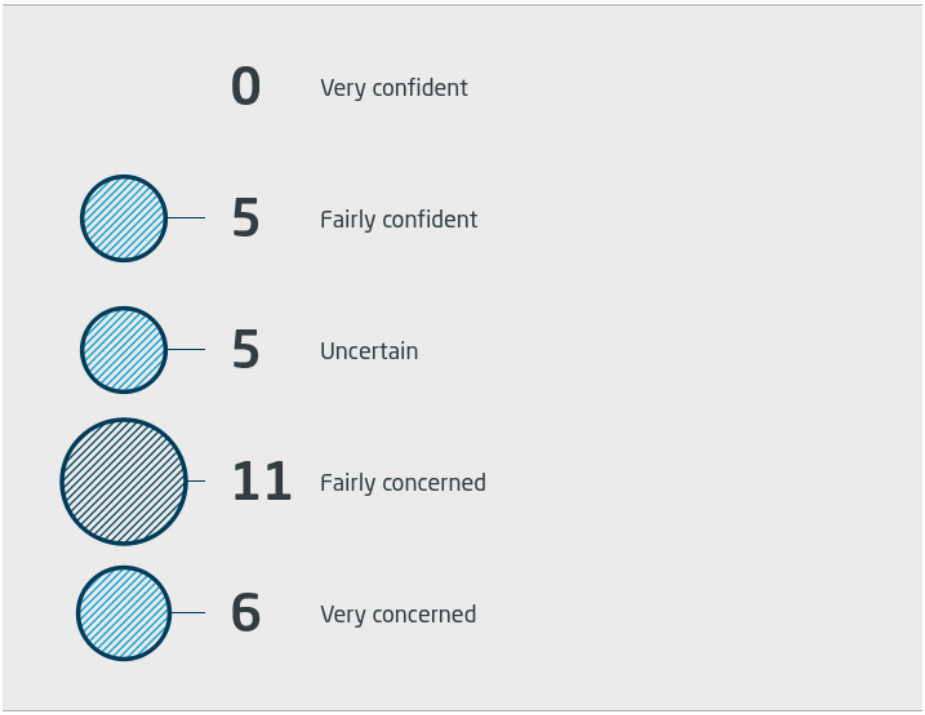
– High risk of failure

9. Mental health funding

- Just under two-thirds (63 per cent) of mental health trusts are fairly or very concerned about commissioners' ability to increasing funding for mental health services in line with the investment standard in 2017/18 (Figure 26). At the same time, only 16 per cent of commissioners feel fairly or very concerned about their ability to increase funding in line with the mental health investment standard (Figure 27). It is possible that the views of providers and commissioners on this issue do not reconcile because NHS mental health providers represent only one element of CCG overall investment in mental health services.

NHS TRUSTS

Figure 26: FOR MENTAL HEALTH TRUSTS ONLY: How confident are you that your commissioners will be able to increase funding for mental health services in line with the mental health investment standard in 2017/18?



27 respondents

Respondent comments

"We are a combined mental health and community trust. I can categorically confirm NONE of the mental health investment standard was provided to our trust and instead has been used by our CCGs to fill holes in their purchasing budgets in other sectors."

– Mental health and community combined provider, very concerned

"They will be able to demonstrate the mental health investment standard percentage, however there is an underlying baseline investment requirement to bring in line with the rest of the country. CCGs also classify prescribing and Continuing Healthcare (CHC) against mental health spend so while investment may increase it's not necessarily in the right areas and certainly not to deliver the Forward View for Mental Health ambitions."

– Mental health provider, fairly confident

"Any funding increases are associated with continuing care commitments and not supporting delivery of Forward View for Mental Health."

– Mental health and disability, very concerned

"Commissioners have already stated they have no funds to allocate to mental health trust unless the equivalent savings are identified from the acute contract via STP work, none of this is in progress."

– Mental health, very concerned

"It has always been difficult to unpick and reconcile the figures presented by local commissioners in respect of mental health, given that we are only an element of their overall investment in the service."

– Mental health provider, fairly concerned

"Commissioners locally have very low levels of allocation growth in 2017/18 (for XXX CCG it is virtually zero). They can meet the financial element of the investment standard by giving mental health providers growth in line with their allocation (ie, zero) with little effort. They then set a QIPP target to fund mental health investment standard and demographic growth, but have asked providers to generate all the QIPP ideas. This means achievement risks to the investment standard are extremely high."

— Mental health trust, fairly concerned

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Figure 27: How confident are you that your organisation will be able to increase funding for mental health services in line with the mental health investment standard in 2017/18?

42 CCG finance leads answered this question for the 50 CCGs they cover collectively

Respondent comments

"Concerned that the pressure to hit a target will miss the point about investing in the right care."

– Fairly concerned

"We have invested in mental health services to achieve the mental health investment standard in every year - but at the same time we have saved money by stopping poor expensive out-of-area care. It should not be deemed as counter to mental health investment standard to disinvest where we have previously had poor value for money. The measure is WRONG!"

– Very confident

"Need to prioritise and get rid of PbR [Payment by Results] for acute which drains resources away from mental health, community and primary care."

– Fairly confident

"It is reflected within our plan, however, we must also target all areas of improvement opportunity identified by RightCare - for my CCG there is a significant opportunity in respect of mental health spending/services."

– Uncertain

"Have built into our plan but will depend on whether we can manage acute activity in-year (including acute QIPP delivery)."

– Uncertain

"My CCGs wanted to re-phase the mental health investment into 2018/19 to contribute to the 2017/18 financial challenge but NHS England would not support this approach."

– *Uncertain*

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, 86 per cent of trust finance directors and 72 per cent CCG finance leads are fairly or very pessimistic (Figures 28 and 29).
- More than half (61 per cent) of NHS trust finance directors are very or fairly concerned about balancing their books in 2018/19 (Figure 30).
- Half of all CCG finance leads are very or fairly concerned about achieving financial balance in 2018/19 (Figure 31).

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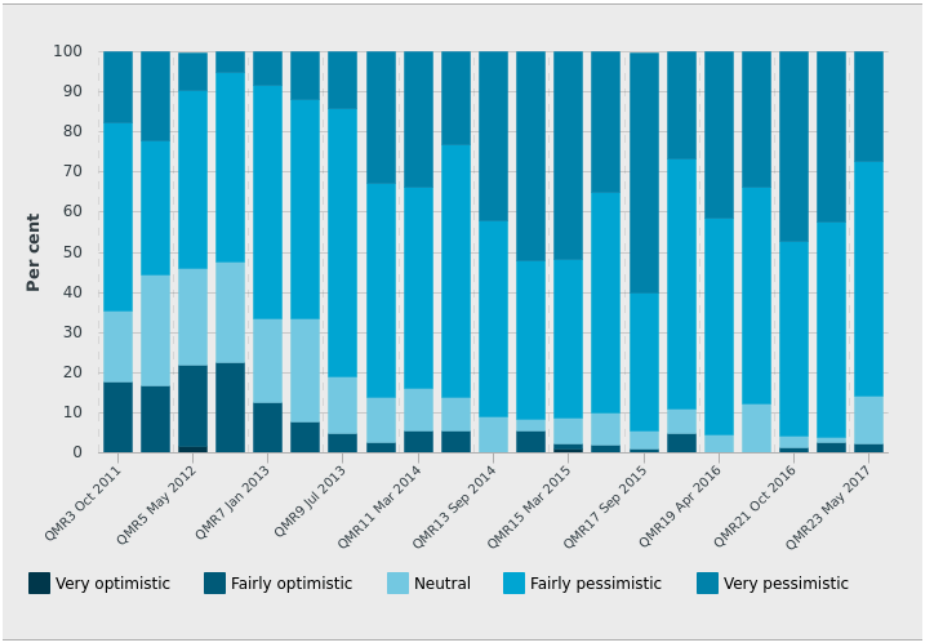
Figure 28: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next 12 months?



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

Respondent comments

"Better discussion on STP and work to deliver but tempered by poor behaviours by some parties particularly CCGs."

– Community foundation trust, neutral

"Acute and community providers in serious financial difficulties."

– Mental health provider, very pessimistic

"STP is particularly challenged financially requiring significant reductions in services which will still not be sufficient to achieve the STP control total."

– Acute and community foundation trust, very pessimistic

"Reduction in the numbers of organisations (mental health, acutes and commissioners) appears to be increasing costs rather than reducing them."

– Community provider (CIC), fairly pessimistic

"Huge local authority budget cuts are starting to become evident via impacts on community teams, social work posts in integrated CAMHS (child and adolescent mental health services) and mental health teams being removed. Concern about how improved Better Care Fund (£2 billion investment in social care) will be used."

– Community and mental health foundation trust, fairly pessimistic

"Only the delusion of signing up to control totals gives the impression that all is well. By quarter one we will be sunk."

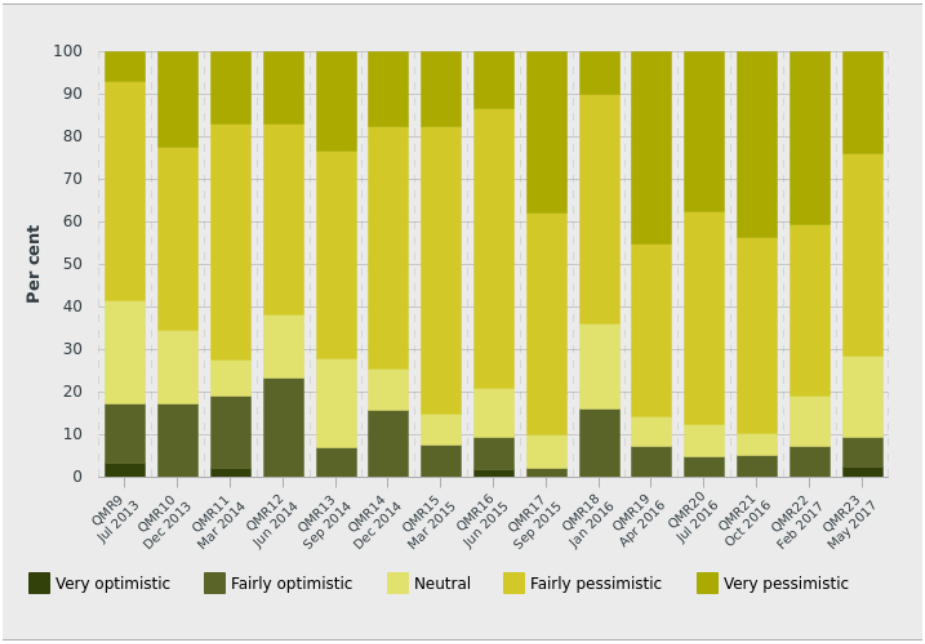
– Medium-sized district general hospital, very pessimistic

"CIP targets are too high and control totals are too demanding. Patient care will suffer sooner or later and trusts will have to be bailed out financially."

– Specialist foundation trust, fairly pessimistic

CCG LEADS

Figure 29: 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

"£80 million QIPP for area as a whole. Providers and commissioners not working together and contracts already agreed now look vulnerable."

– Very pessimistic

"Main provider deficit and extremely challenging savings programmes for provider, CCG and council."

– Very pessimistic

"Significant aged population with 1 in 8 over 75 and planned impact of social care spending reductions mean that pressures will continue."

– Very pessimistic

"This assumes that promises about STP funding are maintained (ie, it's not just a re-badging exercise of monies we were already anticipating as part of our plans)."

– Fairly optimistic

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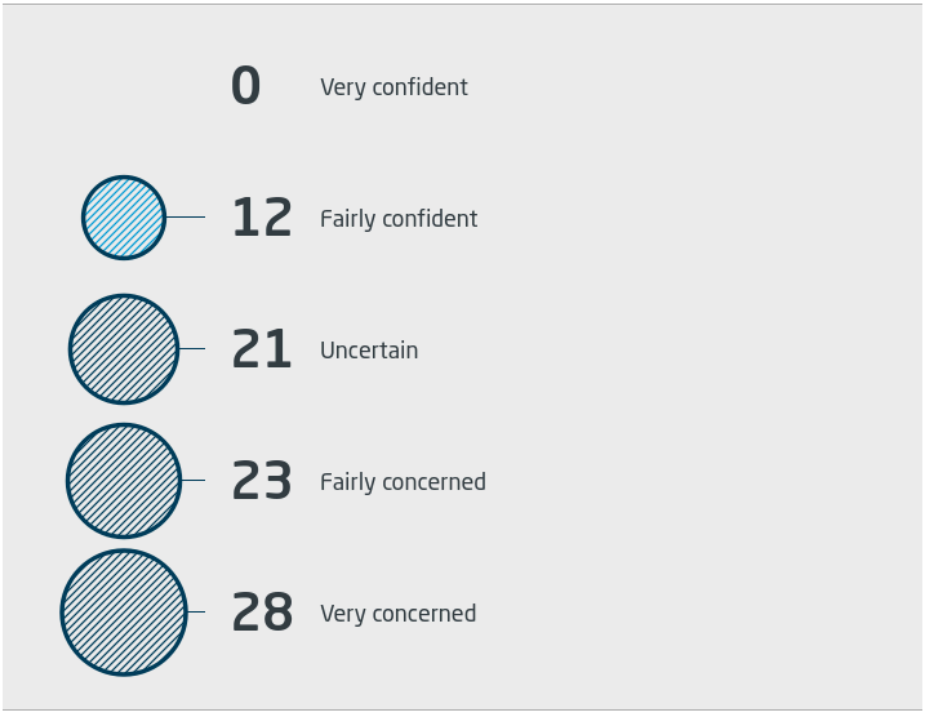
Figure 30: Looking ahead, how confident are you that your organisation will achieve financial balance in 2018/19?



Respondent comments

"Too many variables, from political risk to staff burn out."

– Community foundation trust, uncertain

"Public health grant cuts increase again – to 10 per cent. Really not sure this level is either safe, or achievable (releasing costs)."

– Community and mental health foundation trust, very concerned

"The current expectation is that the trust will be part of a larger provider entity by that stage – enabling the securing of economies of scale."

– Mental health provider, uncertain

"Not a realistic target."

– Acute, very concerned

"Not a chance."

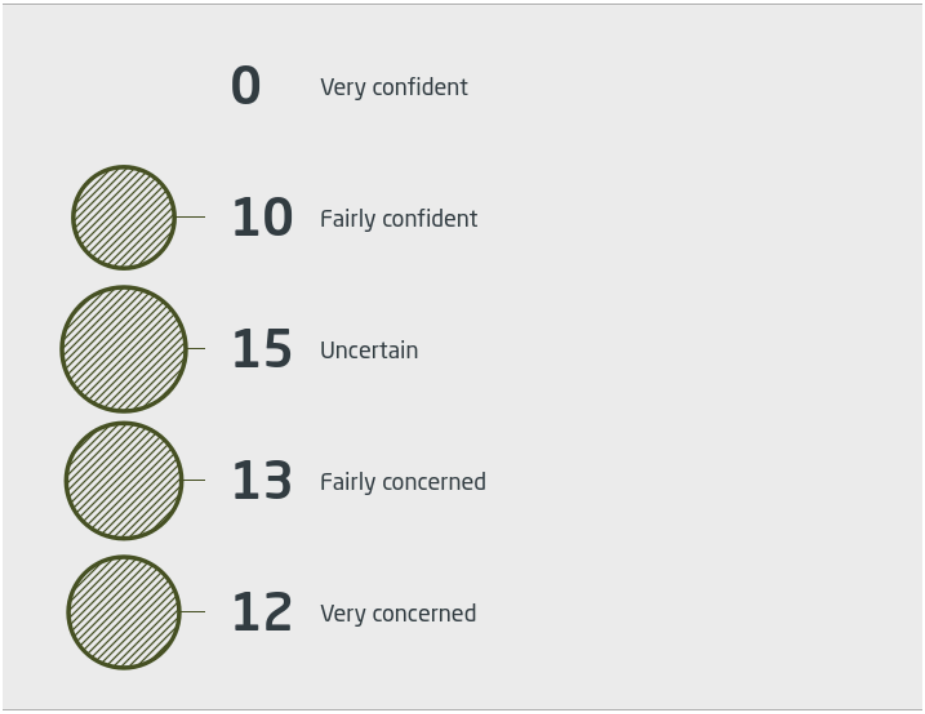
– Medium-sized district general hospital, very concerned

"We are currently expecting a major deficit for 2018/19."

– Specialist foundation trust, very concerned

CCG LEADS

Figure 31: Looking ahead, how confident are you that your organisation will achieve financial balance in 2018/19?



42 CCG finance leads answered this question for the 50 CCGs they cover collectively

Respondent comments

"Not planning to achieve balance until 2021."

– Very concerned

"Almost impossible to develop meaningful plans for 2018/19 when 2017/18 is so uncertain organisationally."

– Very concerned

"We need to get a grip and commission with providers fully engaged. NHS offer needs to be tightened up, nice-to-have stuff is not affordable."

– Fairly confident

"Any shortfall on financial performance in 2017/18 will impact significantly in 2018/19. Although, by this stage STP plans should be progressing..."

– Very concerned

"Given the high risk associated with delivering the 2017/18 positions, the 'fallout' will roll into 2018/19."

– Fairly concerned

11. General practice survey

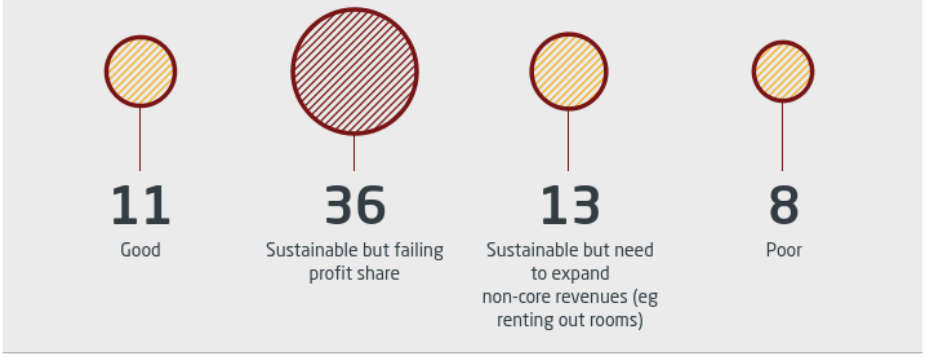
Our snapshot online survey of a panel of GP partners and practice managers received 68 individual responses. This is not intended to be a representative sample, but an ongoing qualitative health check of opinion across a range of practices.

12. Estimated end-of-year financial situation 2017/18

- When asked about their end-of-year financial situation, only 16 per cent of respondents felt their financial situation was good, while 53 per cent felt that it was sustainable but their profits were falling (resulting in pay cuts for partners) and another 20 per cent that it was sustainable but they needed to expand non-core revenue streams. 12 per cent felt their financial situation was poor (Figure 32).
- When asked about the actions they were taking to respond to pressures, the most common answer was changing the skill mix of their team, followed by ending provision of unfunded services (such as suture removal or ECG (recording)) and partner pay cuts (Figure 33).
- Working at scale was clearly seen as a solution for many practices, with more than 60 per cent planning to join a federation or to merge with other practices in the next two years, and an additional 15 per cent already part of a wider practice grouping (Figure 34). The most common reasons for federating or merging were the ability to bid for more contracts and financial security, although multiple respondents felt that national and local policy was driving them towards merger (Figure 35).

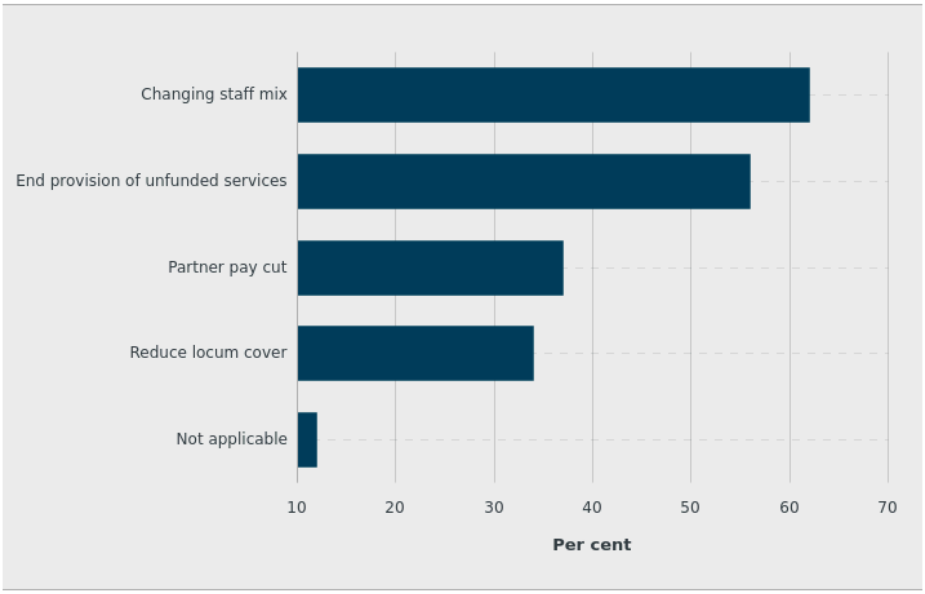
GPs

Figure 32: What is your practice's forecast end-of-year financial situation 2017/18?



GPs

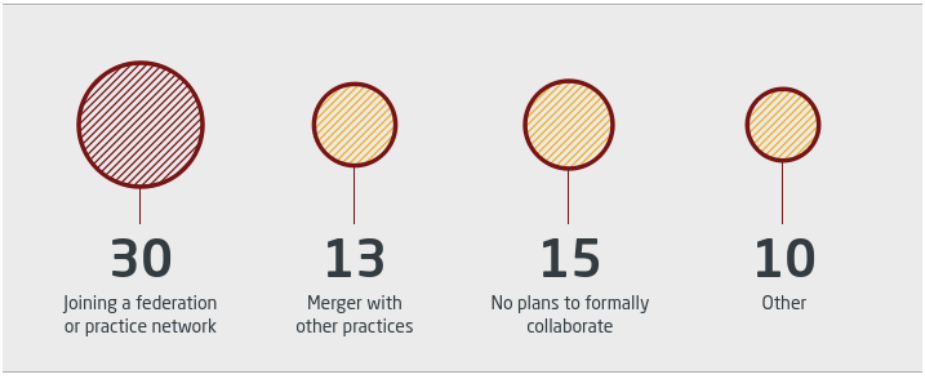
Figure 33: If you are facing financial pressures, what actions are you considering?



Respondents could choose more than one option.

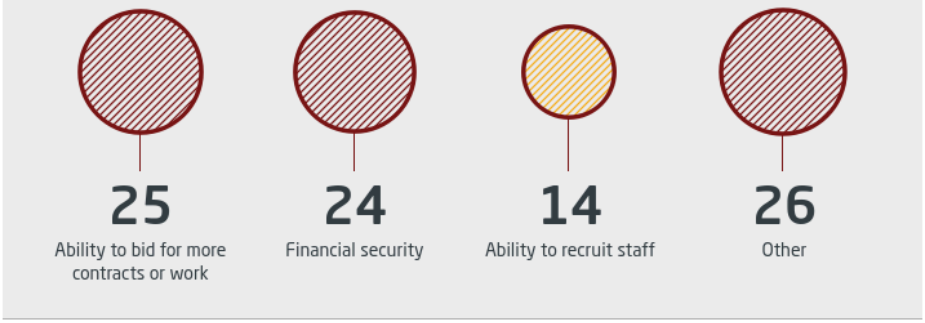
GPs

Figure 34: In the next two years are you planning to collaborate with other organisations through:



GPs

Figure 35: What are your main reasons for collaboration?



Respondents were allowed to choose more than one option

Respondent comments

"A 'must do' for the local CCG which we are trying to support, but for which there is no enthusiasm or belief that it will work/be sustainable."

"Trying to future proof. Collaborative working enables us to share ideas, recruit additional staff, more influence with CCG and more influence to change things. Staying the same not an option."

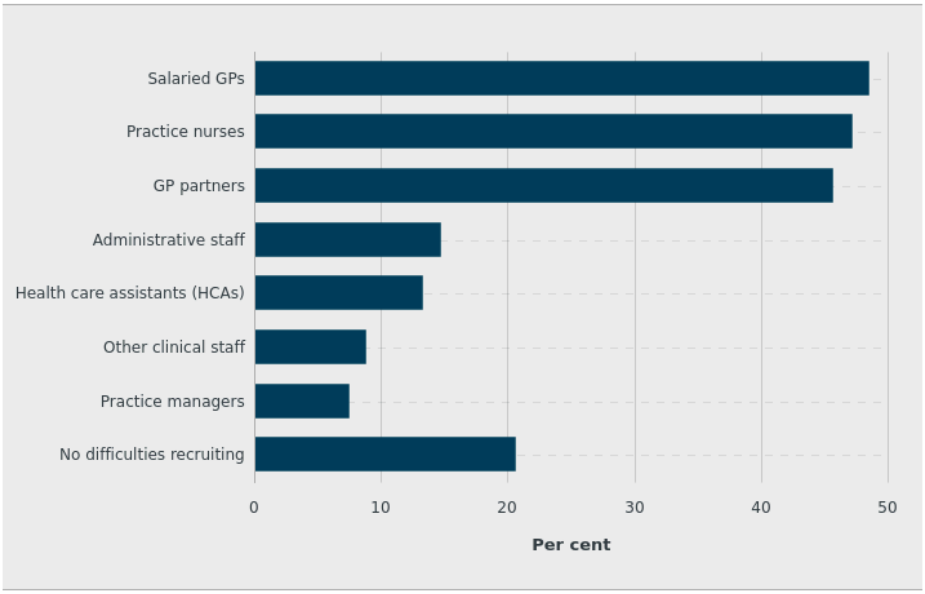
"Security in terms of size – Department of Health and NHS England seem to be trying to close down/get rid of smaller practices."

13. Workforce

- The difficulties in recruiting salaried doctors that we reported in the last survey continue with 49 per cent of respondents in this survey indicating they had difficulty recruiting salaried doctors, and 45 per cent GP partners. Almost half of respondents were also having difficulty recruiting practice nurses (Figure 36).
- We asked how practices were planning to address these difficulties. The most common responses were by using locums and changing the clinical skill mix (for example, employing advanced nurse practitioners or pharmacists). Several practices said that they were having to leave positions unfilled and either reducing appointments or asking existing staff to work harder. A common theme in the responses was that there was a vicious circle of high workload leading to recruitment issues which caused even higher workload for remaining staff. Only by addressing this did practices feel they would be able to recruit staff.
- We asked how optimistic respondents felt about their ability to recruit in the next 12 months and 45 per cent reported feeling fairly or very pessimistic (Figure 37).
- When asked about staff morale, respondents were more positive than in our last survey, with 37 per cent said morale was fairly high or high while 26 per cent said it was fairly low or very low. (Figure 38). Most respondents reporting high morale suggested this was because of a strong team and despite the wider financial situation.

GPs

Figure 36: Are you having difficulties recruiting to any of the following roles?



Respondents could choose more than one option. Figures expressed as a percentage of the total sample

Respondent comments

"We are recruiting a different skill mix and using more allied clinical staff to fill the vacancies."

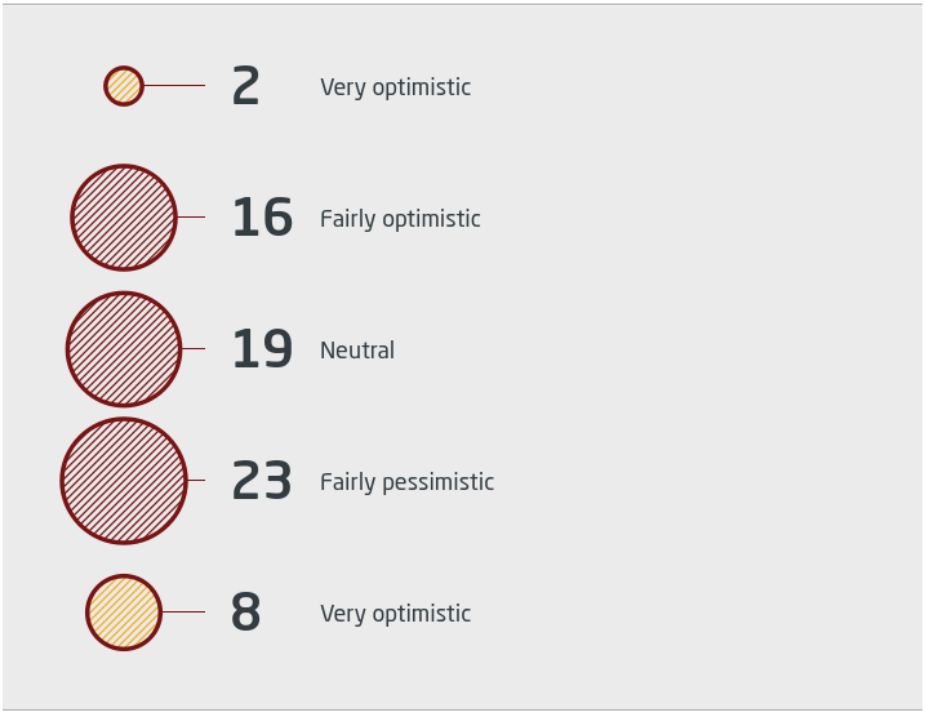
"We recently advertised for advance nurse practitioners (ANPs) with prescribing experience and had only one suitable applicant. We have only been successful in recruiting salaried GP when we paid the medical defence fees, plus additional rise in sessional salary."

"We have been unable to retain partners due to workload. While we have finally filled the gaps with nurse practitioners and salaried GPS while promising less paperwork this has placed an increasing and unsustainable administrative burden on the remaining partners."

"To replace partners we are grooming our salaried workforce. We need to get the practice into really good shape to create a working day that is manageable."

GPs

Figure 37: Looking ahead, how do you feel about your practice's ability to recruit and retain sufficient clinical staff over the next 12 months?



Respondent comments

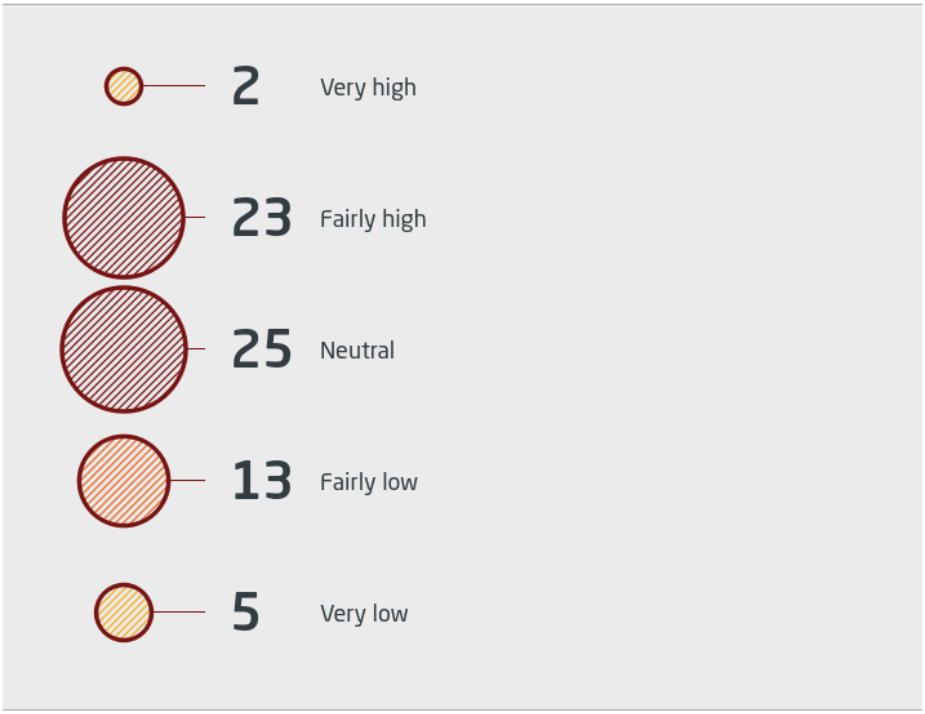
"Unless action is taken to train more GPs and more importantly, retain them, primary care will fail."

"We have managed to recruit but the concern will be whether the remaining partners can continue to shoulder the burden of all the less popular shifts and paperwork while the profit share fails to reflect this."

"While the vanguard, out-of-hours and GP access schemes continue to pay higher salaries for reduced workload and accountability this will become a problem for core general practice. I am not sure how sustainable this will be in the long run. As funding is being cut from core GP to support these initiatives - but neither are sustainable in the long run."

GPs

Figure 38: Thinking about morale, do you feel it is:



Respondent comments

"As a management team, we work hard to ensure the staff are aware of how we are tackling our recruitment situation and keep them shielded as much as possible from the fall-out."

"We are a close-knit team who work closely together. It is remarkable that we have the morale that we do. We have continued to offer pay rises to staff, even though partners take no such increase. We share responsibility and workload in a very equal manner."

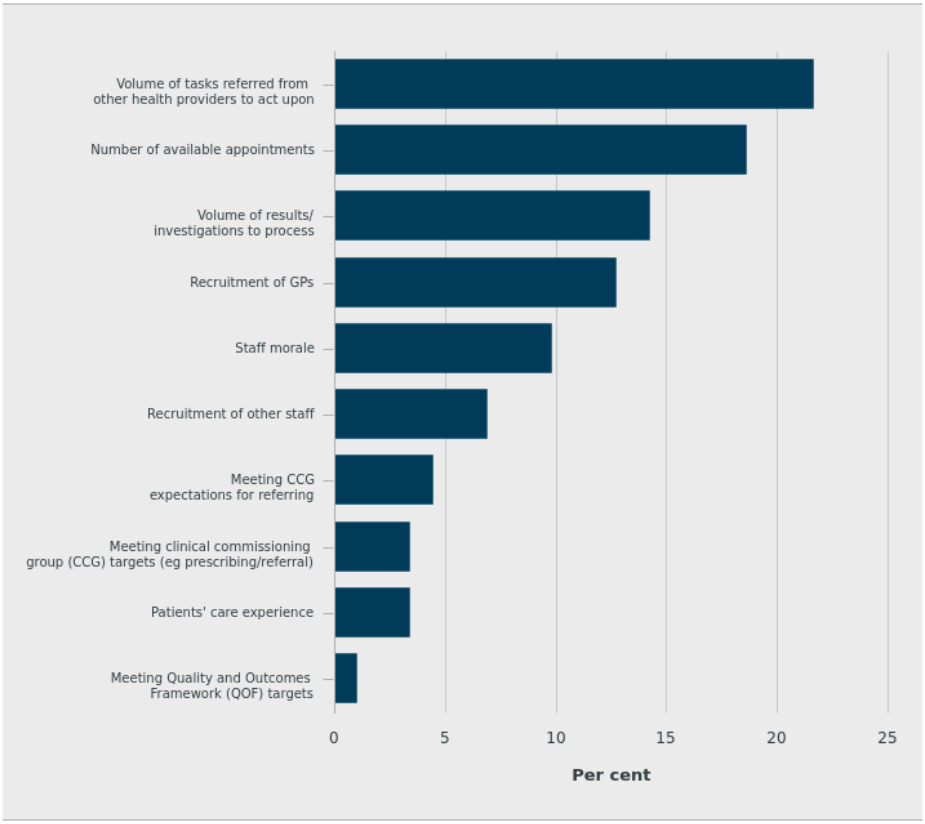
"We have a good core team, but feel very vulnerable."

14. Organisational/general practice challenges

- We asked respondents to identify their top three challenges and they overwhelmingly highlighted workload issues (Figure 39). The most common concern was the volume of tasks from other parts of the health system. The number of available appointments was the second most common concern, followed by the volume of results/investigations to process. Other comments highlighted concerns with CCG pressure to reduce referrals.
- We asked practices what they were doing to manage increasing demand and found diversifying skill mix to be the most common answer, followed by new ways of working, such as telephone triage (Figure 40). Many respondents had implemented new ways of working, but while some reported successful implementation with impact on waiting times, others reported that new ways of working had not helped.

GPs

Figure 39: Which of these issues are giving you the most cause for concern at the moment?



Respondents could choose more than one option. Figures expressed as a percentage of the total number of mentions.

Respondent comments

"Really fed up with constantly being asked to reduce referrals especially when we are at the low end of a low-referring area. Starting to notice that there is a feeling that older people with multiple co-morbid conditions should not have access to specialist care."

"The disconnect between NHS England, area teams and constant organisational change in the CCG. Also lack of decision-making on the transformation fund has lost us £30,000 in 2015 and similar amount in 2016 as, although we have been successful in our bids, decision-making at higher levels has halted progress in the practice with significant waste in our time and funding that we can ill afford to lose."

"Collapse of community services – inability to provide basic care to support patients at home/end-of-life care."

GPs

Figure 40: What measures are you taking in your practice to increase capactiy to manage the increasing demand in primary care?

Respondents were allowed to select more than one answer.

Respondent comments

"We have offered telephone triage for some years now and have developed a model that suits our patient population. Have already alluded to the change in skill mix and are actively recruiting physician associates and have taken on a full-time clinical pharmacist."

"We have transformed our nursing team around population need. Frailty nurse, older people's specialist nurse, care navigators, health and wellbeing co-ordinator, all of this is enabling person-centred care and management of complex patients through comprehensive care planning rather than 10 min GP appointment."

"Piloted e-consultation platform unfunded for a year and unable to sustain as did not have any impact."

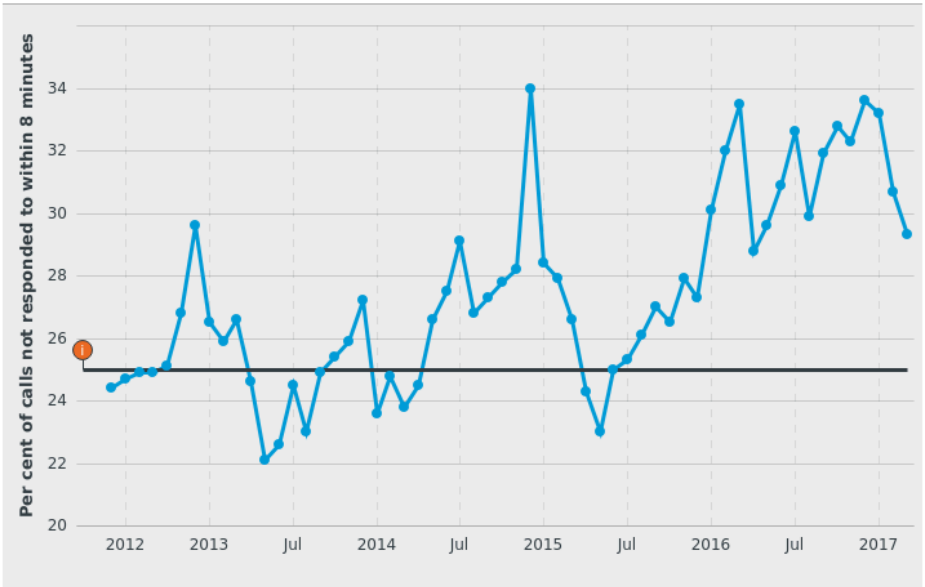
1. NHS performance dashboard

2. Urgent care

Ambulance services

- Since June 2012 ambulance trusts have been given 8 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, 29 per cent of calls were responded to after 8 minutes in March 2017 (Figure 41). It is now 22 months since the target was met.

Figure 41: Monthly performance of ambulance trusts in England for Red 1 calls

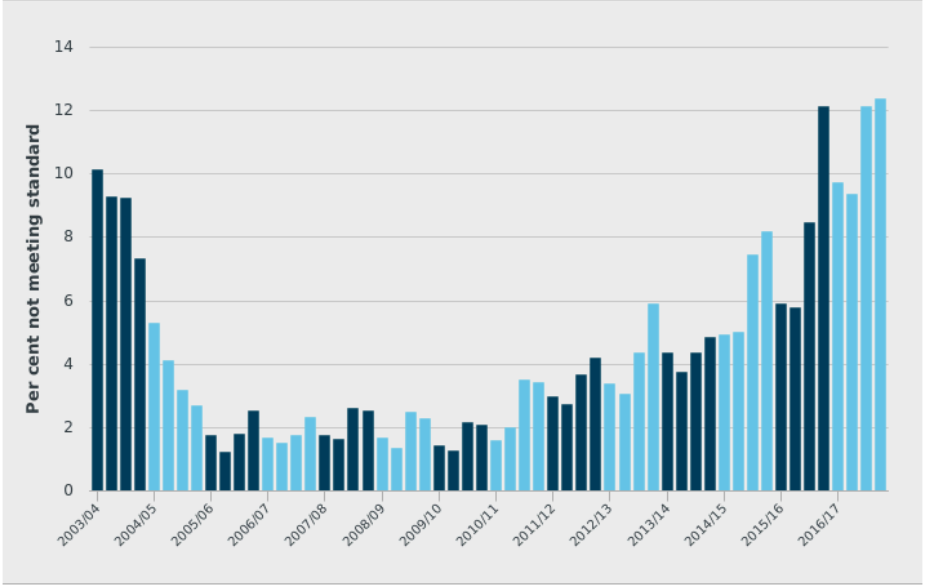


Data source: Ambulance quality indicators www.england.nhs.uk

Accident and emergency

- In quarter four 2016/17 the proportion of patients waiting more than four hours from arrival to discharge, admission or transfer in all A&E departments was 12.4 per cent, the worst performance ever recorded for this target (Figure 42). More than 699,000 patients waited more than four hours during quarter four.
- Over the year, the four-hour target was not met in any month, and 11 per cent of patients (more than 2.5 million) spent more than four hours in A&E before admission, transfer or discharge. This is the worst annual performance for this target that we've seen.
- This is also the third year in a row that the four-hour standard has not been met for the year in aggregate, with performance deteriorating year on year.

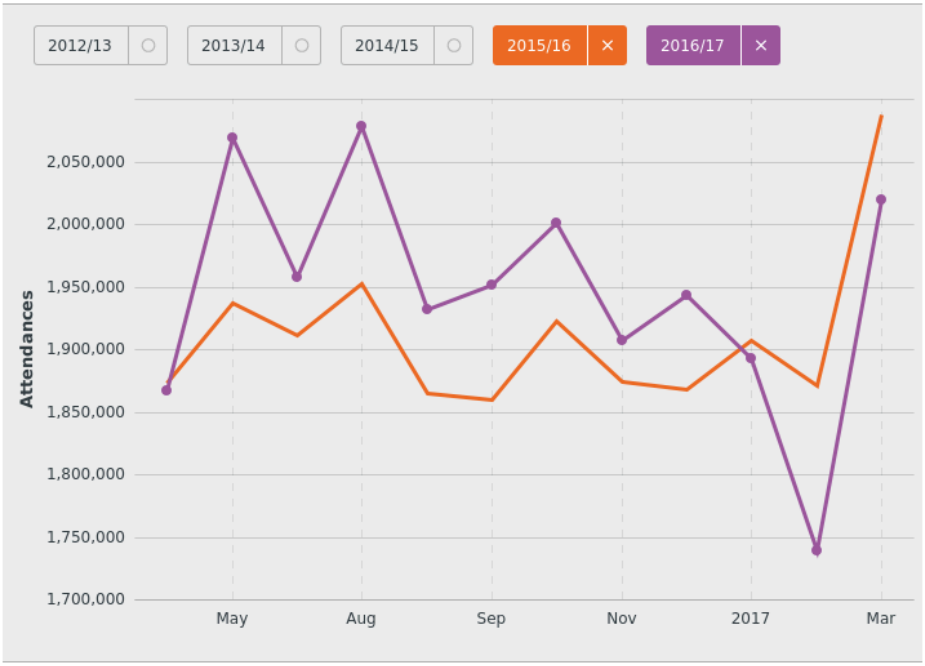
Figure 42: Percentage spending more than four hours in A&E from arrival to admission, transfer or discharge; quarterly data



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

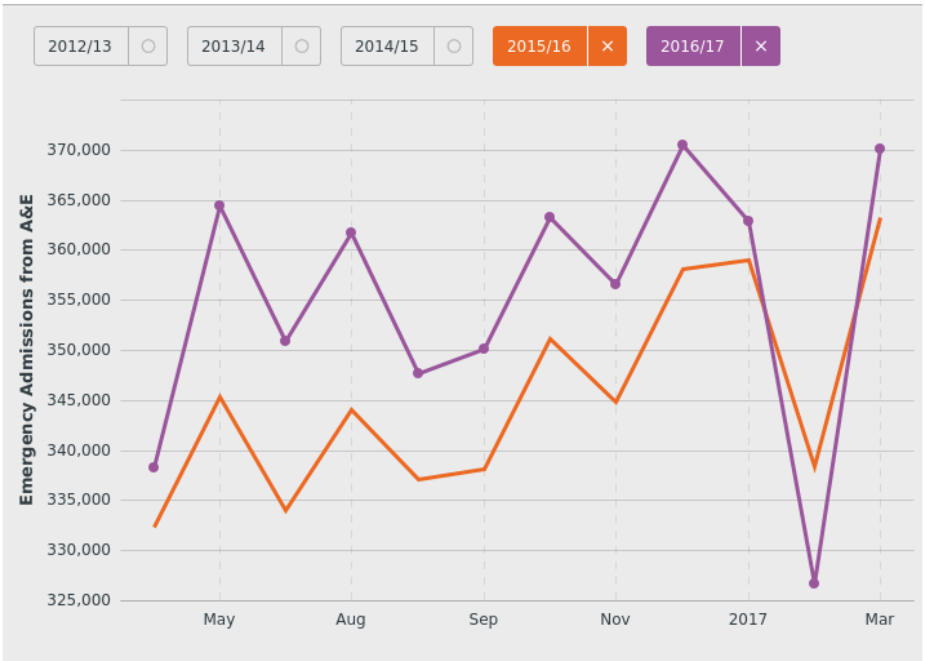
- The poor performance in quarter four 2016/17 was despite a small reduction in attendances. Compared to the same quarter last year, A&E attendances were 4 per cent lower this year (Figure 43), while emergency hospital admissions from A&E were unchanged (Figure 44).
- The small percentage decrease represents a large number of attendances. The decrease equates to almost 209,000 fewer attendances in quarter four 2016/17 compared to the same quarter 2015/16.
- Over the year, however, there were overall increases in the number of attendances at, and admissions from, A&E. In 2016/17, there were an additional 451,500 attendances (up 2 per cent) and 118,200 more admissions (up 3 per cent) in 2016/17 compared to 2015/16.
- Compared to 2012/13, attendances at A&E departments in England are now 7 per cent higher, an increase of more than 1 million additional attendances. There are also approximately 482,000 more emergency admissions from A&E, an increase of 13 per cent.

Figure 43: Total attendances at accident and emergency departments, monthly data



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

Figure 44: Emergency admissions from accident and emergency departments, monthly data

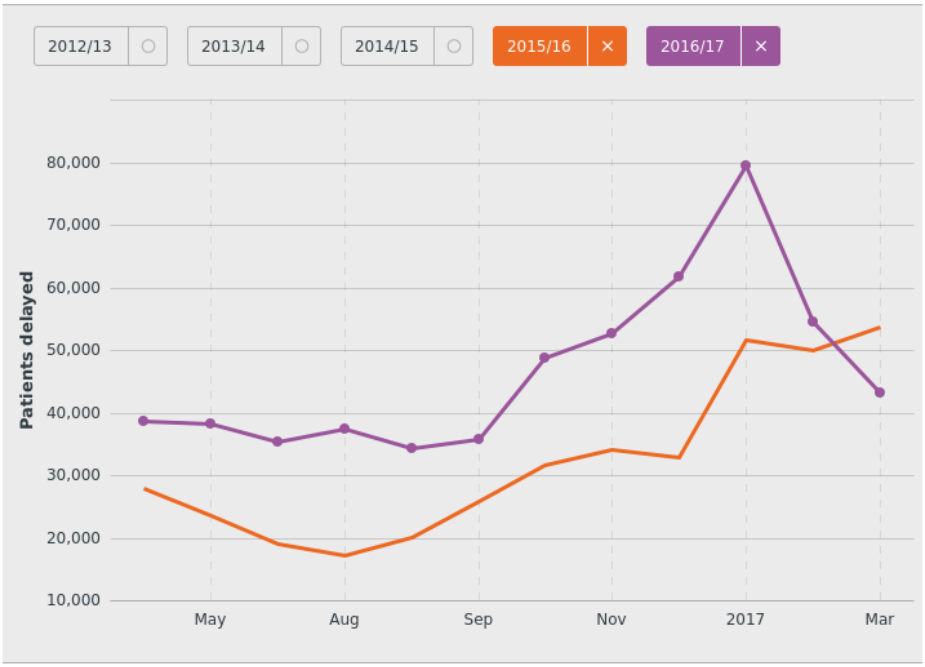


Data source: A&E attendances and emergency admissions www.england.nhs.uk

- 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') remains high. In quarter four 2016/17 more than 177,000 patients spent more than 4 hours waiting for admission, of these, just under 1,600 patients waited more than 12 hours.
- This is approximately 22,000 (14 per cent) more patients spending more than 4 hours in A&E waiting for admission in quarter four 2016/17 than the same quarter 2015/16 (Figure 45).

- Over the year, more than 560,000 patients spent longer than four hours in A&E before they were admitted. This is almost 172,000 (44 per cent) more patients waiting more than 4 hours than in 2015/16 and is more than 407,000 (267 per cent) additional patients compared to 2012/13.

Figure 45: Patients waiting more than four hours in A&E from decision to admit to admission, monthly data

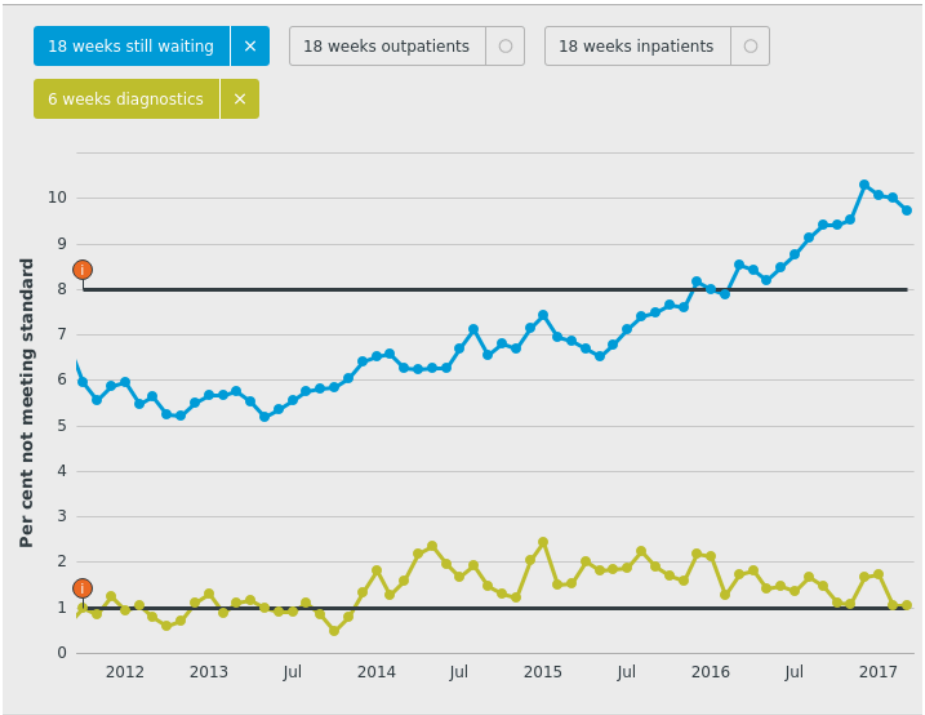


Data source: A&E attendances and emergency admissions www.england.nhs.uk

3. Waiting times

- The proportion of patients waiting more than 18 weeks to begin their treatment fell to less than 10 per cent in March 2017 (Figure 46). This is the fourth month in a row that performance has improved. However, it is the 13th month in a row that the target (8 per cent) has been breached.
- In total, there were more than 362,600 patients still waiting to begin their treatment after 18 weeks at the end of March 2017, and 1,529 of these patients have been waiting for more than a year.
- For the first time since this target was introduced, in April 2012, the 18-week target was not met for a full year.
- However, there have never been more patients beginning elective treatment within 18 weeks. In 2016/17, almost 40 million patients began treatment within 18 weeks, this is 3.6 million (10 per cent) more patients than 2015/16 and 10.6 million (36 per cent) more patients than 2012/13.

Figure 46: Per cent still waiting 18 weeks to begin treatment / having waited more than six weeks for diagnostics

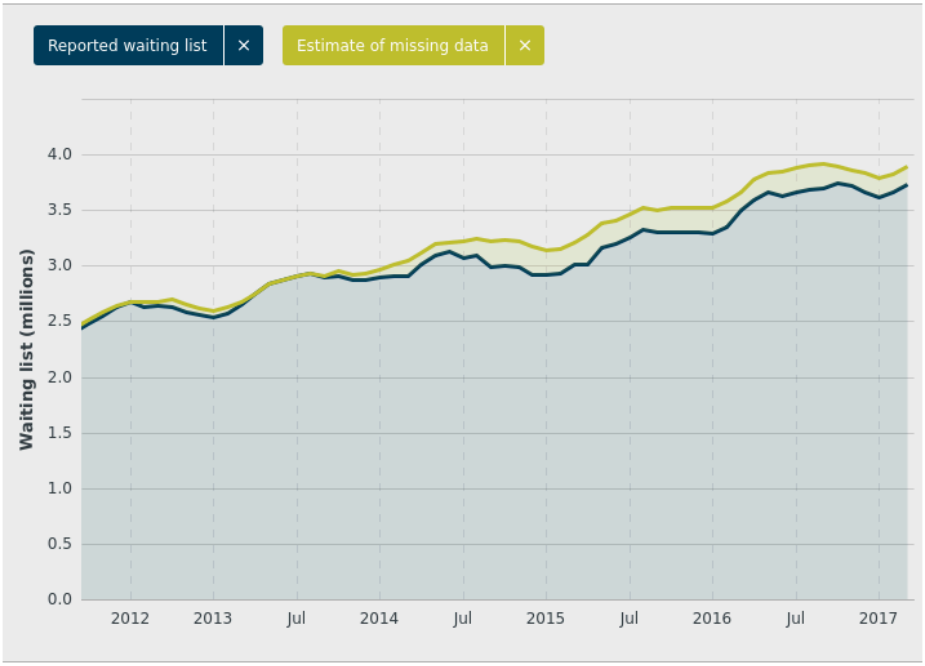


Data source: Referral-to-treatment waiting times statistics www.england.nhs.uk

Diagnostic waiting times statistics www.england.nhs.uk

- The total elective waiting list grew to 3.73 million in March 2017. This is 131,000 more patients than in April 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 March 2017 was more than 3.9 million patients (Figure 47).

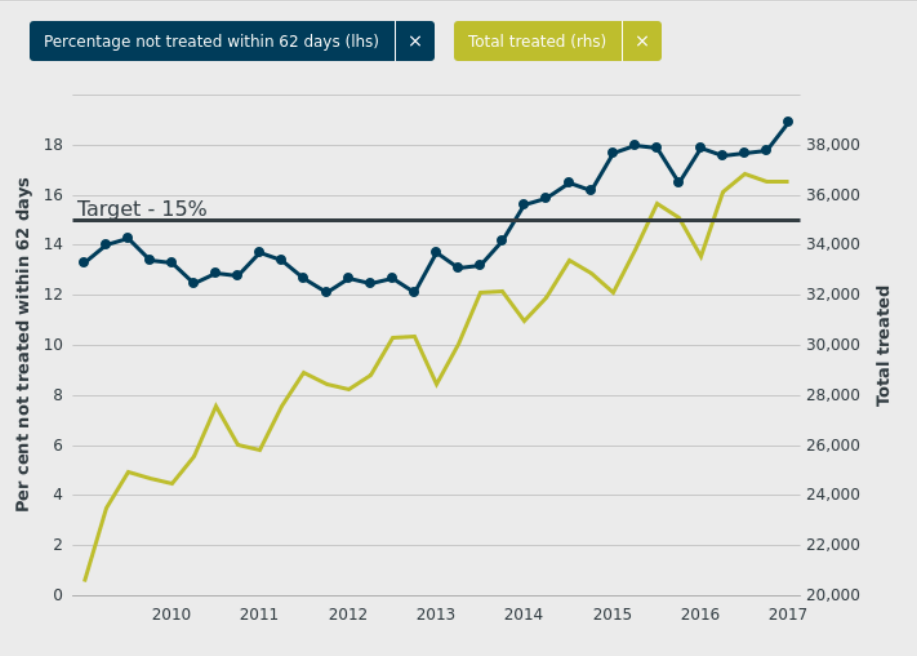
Figure 47: Referral-to-treatment total waiting list size in millions, England



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 40 months in a row (Figure 46).
- During 2016/17, there were more than 15.7 million diagnostic waiting list tests carried out. This is around 620,500 (4 per cent) more tests than 2015/16 and more than 3.1 million (25 per cent) more tests than 2012/13.
- The overall waiting times target 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 target was met from quarter four 2008/9 until quarter four 2013/14, when it was missed (15.6 per cent of patients waited more than 62 days).
- In the latest quarter (quarter four 2016/17 (January to March 2017)) performance worsened, with almost 19 per cent of patients waiting more than two months for treatment, this is the worst-ever performance for this target (Figure 48). It is also the 13th quarter in a row that this target has been missed.
- Over 2016/17, more than 146,000 patients received treatment for cancer following an urgent referral from their GP. This is the highest number we've seen and represents 7,900 (6 per cent) more patients than 2015/16 28,000 (24 per cent) more patients than 2012/13.

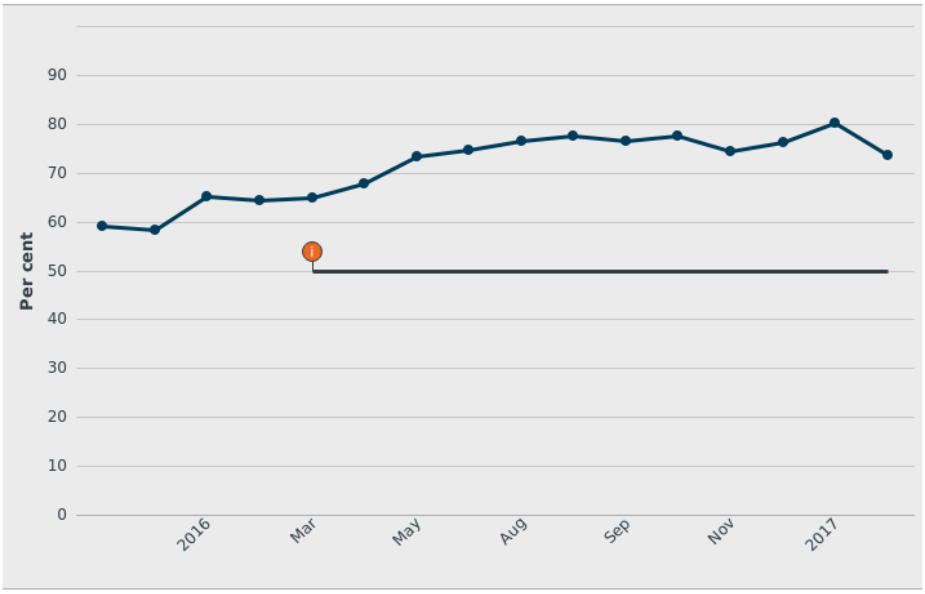
Figure 48: Maximum 62-day wait for first treatment: all cancers (urgent GP referral to treatment)



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

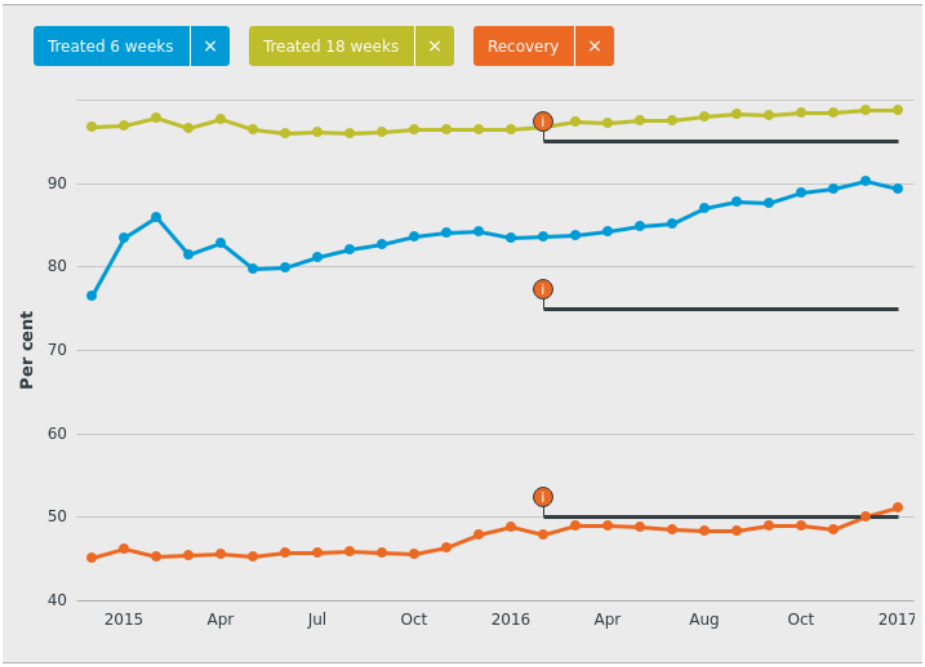
- For patients accessing mental health services, there are currently three waiting time targets; 75 per cent of patients referred to the Improving Access to Psychological Therapies (IAPT) service should begin treatment within 6 weeks of referral, with 95 per cent beginning treatment within 18 weeks. For patients experiencing a first episode of psychosis, more than 50 per cent should be treated within two weeks of referral using a National Institute for health and Care Excellence-approved package of care.
- Data from 2016/17 show that, over the year, 74 per cent of patients accessed early intervention in psychosis services within two weeks (Figure 49).
- For patients accessing psychological therapies, both the target for 75 per cent of patients accessing IAPT services within 6 weeks, and 95 accessing services within 18 weeks, were met for every month in 2016/17 (to date) (Figure 50).

Figure 49: Per cent of patients accessing Early Intervention in Psychosis services within 2 weeks, monthly data



Data source: Early Intervention in Psychosis Waiting Times www.england.nhs.uk

Figure 50: Per cent of patients accessing IAPT services within 6 and 18 weeks, monthly data



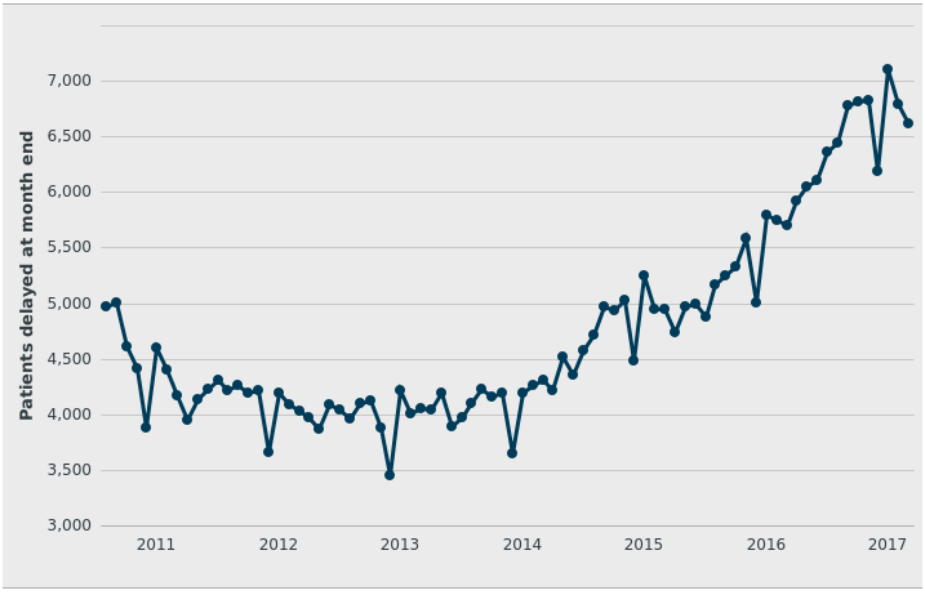
Data source: Improving Access to Psychological Therapies www.digital.nhs.uk

4. Delayed transfers of care

- At the end of March 2017, 6,622 patients were delayed in hospitals. Though a decrease on previous months, this is the highest number published for this time of year since the data began and is an increase of 16 per cent since March 2016 (Figure 51).

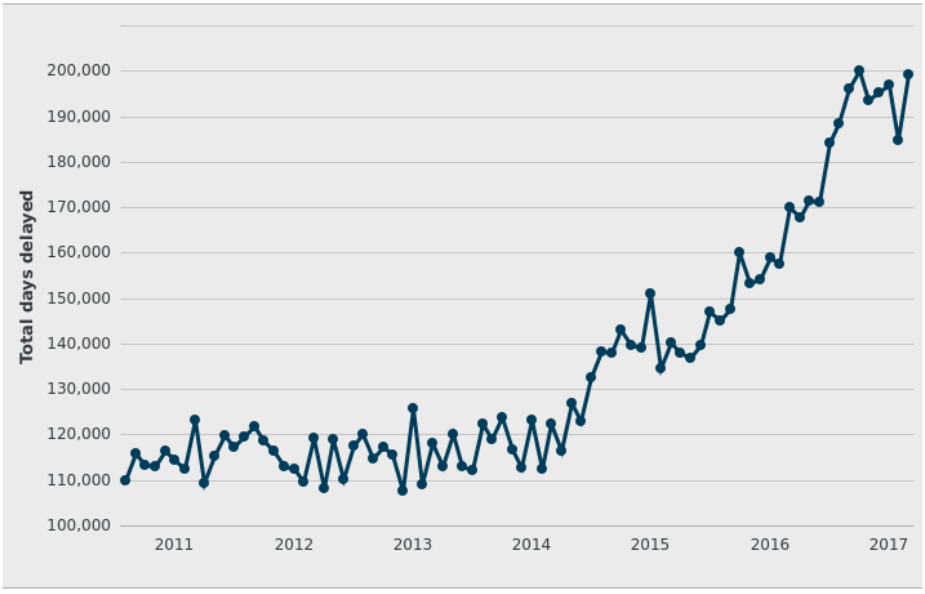
- Over 2016/17 more than 78,000 patients were delayed in hospital at the end of the month. This is the highest we've seen in this data and represents almost 15,000 (23 per cent) more patients than 2015/16 and 30,000 (63 per cent) more patients compared with 2012/13.
- The number of total days delayed increased to more than 199,000 in March 2017, the highest ever recorded for March (Figure 52) and 17 per cent higher than March 2016.
- Over 2016/17 almost 2.25 million bed days were lost due to delayed transfers of care, the highest we've seen in this data. This is more than 441,000 (24 per cent) more delayed days compared to 2015/16 and more than 866,000 (63 per cent) additional delayed days compared to 2012/13.

Figure 51: 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 52: 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. General practice performance

In this section, we have used data from ResearchOne, a health and care research database created using records held on TPP's SystmOne, one of the main providers of information systems in general practice in England, to compare the amount of activity experienced in a sample of 202 practices (approximately 2.7 per cent of all practices in England) in 2016/17 with the same period in 2014/15. Our previous report on this data (QMR21) covered the first two quarters of 2016/17, and this report adds quarters three and four to that analysis.

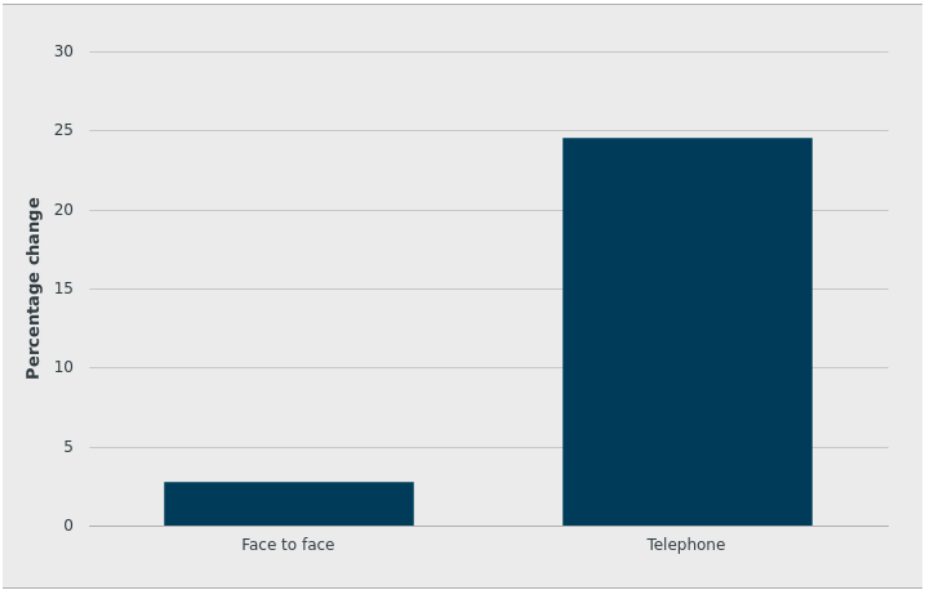
Within our sample, there has been an increase in total contacts with general practice of 7.5 per cent between 2014/15 and 2016/17. The increase in the number of contacts in our sample continues to rise faster than the increase in registered population (see below).

Over the same period, the average number of patients registered with each practice in our sample increased by 6.2 per cent. This increase in was lower than the national average between 2014/15 and 2016/17 (7.2 per cent). The increase in the national average is being driven by two factors in particular – the continuing rise in the number of patients registering in England (up 2.4 per cent) and a reduction in the number of practices operating in the country (from 7,875 in 2014 to 7,527 in 2016) as practices merge.

As we reported in QMR21 (November 2016), in our sample the number of telephone contacts has been increasing at a faster rate than face-to-face contacts for the past 6 years. This trend continued through quarters three and four of 2016/17, with 24 per cent growth in the number of telephone contacts compared to the same quarters in 2014/15 but only a 2.8 per cent growth in face-to-face contacts (Figure 53).

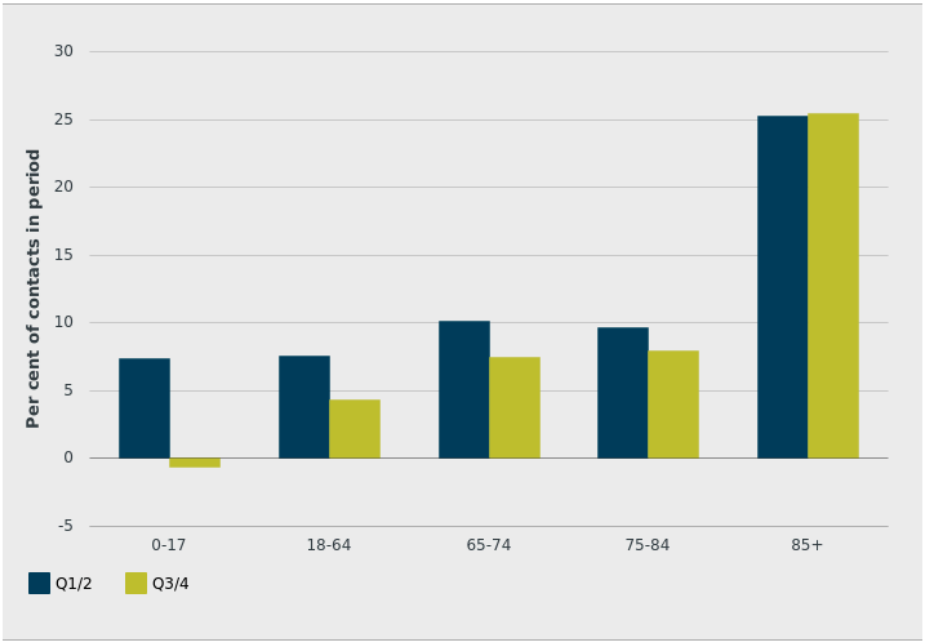
GPs

Figure 53: Percentage change in number of contacts by type in Q3/4, 2014/15 to 2016/17



The share of appointments taken by the oldest patients (aged 85 and over) increased at the same rate in quarters three and four of 2016/17 as it did in quarters one and two, with 25 per cent more contacts compared with quarters three and four in 2014/15 (Figure 54).

Figure 54: percentage change in number of contacts by age group, 2014/15 to 2016/17

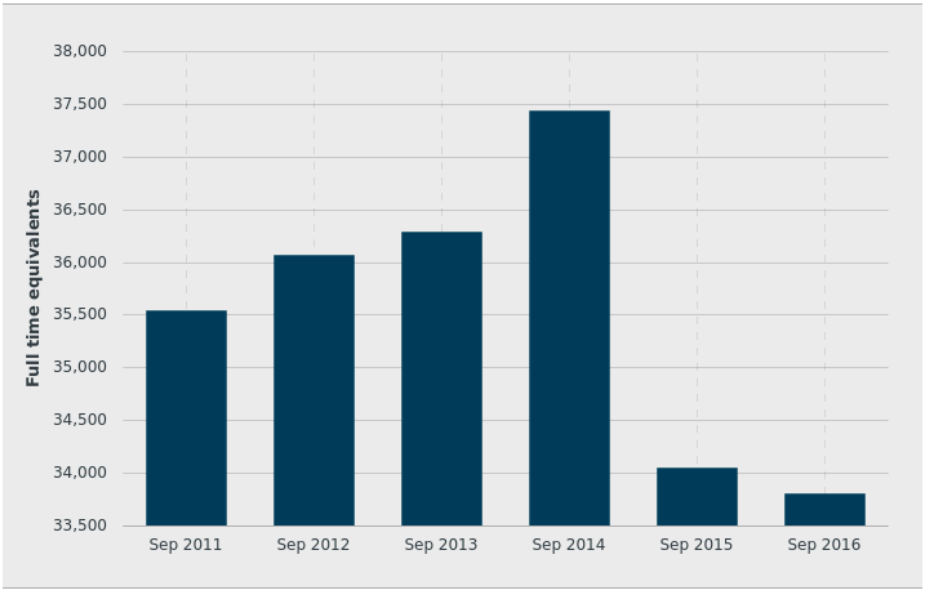


It should be noted that although growth in the number of contacts with people in older age groups was highest, the majority of contacts (approximately 55 per cent) continue to be with people aged 18-64 .

At the same time as the use of general practice has increased, the number of GPs has been largely steady, with a marginal drop between 2015 and 2016 (Figure 55). (The number of GPs in the years prior to 2015 cannot be compared to the data for 2015 and 2016, as there was a significant change in the way the data was collected).

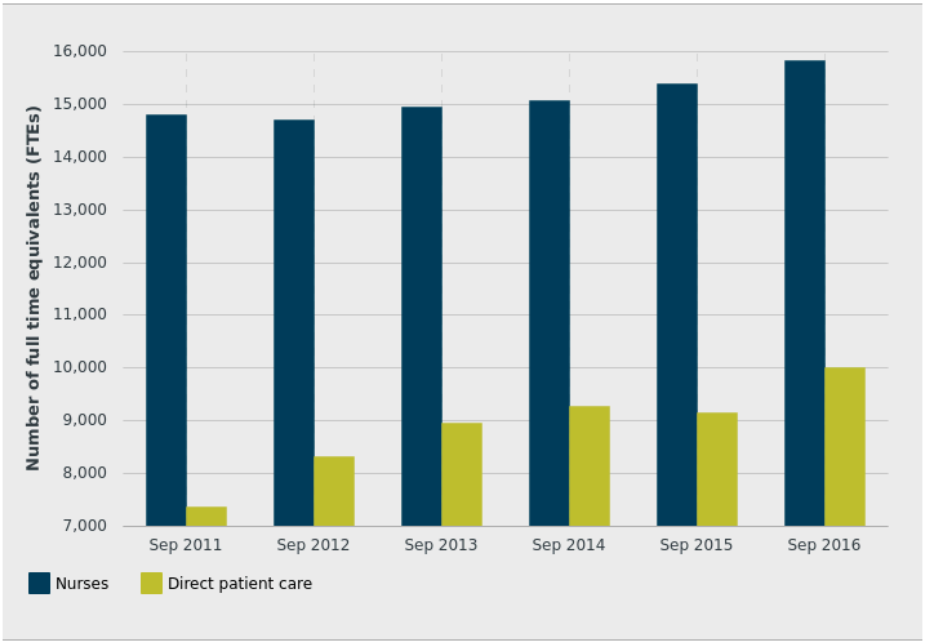
GPs

Figure 55: Number of full time equivalent GP practitioners (excluding locums), 2011 to 2016



There were increases in the number of nurses employed in primary care and the number of 'direct patient care' staff (such as health care assistants, pharmacists and allied health professionals) between 2015 and 2016, with a 2.8 per cent increase in nursing full-time equivalents (FTEs) and a 9.4 per cent increase in direct patient care staff FTEs (Figure 56).

Figure 56: Number of FTE practice staff, 2011 to 2016

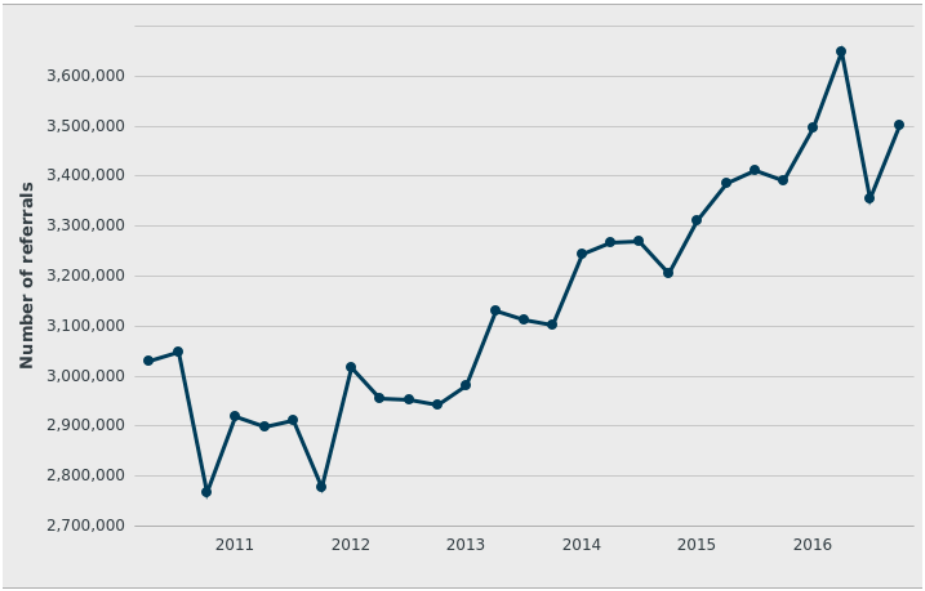


These changes in staffing at the national level are not yet showing up in our activity data sample. The share of activity by different staff groups hasn't changed significantly in the past three years, with GPs undertaking around three-quarters of the contacts and nurses around a quarter.

Referrals from primary to secondary care have remained at historically high levels, though the quarterly trend flattened in 2016/17 after rising at a faster rate between 2012/13 and 2015/16 (Figure 57). If the data is examined on an annual or monthly basis, there are two notable points in the 2016/17 data: first, the annual total for 2016/17 is the highest since the dataset began (14 million referrals, 200,000 more than in 2015/16), and second, the monthly total for March 2017 was the highest on record (1.3 million, 100,000 more than the previous high in July 2015).

GPs

Figure 57: Number of GP referrals



References

- General and Personal Medical Services, England 2006-2016, as at 30 September, Experimental statistics, NHS Digital- March 2017
- Monthly Hospital Activity Data, NHS England- March 2017

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