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Patient care deteriorating as NHS heads into winter on a knife edge

ABOUT THIS REPORT

Performance against a number of key indicators is worse than at this time last year, and finances remain precarious despite an emergency funding injection.

REPORT AUTHORS

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89.7%

of A&E patients were seen within four hours during September 2017, missing the standard of 95%.

4.1 million

patients were on the waiting list for elective treatment at the end of August 2017.

3%

increase in emergency admissions in 2017/18, compared to 2016/17.

The NHS is likely to miss targets for reducing delayed transfers of care, the next performance milestone for improving A&E performance, and financial targets for reducing deficits in the provider sector.

"Without additional funding for the NHS, waiting times for hospital treatment will get longer and the deterioration in patient care is set to continue. This should be a warning for the Chancellor as he prepares the Budget."

We have not arrived at this situation because of a lack of effort or because of poor management within individual NHS organisations. As frontline staff try their best to improve quality of care and access for patients, it is

Siva Anandaciva, Chief Analyst

increasingly apparent that we are setting them an unachievable task.

1,300

fewer nurses and health visitors (full-time equivalents) employed in the NHS than in July last year, with concern around staff morale and pay restraint.

The impact of funding constraints in the wider health and care system may be even more dramatic than those facing NHS commissioners.

"Social care cuts are frightening, and councils face nightmarish decisions. Health visiting and school nursing as we know it will no longer exist."

NHS trust finance director

51%

of NHS trust finance directors think patient care in their area has got worse over the past year, as do 59% of clinical commissioning group finance leads.

Once again, we wait to see if winter sends provider income and performance plans off track, and we start the long run-in to March wondering if CCGs can land their savings plans or if NHS England can find a large enough underspend to cover any remaining deficits.

Headlines

The King's Fund published its first quarterly monitoring report in April 2011 as part of our work to track, analyse and comment on the changes and challenges the health and care system is facing. This is the 24th report and aims to take stock of what has happened over the past quarter.

This report details the results of an online survey of NHS trust finance directors carried out between 14 September and 5 October 2017. We contacted 233 NHS trust finance directors to take part, and 85 responded (36 per cent response rate). The sample included 36 acute trusts; 36 community and mental health trusts; 2 specialist trusts; 1 ambulance trust and 10 trusts that were not categorised. In addition, we contacted 151 clinical commissioning group (CCG) finance leads, and 27 responded. Between them these finance leads covered 32 CCGs (15 per cent of all 207 CCGs). This is a lower number of responding CCGs than in previous surveys.

How is the NHS performing?

Winter is approaching, and with it comes a familiar sense of deepening seasonal gloom about NHS finances and performance. The aspirations for the NHS set out in the September 2016 planning guidance were comprehensive and ambitious: both the commissioner and provider sectors were expected to be in financial balance at a national level and delivering national waiting time standards in 2017/18. It is now halfway through the year and these ambitions have been tempered.

With the 18-week standard for planned treatment in hospitals given lower priority in *Next steps on the NHS five year forward view* (March 2017), limiting financial deficits to £500 million and improving waiting times in accident and emergency (A&E) departments would be considerable achievements for the provider sector. The latest survey of trust financial directors and clinical commissioning group (CCG) finance leads shows increasing concern over whether local CCGs can deliver their financial targets in 2017/18. This, in turn, increases the focus on NHS England's central budget, which will have to bear more of the financial burden than planned if the NHS is to achieve financial balance and the Department of Health is to avoid overspending the budget it was allocated by parliament.

Over the past few months, a series of national policy announcements has highlighted the NHS's focus on recovering A&E performance and reducing financial deficits. *Next steps on the NHS five year forward view* set an ambition that the proportion of patients seen within four hours in A&E should reach 90 per cent by September 2017, with the majority of trusts meeting the 95 per cent standard in March 2018, and the NHS overall performing at 95 per cent within the course of 2018. To help achieve this, the Spring Budget 2017 provided £100 million extra funding for GP triage projects in A&E and £1 billion for the social care system to help reduce delayed transfers of care from hospital. The national NHS bodies have also put considerable emphasis on preparing for winter, with winter planning guidance issued in July and funding made available to offer flu jabs for care home staff. It was hoped that these actions, combined with giving lower priority to the 18-week standard for accessing planned care, would free up hospital bed capacity, improve A&E waiting times and relieve some of the financial pressures on commissioners.

Our most recent quarterly monitoring report brings together publicly available data on NHS performance measures and views from NHS trust finance directors and CCG finance leads to explore just how well the NHS is performing against the set of ambitions it has been given.

Performance on NHS waiting time standards

The NHS missed its first performance milestone – of seeing 90 per cent of A&E patients within four hours in September 2017 – by a hair's breadth: 89.7 per cent of patients were seen within four hours. If just 6,400 more of the 1.9 million patients attending A&E in September had been seen within four hours the milestone would have been achieved. This performance needs to be seen within the context of rising demand for services, with a 3.4 per cent increase in all emergency admissions compared to September 2016 (when 90.6 per cent of patients were seen within

four hours in A&E). With rising demand continuing to run well ahead of increases in funding, the surprise is not that the milestone was missed but that it was missed so narrowly.

Current A&E waiting times do not bode well for the next performance milestone in March 2018, or the winter period in between. The A&E waiting time standard applies to all types of A&E – including minor injury units and walk-in centres – but most attendances (and long waits) occur in major or type 1 A&E departments attached to hospitals. In September 2017, only 11 of the 137 trusts with a type 1 A&E unit achieved the standard (Figure 1), with some demonstrating considerably lower standards.

Figure 1: Percentage of patients seen within four hours at major (type 1) A&E departments, September 2017

Departments are ranked in order of performance, with those meeting the standard highlighted in green.

97.84%	94.87%	92.06%	90.71%	89.65%	88.18%	85.82%	84.45%	82.19%	79.81%	72.45%	67.52%
97.73%	94.63%	91.88%	90.67%	89.60%	87.94%	85.82%	83.83%	81.79%	79.74%	72.33%	65.82%
97.18%	94.62%	91.77%	90.56%	89.57%	87.70%	85.75%	83.78%	81.66%	79.39%	71.90%	62.50%
96.79%	94.06%	91.48%	90.43%	89.44%	87.54%	85.57%	83.49%	81.48%	78.46%	71.42%	62.28%
96.59%	93.53%	91.33%	90.32%	89.42%	87.50%	85.55%	83.19%	81.38%	78.35%	70.94%	57.00%
95.67%	93.38%	91.17%	90.30%	89.22%	87.41%	85.45%	83.13%	81.29%	78.29%	70.79%	
95.58%	93.36%	91.13%	90.29%	89.06%	86.82%	84.96%	82.92%	80.95%	78.18%	70.42%	
95.56%	93.16%	91.12%	90.25%	89.02%	86.71%	84.92%	82.87%	80.77%	77.65%	70.32%	
95.33%	93.01%	91.12%	90.17%	88.94%	86.44%	84.92%	82.86%	80.33%	77.34%	69.98%	
95.07%	92.66%	91.11%	90.08%	88.82%	86.10%	84.87%	82.64%	80.25%	76.68%	69.70%	
95.02%	92.60%	91.08%	89.94%	88.35%	86.03%	84.56%	82.64%	80.17%	76.41%	68.98%	
94.98%	92.40%	90.81%	89.93%	88.30%	85.87%	84.53%	82.56%	79.98%	75.49%	68.26%	

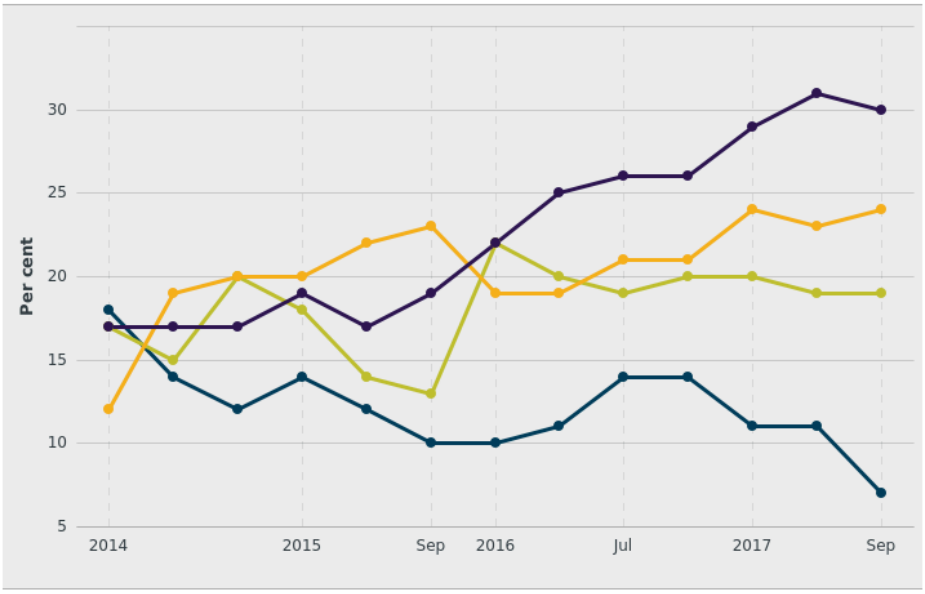
Source: A&E Attendances and Emergency Admissions 2017-18.

Each cell represents one of the 137 providers of major (type 1) A&E departments submitting data within the month. The performance standard is for at least 95 per cent of patients to be seen within four hours of arrival at A&E.

Our latest survey results reflect this challenging situation. Only 28 per cent of trust finance directors in our survey were very or fairly confident about meeting the commitment to return A&E performance to the 95 per cent standard by March 2018. This concern was mirrored on the commissioner side, with only 4 per cent of CCGs very or fairly confident that their local trusts would achieve the required standard. Some trusts noted they would pull out all the stops to improve performance: 'If the finances have already gone south, then we will probably spend everything we can to hit 95 per cent,' while others were less sanguine about their prospects of achieving the standard by March 2018: 'We have a snowball's chance in hell.'

The relaxation of the 18-week referral-to-treatment standard in *Next steps on the NHS five year forward view* was, in part, intended to focus attention and resources on A&E performance, but it also helps to reduce the pressures on CCG budgets, which may have been a strong motivating force in some parts of the country. Both national performance indicators and our survey suggest performance against the 18-week standard may indeed be slipping further down the list of priorities. At the end of August 2017, only 89.4 per cent of patients waiting to start treatment were waiting up to 18 weeks, below the 92 per cent national standard. The waiting list for elective treatment reached 4.1 million patients, the highest level since August 2007 (this includes an estimate of waiting time data for trusts that did not submit data to the national data collection). Despite this decline in performance, there was a sharp drop in the level of concern from trust finance directors on meeting the 18-week referral-to-treatment standard, perhaps reflecting its lower priority (Figure 2).

Figure 2: Areas of performance that give NHS provider finance directors most cause for concern



Respondents were allowed to select top three causes for concern from a list of options.

There is, of course, a potential sting in the tail for NHS trust finances as profitable elective work is replaced by unprofitable emergency work. This reduction in income is material enough on its own, but it could also have a serious knock-on effect for trusts that miss their financial targets and lose access to portions of the £1.8 billion sustainability and transformation funding as a result.

There was one further area of national action that was intended to give A&E departments a clearer run at achieving their performance standards: reducing delayed transfers of care from hospital. The 2017/18 Mandate from the Department of Health to NHS England set an ambition that delayed transfers of care (attributable to both social care and the NHS) should be reduced to 3.5 per cent of occupied bed days by the end of September 2017. Additional funding in the Spring Budget was intended to support this, with the hope that councils could fund more care packages and support social care providers to reduce pressures on NHS beds.

This extra funding was welcomed, though councils were quick to point out that directors of social care have many other calls on their budgets in 2017/18, including increasing costs from the National Living Wage and stabilising the home care market. Official data on September 2017 delayed transfers of care performance will be available in early November. In recent months the rocketing growth in delayed transfers has been halted (and slightly reduced) – suggesting the NHS and care system are delivering a return for the extra investment. However, just 13 per cent of trust finance directors and 15 per cent of CCG finance leads were very or fairly confident that the September target performance of 3.5 per cent could be achieved. Progress in reducing delayed transfers has also come at some cost to relationships between councils and the NHS in parts of the country, as local systems are put under increasing pressure to deliver these ambitious national targets.

NHS financial performance

The NHS planning guidance for 2016/17 stated that 'during 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance'. The fact that the provider sector fell £791 million short of this aspiration in 2016/17 did not dissuade NHS England and NHS Improvement from repeating this goal for CCGs and trusts in both 2017/18 and 2018/19. To support the delivery of financial balance this year, national NHS bodies added a capped expenditure process to the litany of regulatory controls to exert greater financial control in areas at risk of overspending their budget.

But our survey suggests just how far off these financial targets trusts are. 43 per cent of NHS trust finance directors were forecasting their trust will end the year in financial deficit and 16 per cent of CCGs were expecting to overspend their budgets in 2017/18. Just 45 per cent of all trusts, falling to 21 per cent for acute trusts specifically, were fairly or

very confident of achieving their financial control total for this year. National data for the first three months of this year also indicates the provider sector is on course for an aggregate net deficit of £523 million in 2017/18.

NHS providers are planning to make £3.7 billion of efficiency savings in 2017/18, with just 8.3 per cent of these savings expected to be achieved through non-recurrent means. However, only 28 per cent of trust finance directors were fairly or very confident of achieving this year's savings plan. And if a word cloud was built from comments in this part of our survey 'non-recurrent' would surely take centre stage, as trust finance directors spoke of their reliance on one-off measures such as land sales, recruitment freezes and cancelling planned capital investment. In some cases, trusts' 2017/18 savings plans were still being developed six months into the year: '20 per cent of the total savings are not yet fully identified,' according to one NHS trust finance director.

The financial pressures in 2017/18 have also led to increasing unpredictability in NHS finances, and several trust finance directors voiced concern over their cash position. To manage this uncertainty, NHS trusts are resorting to a range of actions to maintain an appropriate cash balance, including delaying payments to suppliers and taking out loans from the Department of Health for interim financial support. Other analysis has highlighted just how significant and widespread this financial support is within the NHS.

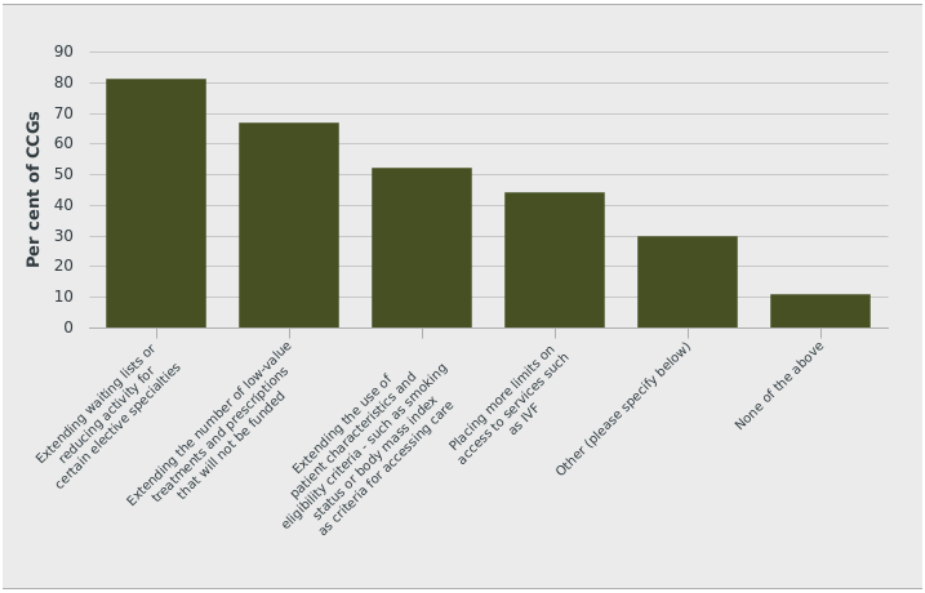
For the first time, our survey suggested just how unlikely it is that these loans will ever be paid back in full. 52 per cent of trust respondents receiving interim financial support were very concerned about being able to pay back the loan, and only 19 per cent were fairly or very confident of their ability to repay. One finance director noted their trust had been reliant on a 'Department of Health cash drip feed for years' and another was emphatic in their view on repayment: 'Loans will never be repaid – it's impossible.' In a sufficiently funded health system, interim financial support and loans might still be needed to smooth over short-term cashflow issues, but we are a long way from that system, with loans increasingly needed to pay the bills and staff salaries. Trusts are expected to repay the interest and principal on these loans through the normal course of business. However, many trusts take on loans in the knowledge this will never happen and that they will stay on a permanent financial merry-go-round despite their best efforts.

If there is a familiar gloom to the NHS provider financial position, the pressures on CCG finances are leading to some stark decisions to avoid overspending this year. Several CCGs noted their end-of-year financial position would rely on access to the 0.5 per cent of their funding that is currently – in line with national guidance – held back in reserve. 53 per cent of the 27 CCG finance leads in our survey were also expecting to delay or cancel spending plans to support their financial position in 2017/18.

The list of unpalatable options considered by CCGs includes extending waiting lists or reducing activity for certain elective specialties; increasing the number of low-value treatments and prescriptions that will not be funded; increasing use of patient characteristics and eligibility criteria – such as smoking status or body mass index as criteria for accessing care; and placing more limits on access to services such as IVF (Figure 3). Only three of the 27 CCG finance leads were considering none of these options, with more than two-thirds of CCGs considering extending waiting lists for planned elective care.

CCG LEADS

Figure 3: Options CCGs are considering to help them remain within their 2017/18 budget



Respondents were allowed to select more than one option. Data refers to the proportion of CCG finance leads selecting each option.

None of these options would be considered lightly, and CCGs also noted these actions would be unlikely to accrue any financial benefits until 2018/19. And as one finance director noted, the impact of funding constraints in the wider health and care system may be even more dramatic than those facing NHS commissioners: 'Social care cuts are frightening, and councils face nightmarish decisions. Health visiting and school nursing as we know it will no longer exist.'

A wider 'systems not institutions' approach to managing finances was also referred to in comments from commissioners and providers in our survey. There was some positivity that 'systems' working was beginning, not least because – as one finance director put it – 'for the first time both providers and commissioners are in financial difficulty' and need to work together to resolve financial pressures. However, other responses noted that the split between purchasers and providers of care was still very much in force, as providers try to maximise their income and CCGs try to limit their spending. Providers in our survey expressed particular concern that they would not receive their full CQUIN funding this year from commissioners, which would impact on their ability to hit their own financial control totals. (Commissioning for Quality and Innovation (CQUIN) funding makes a proportion of NHS providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.) As one trust finance director noted: 'The level of effective collaboration is decreasing due to application of pressures on individual organisational results.'

With providers and CCGs broadly on track for a similar level of financial performance in 2017/18 as last year, the focus for finding savings will increasingly shift to NHS England and the Department of Health. If providers and CCGs fail to hit their financial targets, which appears increasingly likely, these national bodies will need to deliver the underspends necessary to achieve financial balance. When asked about their financial prospects for 2017/18 one trust finance director observed 'Our margin for error is being eroded year by year.' While financial deficits remain stubbornly in place across the provider and CCG sectors, the eroding margin for error must be of increasing concern at all levels of the NHS.

Workforce

One further high-profile (and high-risk) choice for containing spending, and remaining within this year's budget, is to reduce the NHS staff pay bill.

As our previous analysis has shown, the number of nurses and health visitors employed in the NHS is falling for the first time in more than three years. However, the enthusiasm for recruiting nurses remains undimmed among trust finance directors, with 65 per cent planning to increase the number of permanent nursing staff in the next six months.

In many cases this was to fill existing vacancies (with two trusts commenting they currently had a nurse vacancy rate of 15 per cent or more), rather than recruiting to new posts to keep pace with rising demand and population growth.

Trusts were realistic about the prospects of filling nurse vacancies. The impact of the EU referendum and changes to language-testing requirements on nursing recruitment and retention have rightly been highlighted. However, deeper widespread issues – such as morale, pay restraint and shortages in qualified nursing staff – came out even more strongly in responses from trust finance directors (Figure 4).

Difficulties in recruiting nursing staff will not improve the NHS financial situation, as trusts will have to employ more costly agency nursing staff as the demand for care starts to increase over winter. Trust finance directors also echoed warnings from national leaders that the mooted lifting of pay caps for NHS staff would require additional funding, as there is little room to manoeuvre within the existing NHS funding settlement.

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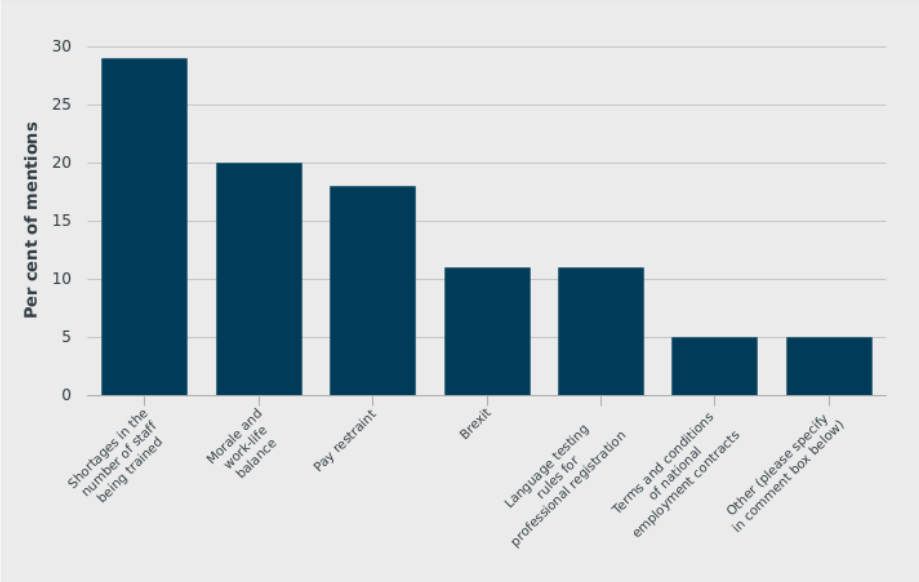
Figure 25: If you are experiencing difficulties in recruiting and/or retaining sufficient nursing staff to fill available posts, which factors have had the most significant impact?



Note: Of the 82 respondents for whom the question was applicable, one respondent selected 'no difficulties in recruiting or retaining nursing staff'. Respondents allowed to select more than one option. Figures expressed as a percentage of the total number of mentions for all options.

Respondent comments

"Other trusts are paying golden handshakes to attract nursing which is increasing the supply issue."

– Small acute trust

"The delay in obtaining visas has also been a real problem for us. Many candidates have gone elsewhere in the interim."

– Acute

"We were assigned far fewer visas than we requested and told we can only apply for more when we have a small number of visas left, the time lag will significantly impact our international recruitment programme."

– Acute teaching provider

"Skills shortage, levels of pay and benefits, the changing nature and intensity of the work and the agency alternative (higher pay, greater flexibility and less responsibility)."

– Mental health and community

Conclusion

The ambitions for the NHS this year were focused on improving financial performance, reducing waiting times in A&E and preparing for winter. Significant efforts have been made both nationally and locally to support this. But despite the hard work of staff in the health and care system, both our survey and national performance data suggest the NHS is to miss targets for reducing delayed transfers of care, the next performance milestone for improving A&E performance, and financial targets for reducing deficits in the provider sector. As a result, patients are waiting longer for both routine and urgent treatment, and CCGs are facing troubling decisions on restricting access to some services.

And all this comes just as the NHS is about to enter winter, with high levels of bed occupancy and hopes that the high levels of flu in the southern hemisphere do not travel north.

We have not arrived at this situation because of a lack of effort or because of poor management within individual NHS organisations. The health and care system is now so over-stretched that even when effort and resources are focused on a smaller set of priorities the required performance levels remain elusive. What concerned the trust finance directors in our survey even more than A&E performance? The morale of their staff. As frontline staff try their best to improve quality of care and access for patients, it is increasing apparent that we are setting them an unachievable task.

There has been an almost Sisyphean aspect to the management of NHS finances and performance since the onset of austerity in 2010, with a familiar rhythm emerging for each year. Now, once again, we wait to see if winter sends provider income and performance plans off track, and we start the long run-in to March wondering if CCGs can land their savings plans or if NHS England can find a large enough underspend to cover any remaining deficits. 'Sustainability' and 'transformation' have been the two watchwords for the NHS in recent years, but as financial, operational and workforce pressures increase, it seems that we are at increasing risk of achieving neither.

See the box below for further details of recent measures that have been put in place to manage NHS finances and performance.

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 providing emergency care 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.

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, 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.

Additional financial controls

In 2017/18 NHS Improvement and NHS England introduced the capped expenditure process (CEP) – an intensive process to contain expenditure in areas of the country with high financial risk and/or historical overspending of their share of funding. The CEP is the latest addition to a wide range of actions to address financial challenges in the NHS. These further actions include the introduction of financial special measures regimes – an intensive process to develop financial recovery plans for challenged organisations – for trusts and commissioners in July 2016.

1. Health care surveys

This quarter's report is based on an online survey of 85 NHS trust finance directors and 27 clinical commissioning group (CCG) finance leads (covering 32 CCGs).

Respondents were asked about their organisation's forecast end-of-year financial situation for 2017/18 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) milestones as set out in the 2017/18 Mandate document.

2. Forecast end-of-year financial situation 2017/18

- In our recent survey, 44 per cent of trust finance directors forecast their organisation would end 2017/18 in deficit (Figure 5). 79 per cent of trust finance directors reported that their forecast position for 2017/18 would depend on significant financial support (Figure 7). Furthermore, 47 per cent of providers expecting to receive Sustainability and Transformation Fund monies still forecast a deficit by the end of the year.
- 63 per cent of respondents receiving interim financial support from the Department of Health were either fairly or very concerned about being able to meet the total repayment requirements of the loan (Figure 8).
- We also asked trusts to provide details of their agreed control totals for 2017/18. Of the 76 trusts that have agreed control totals (or that are in the process of agreeing control totals), 12 per cent forecast a worse end-of-year position against their control total. Furthermore, 37 per cent of all providers were either fairly or very concerned about meeting their agreed control totals in 2017/18 (Figure 11).
- 41 per cent of all CCGs forecast a surplus for 2017/18, and 16 per cent were expecting to overspend (Figure 6). Furthermore, 53 per cent of all CCGs expect to delay or cancel spending plans to support their finances in 2017/18 (Figure 9). The potential threat to the commissioner portion of the risk reserve (ie, the 0.5 per cent of CCG budgets that are held back and uncommitted to in-year spending) is underlined by the fact that 38 per cent of CCGs are relying on their share being returned to them, rather than being used to support provider deficits (Figure 9). 44 per cent of all CCGs were fairly or very concerned about meeting their control total for 2017/18 (Figure 12).
- 81 per cent of CCG respondents were considering extending the number of low-value treatments and prescriptions that will not be funded, and 67 per cent were considering extending waiting lists or reducing activity for certain elective specialties (Figure 10).

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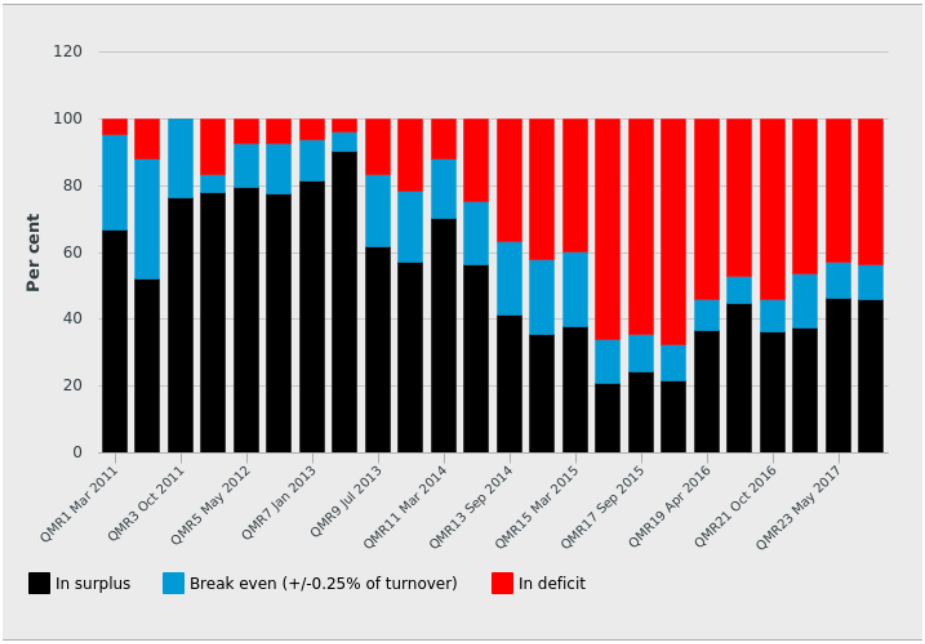
Figure 5: What is your organisation's forecast end-of-year financial position?



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

Respondent comments

"This is on the basis of the plan but there are emerging risks that could influence this."

– Mental health and community provider, in surplus

"This is our control total and haven't officially reforecast. Being honest at the moment the more likely place is to be in deficit."

– Acute and community foundation trust, in surplus

"Planned deficit to support agreed investment from balance sheet reserves. Forecast deficit now over and above this."

– Social enterprise, in deficit

"In line with control total although there are some major risks to achievement."

– Specialist foundation trust, in deficit

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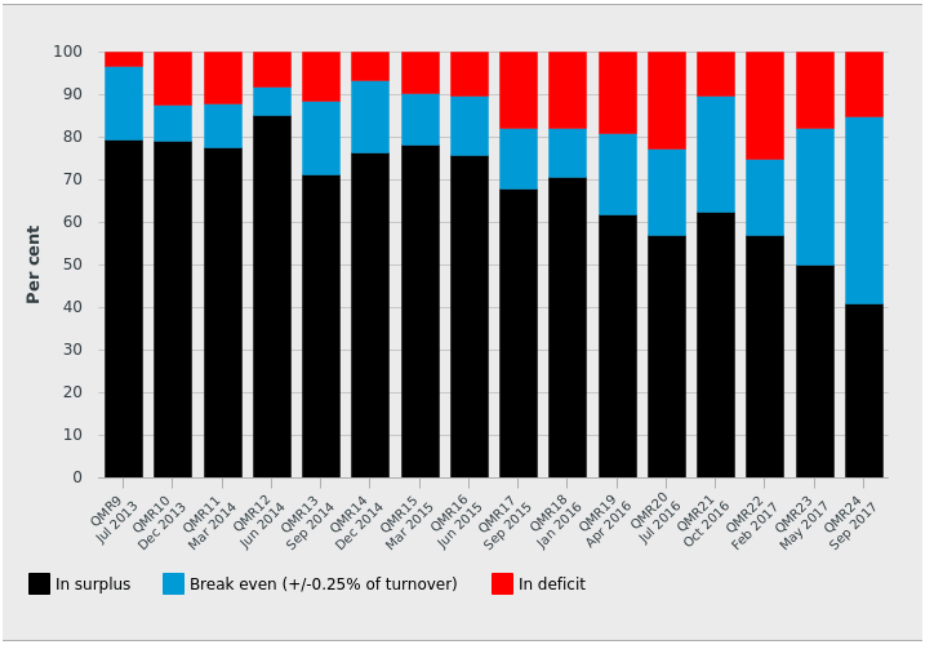
Figure 6: What is your organisation's forecast end-of-year financial position?



27 CCG finance leads answered this question for the 32 CCGs they cover collectively. CCGs only surveyed since their establishment in April 2013.

Respondent comments

"The achievement of the forecast year-end position relies on mitigating actions to generate savings of over £2.5 million. The surplus to be delivered is historic brought forward."

— Break even

"Taking into account approved in-year draw down, the in-year position is classed as break even."

— In surplus

"We are currently forecasting hitting our target surplus requirement as set by the business rules, this however is getting increasingly difficult to achieve and as the year progresses this may change. We are essentially using non-recurrent monies to achieve this, for the first time our CCG is using non-recurrent funding to balance the recurrent position."

— In surplus

"We are recognising a high degree of risk of non-achievement of this position, with a move into deficit."

— Break even

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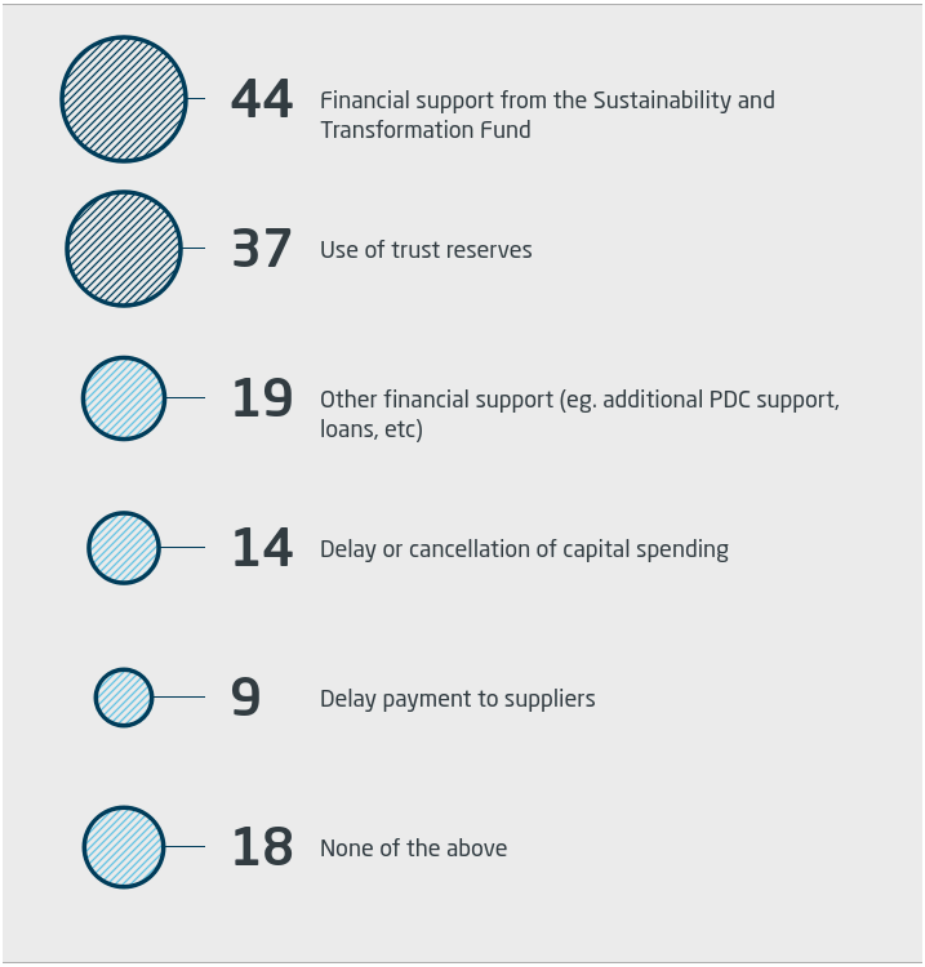
Figure 7: What is your forecast 2017/18 end-of-year outturn likely to depend on:



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

Respondent comments

"It will depend on commissioners being reasonable and trying to support the trust. In the past few years they have been very aggressive with challenges we do not think are appropriate."

– Acute, in deficit

"Cancelling cap ex, loans and delaying payments to suppliers are required to manage the cash position rather than the I&E [income and expenditure] forecast."

– Acute foundation trust, in deficit

"Also, revaluation of investment assets, which are technical and not real benefits."

– Acute, in deficit

"Receipt of all four quarters full STF funding is fundamental to delivery of control total plan but is likely to be compromised by ability to deliver internal CIPs and impact on income from CCG QIPP schemes."

– Acute and community provider, in deficit

"Achievement of control total. We already have long-term loans (NB not 'interim financial support') from both ITFF [Independent Trust Finance Facility] and a commercial lender."

– Specialist foundation trust, in deficit

"Massive risks around: agency usage, operational performance, CCG challenges, drug costs, winter, flu. If medical patients take surgical beds out then forget the finance plan."

– Acute, in deficit

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Figure 8: If you are in receipt of interim financial support via a loan from the Department of Health, how confident are you that you will be able to meet the total repayment requirements of the loan (without taking a further loan to support repayment)?

27 respondents (for whom the question was applicable).

Respondent comments

"Only for cashflow to cover deficit."

– Acute, fairly confident

"Not YET in receipt anyway!"

– Acute, not applicable

"Cash flow is a growing issue."

– Specialist foundation trust, fairly concerned

"There is no cash left in the system."

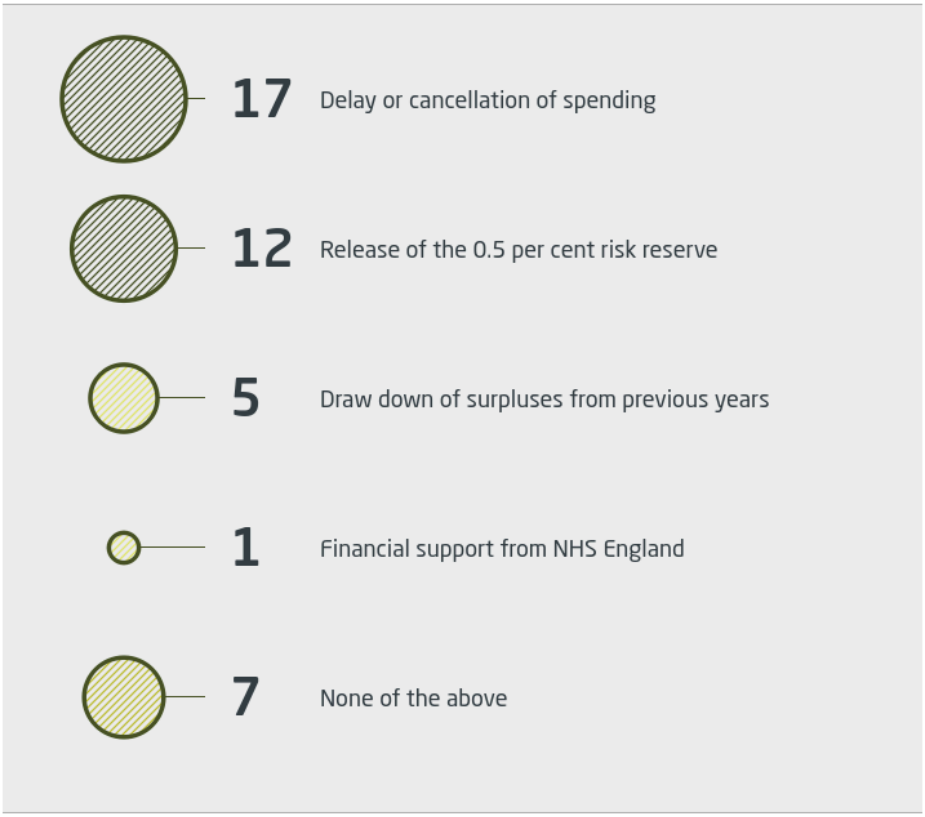
– Acute, very concerned

"Loans will never be repaid – impossible."

– Acute and community, very concerned

CCG LEADS

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



27 CCG finance leads answered this question for the 32 CCGs they cover collectively. Respondents were allowed to select more than one form of additional financial support.

Respondent comments

"Also dependent upon NHS England not clawing back 'unplanned' prescribing benefits but leaving CCG with unplanned cost pressures such as 'no cheaper supply obtainable' prescribing pressure."

– In surplus

"As well as non-recurrent flexibilities."

– Break even

"Delivery of QIPP phased into final six months of year."

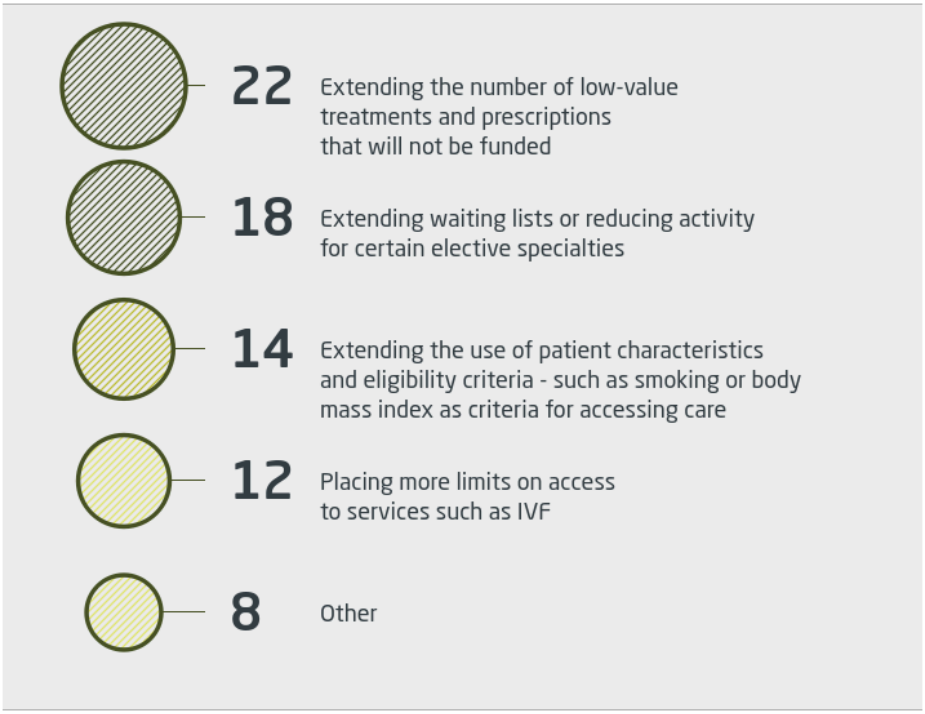
– In surplus

"Will improve if 0.5 per cent risk reserve is released into the financial position."

– In deficit

CCG LEADS

Figure 10: What, if any, of the following actions will your organisation consider taking in 2017/18?



Respondents were allowed to select more than one option.

Respondent comments

"Getting a bit late for these changes to impact in 2017/18."

"Disinvestment in services."

"Decisions may be made on these during 2017/18, benefit would accrue in 2018/19."

"Rightcare initiatives, prescribing and pass through drugs and devices efficiencies."

"Avoiding growth in activity levels and significant prescribing savings."

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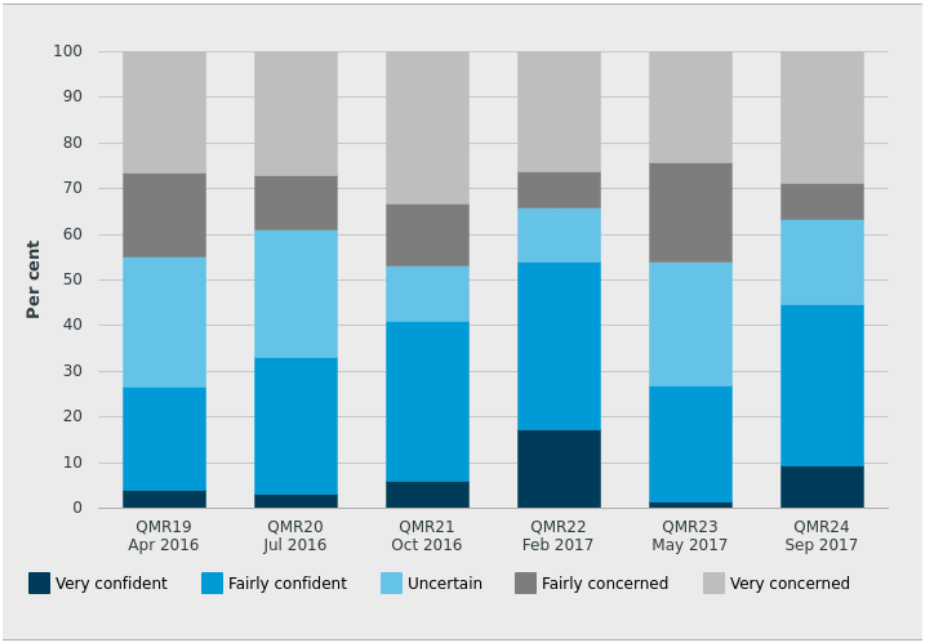
Figure 11: How confident are you that organisation can meet its control total for the year ahead?



76 respondents (for whom this question was applicable).

Respondent comments

"This year is looking hugely challenging. Our contract is unaffordable, CIPs are slipping, staff shortages are crippling (operationally and financially) and CQUIN monies are being top sliced. Cash is also a concern – not helped by the fluid nature of timing of STF monies. PDC dividends are removed from our bank accounts directly on particular dates – can the Treasury not afford us the same courtesy when the money comes the other way."

– Acute, very concerned

"Current concern about being defunded for 0.5 per cent CQUIN 'reserve'. This would reduce our income, and we would struggle to hit our control total in these circumstances. This in turn would lead to failure to receive sustainability and transformation funding, further reducing our overall surplus."

– Mental health, fairly confident

"Pressure from agency staff rates and activity."

– Mental health and community, uncertain

"Internal risks and issues re consequences of commissioner financial pressures."

– Acute and community teaching hospital, uncertain

"Loss of services via tender will adversely impact our ability to meet the control total."

– Mental health and community provider, very concerned

"Depends on executing a gain on sale of a property."

– Specialist foundation trust, uncertain

"Cash is also a big issue as CCGs are not paying their bills and raising more and more challenges."

– Acute, very concerned

"No chance!"

– Acute and community, very concerned

CCG LEADS

Figure 12: How confident are you that your organisation can meet its expenditure control total for 2017/18?

27 CCG finance leads answered this question for the 32 CCGs they cover collectively.

Respondent comments

"Overspends relate to non-elective and Continuing Health Care. Primary care prescribing is particularly complex due to national policy on shortages in drugs which has resulted in significant price increases."

– Very concerned

"Large number of risks around increasing GP referrals."

– Uncertain

"We have sufficient flexibilities to meet this year, however the recurrent underlying position is worse."

– Very confident

"Interdependency with trust recovery plans remains the biggest uncertainty."

– Uncertain

3. 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 4.4 per cent, ranging from 1 per cent to 8 per cent of turnover (Figure 13).
- The average quality, innovation, productivity and prevention (QIPP) target for CCGs for 2017/18 is 3.8 per cent, ranging from 1 per cent to 6 per cent of allocation (Figure 13).
- 47 per cent of all NHS trust finance directors were either fairly or very concerned about achieving their savings plans this year (Figure 14).
- 59 per cent of all CCG finance leads were 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

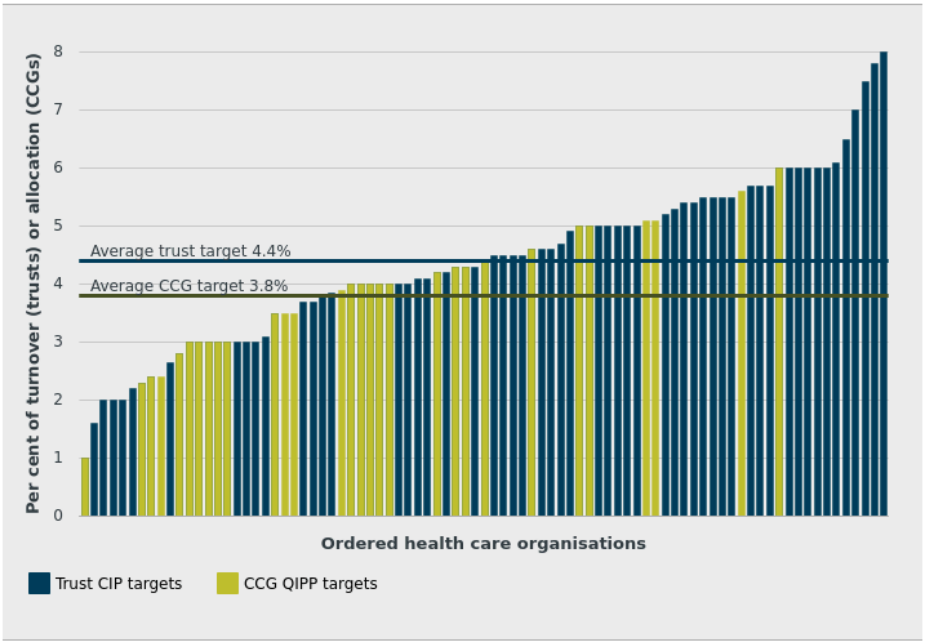


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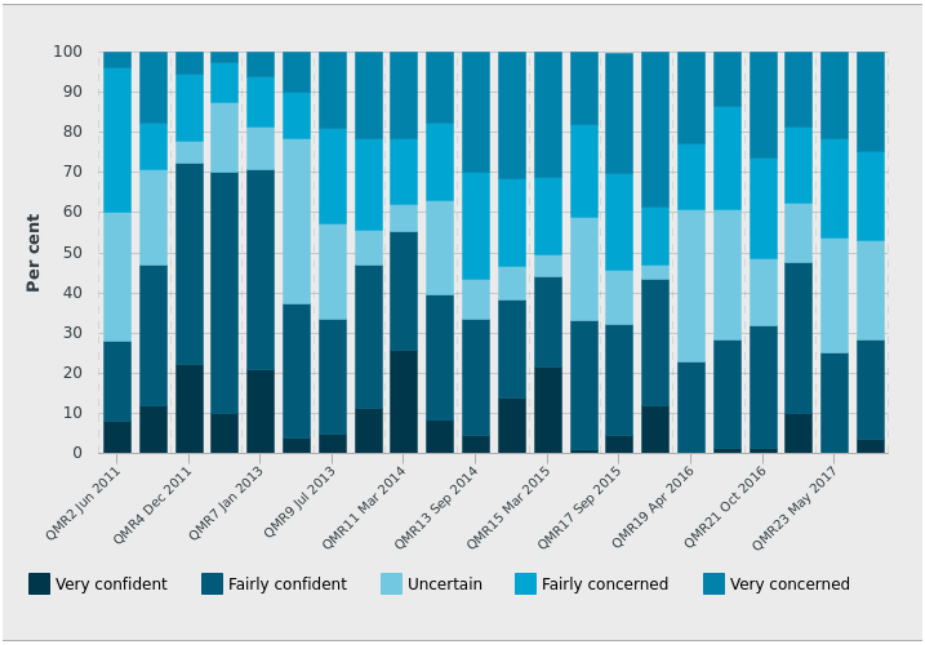
Figure 14: How confident are you of achieving your CIP target?



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

"CIP confident but additional QIPP more at risk."

– Community, fairly confident

"Predominantly based around income generation through trading services so is variable."

– Mental health social enterprise, fairly confident

"Reliance on non-recurrent savings."

– Community NHS trust, fairly confident

"Majority of plans in place - plans to cover gap being devised - mobilisation delays mean lower than required in-year benefit."

– Mental health and community, fairly concerned

"Slippage on programme covered by over-delivery elsewhere."

– Mental health, uncertain

"We are reliant on a considerable amount of non-recurrent funding generated from within the trust."

– Mental health foundation trust, fairly concerned

"Non-recurrent measures hoping to reduce corporate costs via restructure if can afford in 2017/18 to maintain underlying recurrent CIP."

– Community and mental health foundation trust, uncertain

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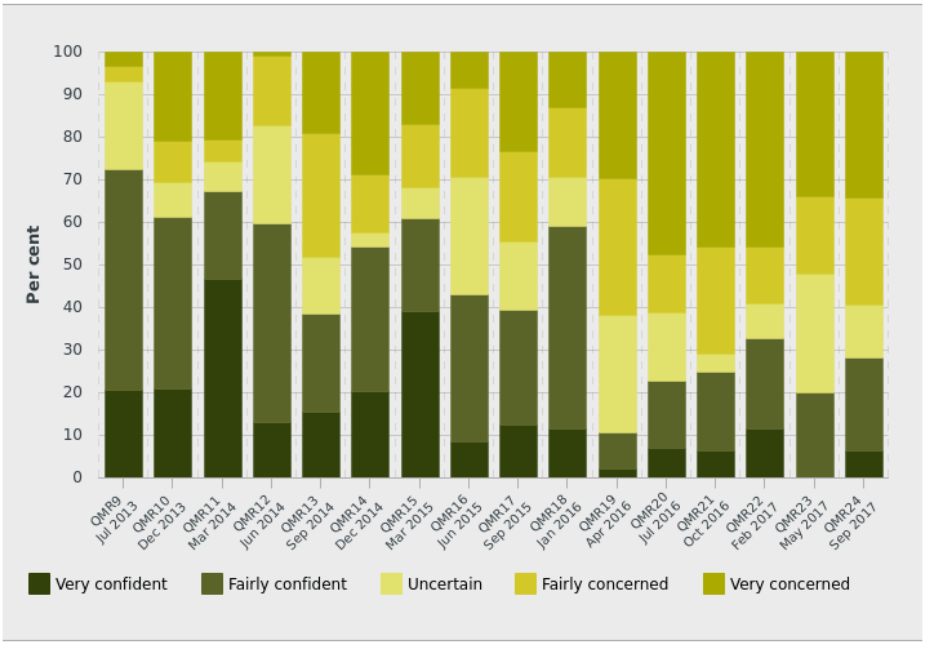
Figure 15: How confident are you of achieving your QIPP target?



27 CCG finance leads answered this question for the 32 CCGs they cover collectively. CCGs only surveyed since their establishment in April 2013.

Respondent comments

"We will not meet all of our QIPP."

– Very concerned

"Delivered approx 3 per cent last year (with a number of non-recurrent schemes), never delivered QIPP in excess of that 3 per cent before..."

– Very concerned

"Will not meet our QIPP targets."

– Very concerned

4. The state of patient care

- 51 per cent of finance directors and 59 per cent of CCG finance leads felt 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 had 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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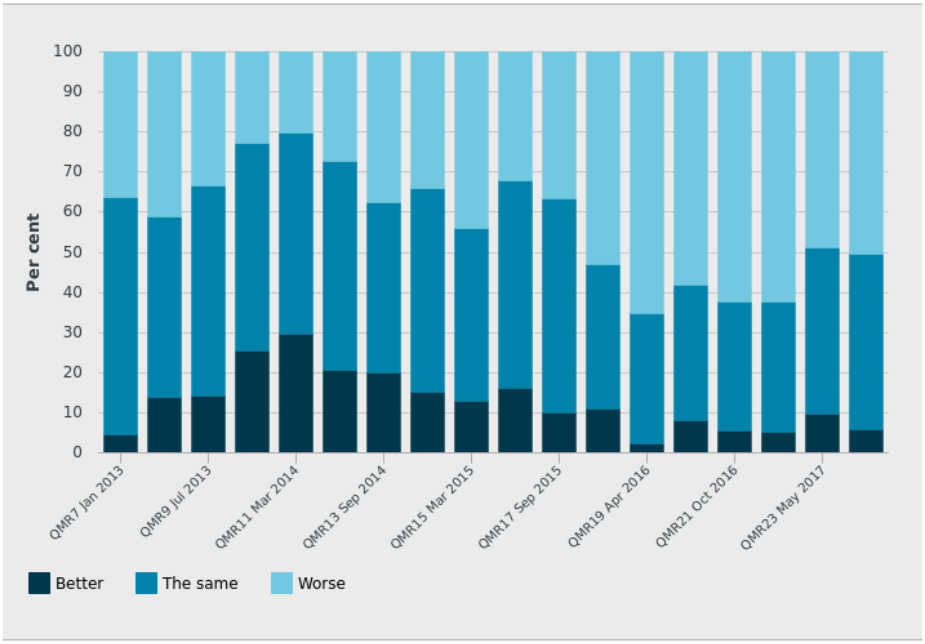
Figure 16: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



Question not asked before QMR6.

Respondent comments

"Out-of-hospital care concerns."

– Unknown, worse

"Demand rising, resource and staffing availability falling."

– Community NHS trust, worse

"The CCG is limiting elective services provided and seeking to increase waiting lists to reduce activity."

– Acute, worse

"Waiting times universally worse."

– Acute, worse

"Commissioners tendering and removing services at full cost leaving providers with stranded costs."

– Community trust, worse

"Real improvements in quality, safety and patient and staff experience."

– Acute foundation trust, better

"Shortages now starting to bite."

– Community provider - social enterprise, worse

"2016/17 was delivered both as an organisation and as local health economy via non-recurrent measures, many of which were one offs."

– Acute and community provider, worse

"Clear evidence of tendering reducing access to services."

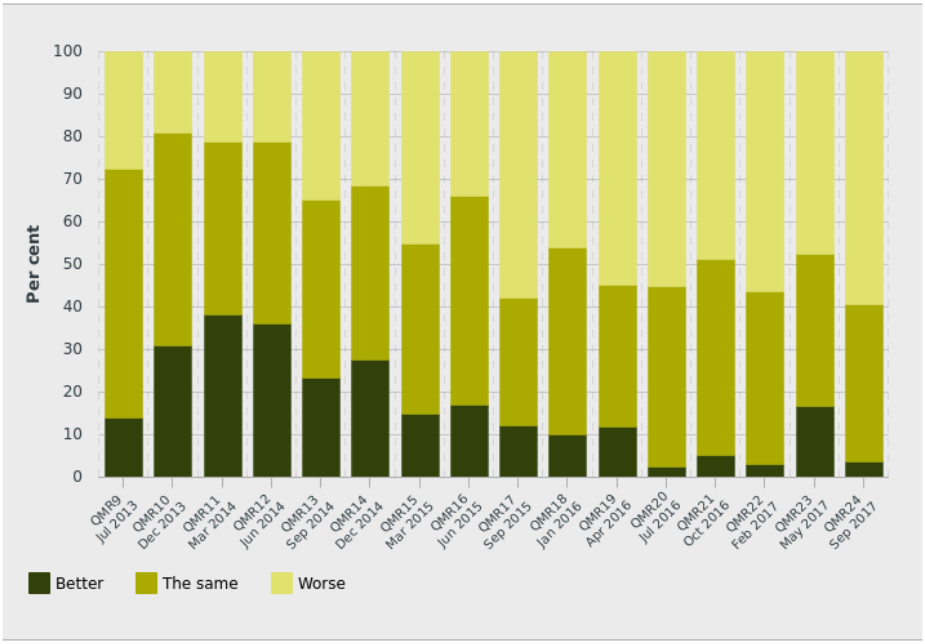
– Acute teaching, worse

"Medical staff and lack of primary care resources are as extreme as they have ever been against rising emergency pressures."

– Acute, 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

"Staff shortages and budget squeezes."

– Worse

"Systemic failure to manage demand, poor performance indicators, availability of workforce."

– Worse

"Increasingly difficult to fill vacancies, particularly GPs."

– Worse

"Care has stayed the same, but pressures have increased (demand for services, financial, targets)."

– The same

"Pressures in primary care remain concerning although performance/satisfaction levels holding up."

– The same

5. Organisational challenges

- For trust finance directors, delayed transfers of care continued to be their main concern. As in the previous QMR, staff morale was the second highest concern for finance directors, with A&E returning to the top three concerns, followed closely by bed occupancy (Figure 18).
- For CCG finance leads, the four-hour A&E waiting time standard continued to be their main concern for a fourth QMR in a row. Their second biggest concern was pressures on general practice, introduced as an option in QMR23. They also continued to be concerned about delayed transfers of care and the cancer treatment waiting times standard (Figure 19).

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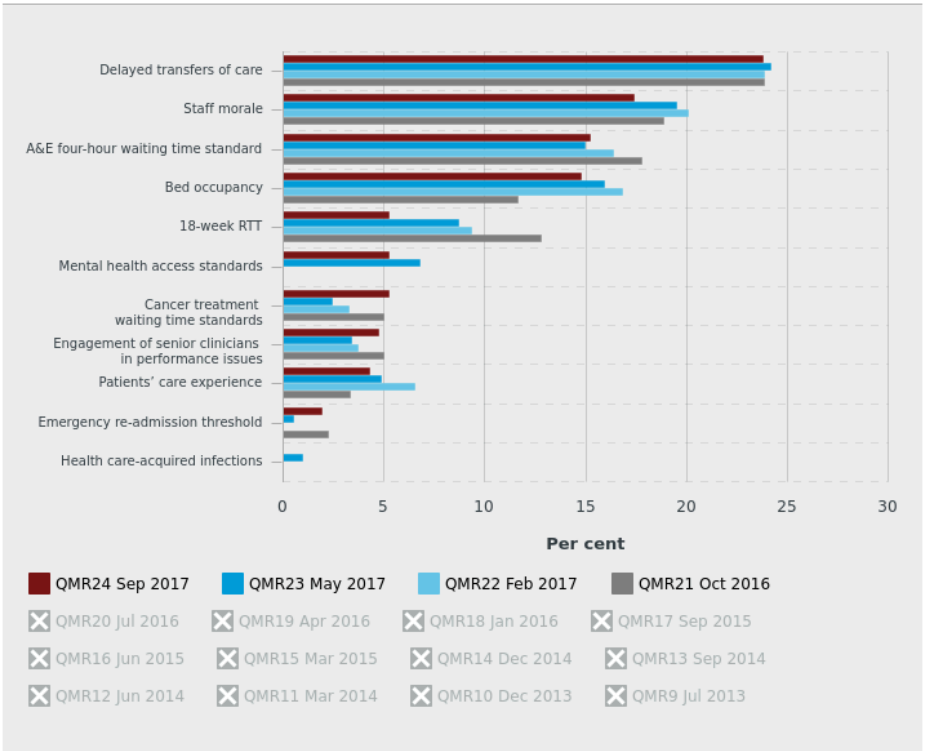
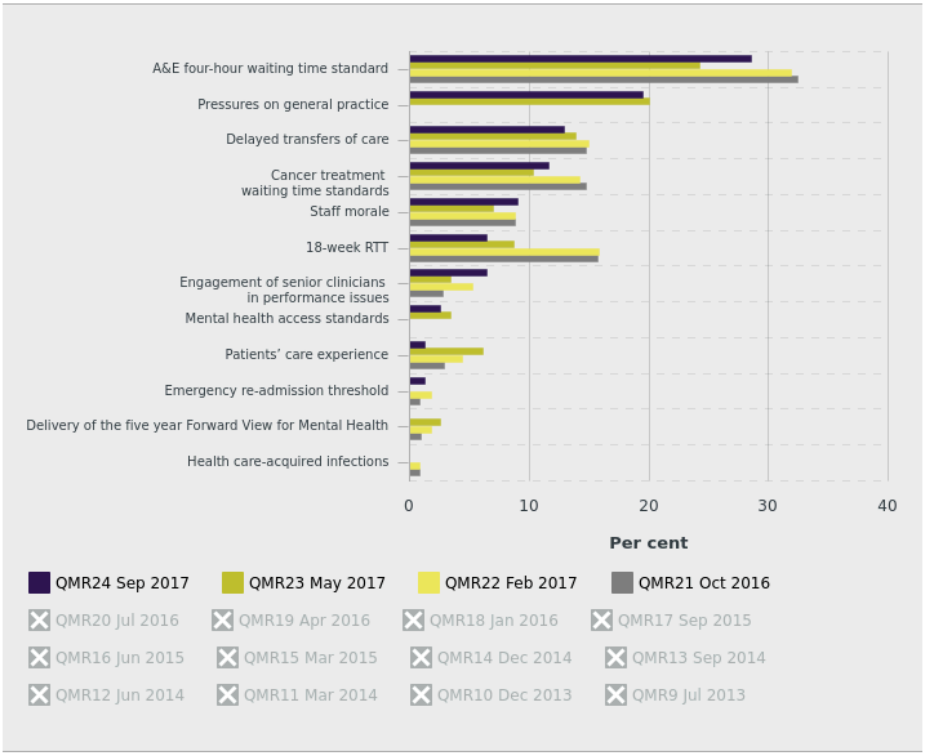
Figure 18: Which aspects of your organisation's performance are giving you most cause for concern at the moment?



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

CCG LEADS

Figure 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. New options have recently been added, implementation/delivery of *The five year forward view for mental health* (introduced in QMR21), and pressures on general practice (introduced in QMR23).

6. Waiting time standards

- As a condition of receiving sustainability and transformation funding, trusts are expected to develop credible plans for maintaining the delivery of core standards for patients, including the A&E four-hour performance standard.
- We asked trust finance directors how confident they were in their organisation's ability to deliver on the A&E four-hour performance standard by March 2018. Worryingly, 57 per cent of all trust finance directors (Figure 20) were either fairly or very concerned that their organisation will not be able to deliver this performance standard by March 2018. At the same time, 74 per cent of CCG finance leads felt fairly or very concerned that the organisations from which they commission services would not be able to deliver this performance standard by March 2018 (Figure 21).
- The 2017/18 NHS Mandate set out that total delayed transfers of care (attributable to the NHS, adult social care or both) should be reduced by September 2017 to 3.5 per cent of occupied hospital beds. Following this announcement, just under 13 per cent of trust finance directors said they felt fairly or very confident about their organisation meeting the planned trajectory for reducing delayed transfers of care by September (Figure 22). At the same time, 56 per cent of all CCGs finance leads were fairly or very pessimistic about providers achieving their planned trajectories by September (Figure 23).

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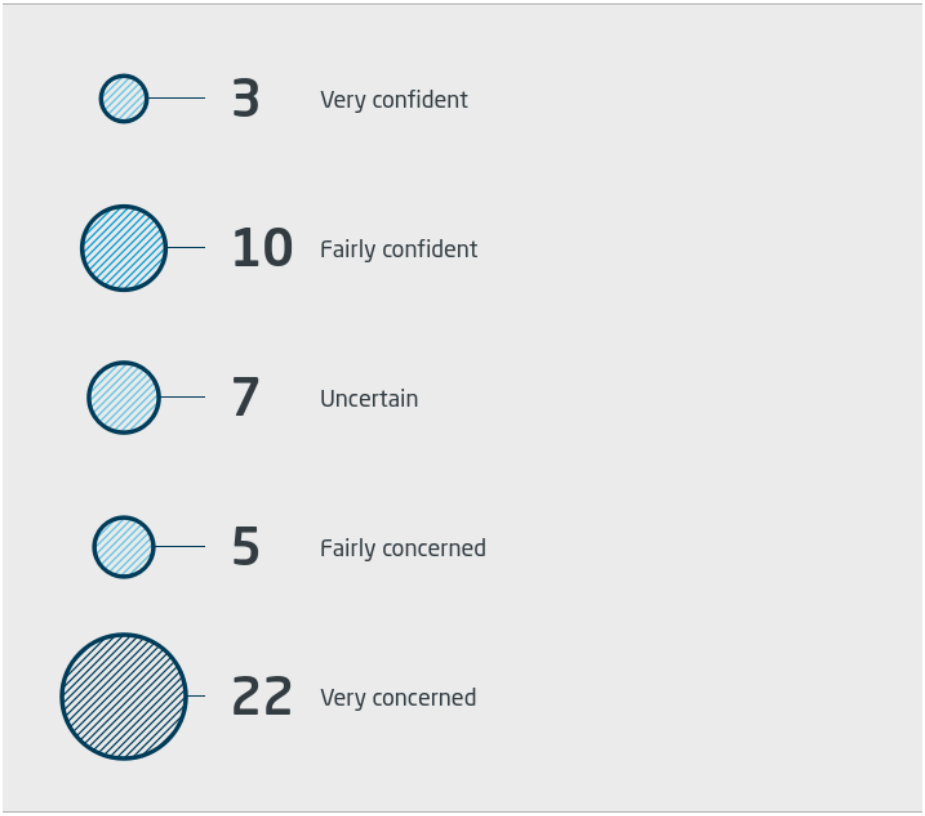
Figure 20: How confident are you that your trust will meet the 95 per cent A&E four-hour performance standard by March 2018?



47 respondents (for whom the question was applicable).

Respondent comments

"Concerned that pressure to achieve A&E may impact on elective programme which is needed to deliver financial performance."

– Acute teaching provider, fairly confident

"Paradoxically, if the finances have already gone south, then we will probably spend everything we can to hit 95 per cent. But we already in low 90 per cents so not that great a leap for us."

– Acute, uncertain

"Currently at 91-92 per cent but hard to see why it would get much better over winter."

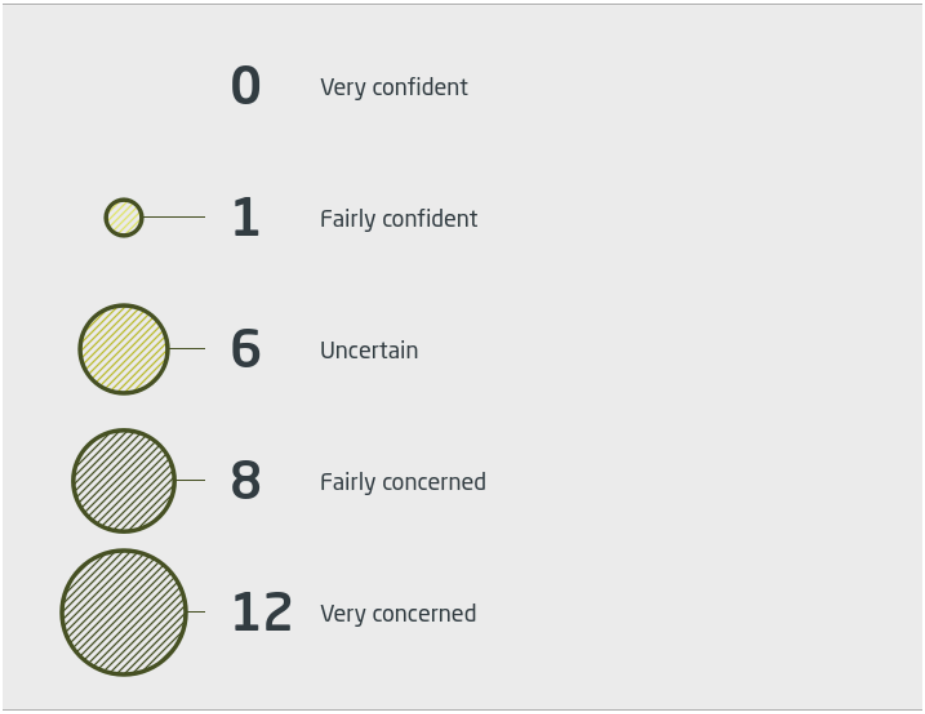
– Acute/community teaching hospital, fairly concerned

"Not a snowball's chance in hell!"

– Acute, very concerned

CCG LEADS

Figure 21: How confident are you that the trusts you commission services from will meet the 95 per cent A&E four-hour performance standard by March 2018?



Respondent comments

"It is almost certainly not going to happen."

– Very concerned

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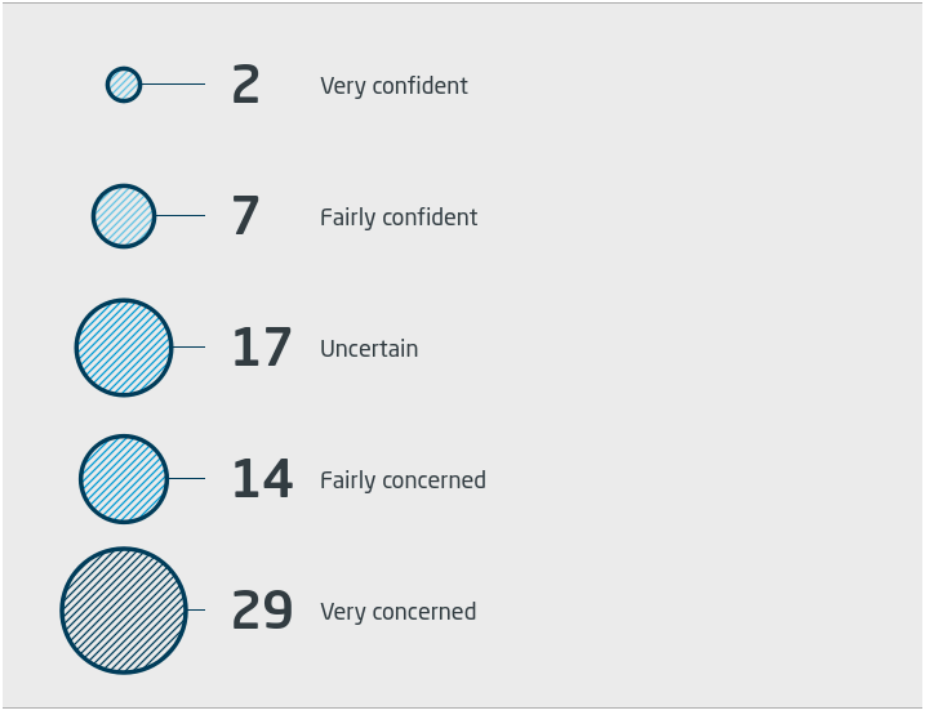
Figure 22: The 2017/18 NHS Mandate set out that total delayed transfers of care (attributable to the NHS, adult social care or both) should be reduced by September 2017 to 3.5 per cent of occupied hospital beds. How confident are you that your organisation will meet (or has met) your planned trajectory for reducing delayed transfers of care by September?



69 respondents (for whom the question was applicable).

Respondent comments

"Local authority cutting provision."

– Community, very concerned

"As we are an acute trust we are left with DTOC patients we can't control them."

– Acute, very concerned

"Reduced by 50 per cent over the past 12 months but from a very poor position."

– Acute foundation trust, fairly concerned

"Local authority not signing up to the target as part of the 'new' money it has received."

– Acute and community foundation trust, very concerned

"No chance."

– Acute, very concerned

"Good progress but still many issues, including affordability."

– Acute/community teaching hospital, uncertain

"System working is still poor."

– Acute and community, very concerned

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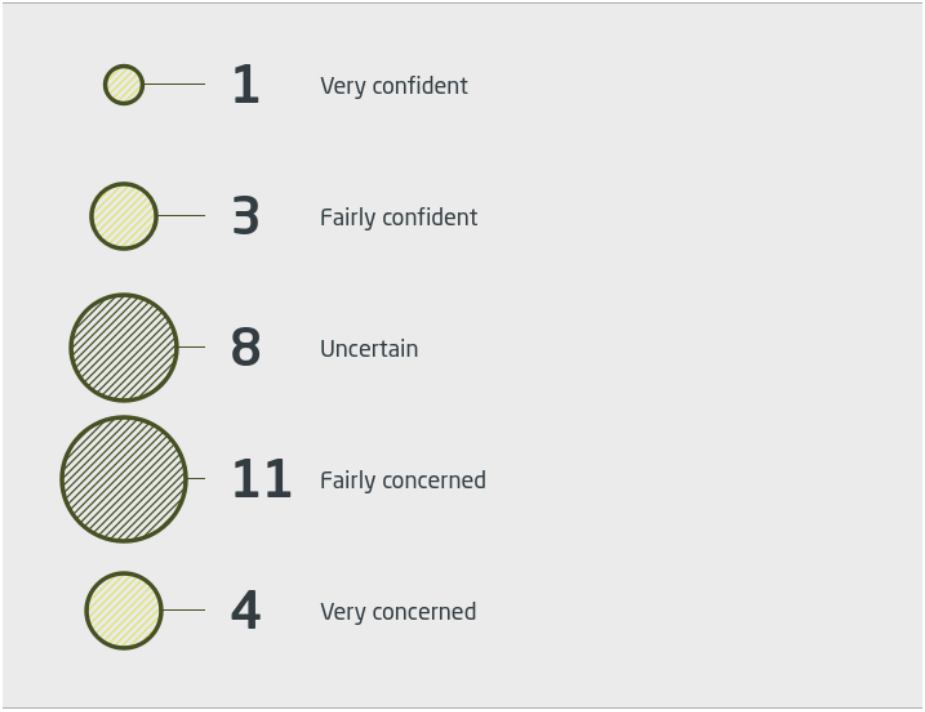
Figure 23: The 2017/18 NHS Mandate set out that total delayed transfers of care (attributable to the NHS, adult social care or both) should be reduced by September 2017 to 3.5 per cent of occupied hospital beds. How confident are you that the organisations from which you commission services from will meet (or has met) their planned trajectories for reducing delayed transfers of care by September?



Respondent comments

"Coming down but a long way to go, need for internal processes in acute to change."

– Very concerned

"Low levels of DTOC to start with. Bigger issue is bed occupancy at 95 per cent plus. First benefits in efficiency will be used to lower bed occupancy not deliver financial savings – impact on delayed transfers is uncertain."

– Very concerned

7. Workforce

- 65 per cent of all trusts were planning to increase the number of permanent nursing staff in the next six months (Figure 24).
- Shortages in the number of staff being trained was the top reason NHS trust finance directors gave for experiencing difficulties in recruiting and/or retaining sufficient nursing staff; this was followed closely by morale/work-life balance and the pay restraint affecting the public sector. It is worth noting that for those to whom this question was applicable, only one respondent did not have any difficulties in either recruiting or retaining sufficient nursing staff (Figure 25).

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Figure 24: Is your organisation planning to increase the number of permanent nursing staff in the next six months?

82 respondents (for whom the question was applicable).

Respondent comments

"Filling vacant posts currently being done by overtime, bank and agency."

– General acute, yes

"In terms of those employed but not more posts. We have 15 per cent vacancies."

– Integrated care, yes

"Very unclear where these additional nurses will come from."

– Acute, yes

"Subject to ability to recruit - acuity of patients driving need for safe staffing numbers."

– Acute, yes

"Need to control costs, principally by reducing agency staff."

– Specialist foundation trust, no

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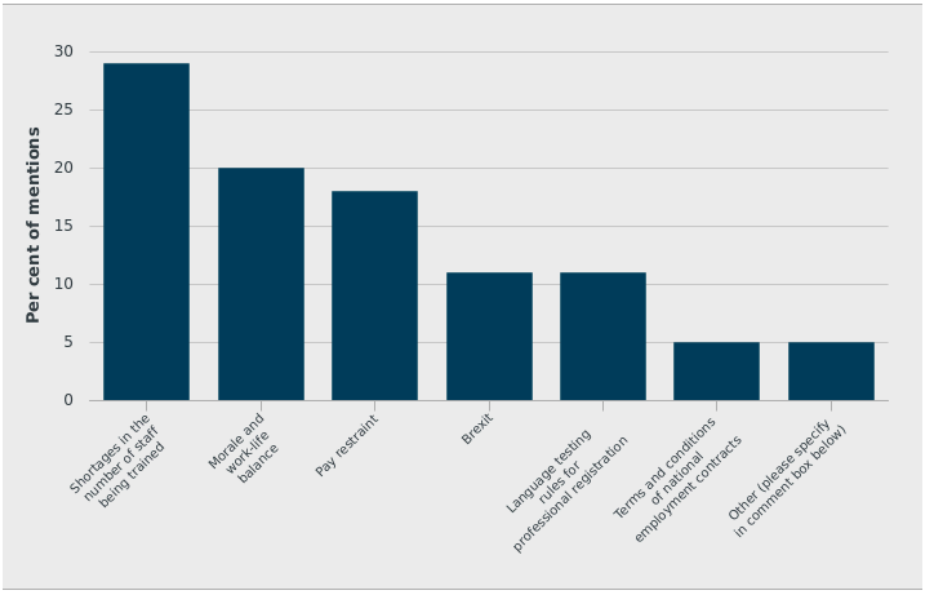
Figure 25: If you are experiencing difficulties in recruiting and/or retaining sufficient nursing staff to fill available posts, which factors have had the most significant impact?



Note: Of the 82 respondents for whom the question was applicable, one respondent selected 'no difficulties in recruiting or retaining nursing staff'. Respondents allowed to select more than one option. Figures expressed as a percentage of the total number of mentions for all options.

Respondent comments

"Other trusts are paying golden handshakes to attract nursing which is increasing the supply issue."

– Small acute trust

"The delay in obtaining visas has also been a real problem for us. Many candidates have gone elsewhere in the interim."

– Acute

"We were assigned far fewer visas than we requested and told we can only apply for more when we have a small number of visas left, the time lag will significantly impact our international recruitment programme."

– Acute teaching provider

"Skills shortage, levels of pay and benefits, the changing nature and intensity of the work and the agency alternative (higher pay, greater flexibility and less responsibility)."

– Mental health and community

8. 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 85 per cent CCG finance leads were fairly or very pessimistic (Figures 26 and 27).

- 58 per cent of NHS trust finance directors were very or fairly pessimistic about balancing their books in 2018/19 (Figure 28).
- 44 per cent of CCG finance leads were very or fairly pessimistic about achieving financial balance in 2018/19 (Figure 29).

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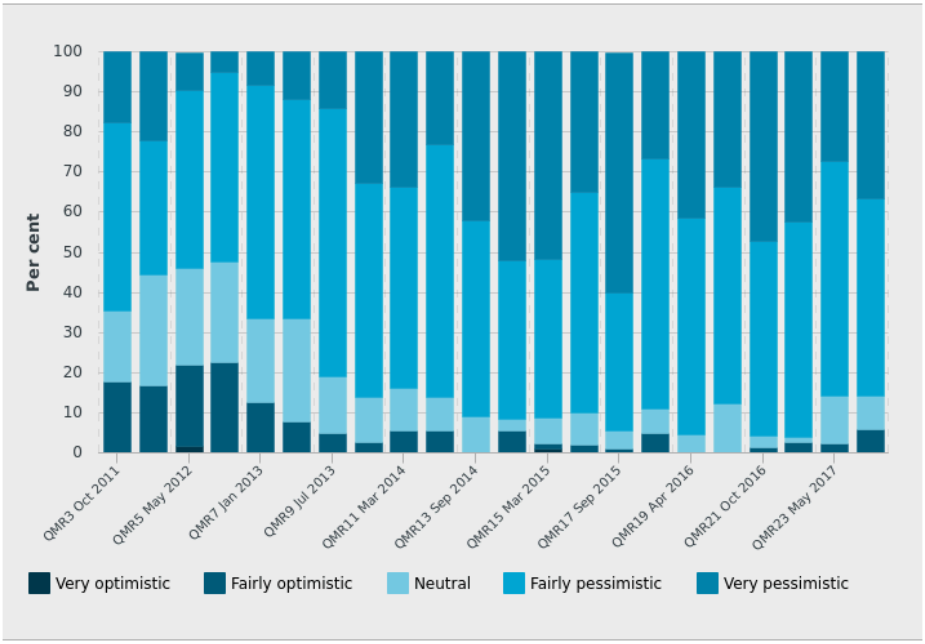
Figure 26: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next 12 months?



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

Respondent comments

"Level of non-recurrent support required belies the underlying picture. Level of optimism in demand reduction proposals not backed up by credible plans. Level of effective collaboration is decreasing due to application of pressures on individual organisational results."

– Acute, very pessimistic

"Finance and activity pressures at the same time as building STPs [sustainability and transformation partnerships] and ACSs [accountable care systems]."

– Mental health and community, fairly pessimistic

"To achieve control total we will have to do more work which will bust CCG."

– General acute, very pessimistic

"A combination of growing provider, commissioner and council financial pressures with no obvious solutions."

– Acute/community teaching hospital, very pessimistic

"For the first time both providers and commissioners in financial difficulty."

– Acute and community provider, fairly pessimistic

"Social care cuts are frightening. Health visiting and school nursing as we know it will no longer exist. Councils face nightmarish decisions."

– Community and mental health foundation trust, fairly pessimistic

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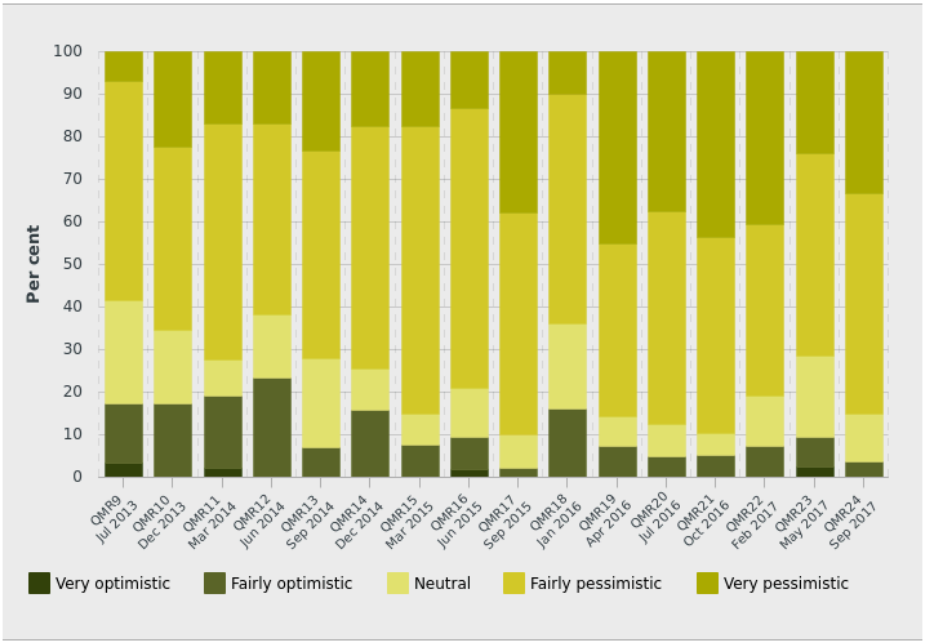
Figure 27: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next 12 months?



CCGs only surveyed since their establishment in April 2013.

Respondent comments

"Expect 2018/19 to be even more difficult."

– Very pessimistic

"CCG positions, until recent years holding relatively steady, have been hit very hard by changes to the tariff reducing the savings requirement. The reality of NHS spending is that the embedded efficiency requirement has to come from frontline costs as this is where the money is spent."

– Very pessimistic

"Every year the opportunities for financial savings are diminishing and becoming more difficult to identify and challenging to deliver."

– Fairly pessimistic

"Pressures on social care budgets continue to take their toll on NHS delivery."

– Fairly pessimistic

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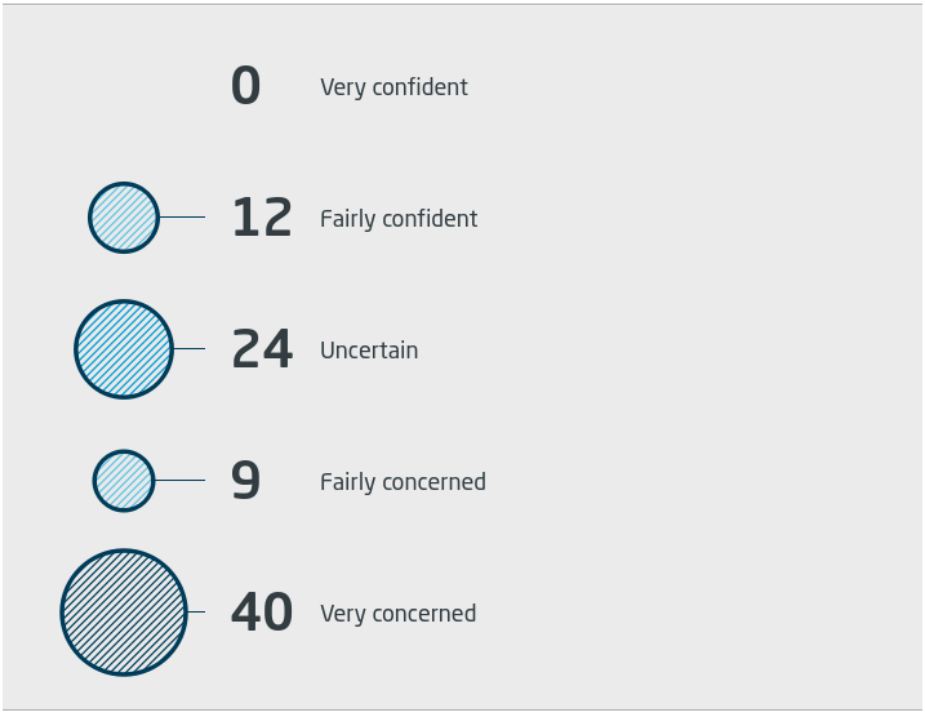
Figure 28: Looking ahead, how confident are you that your organisation will achieve financial balance in 2018/19?



Respondent comments

"The need for further efficiencies is a challenge, along with managing demand without spending above funded levels."

— Mental health and community, uncertain

"Local system pressure/financial deterioration. Uncertainty re Autumn Statement and likelihood of pay award increase but how funded?"

— Mental health and community, uncertain

"Pay awards prospect most concerning given two-year tariff and CCG financial position (which we view jointly as STP [sustainability and transformation partnership] problem)."

— Community and mental health foundation trust, uncertain

"Will achieve control total, but will remain in deficit."

— Acute, very concerned

"Only with more non-recurrent stuff and STF [Sustainability and Transformation Fund]."

— Acute, very concerned

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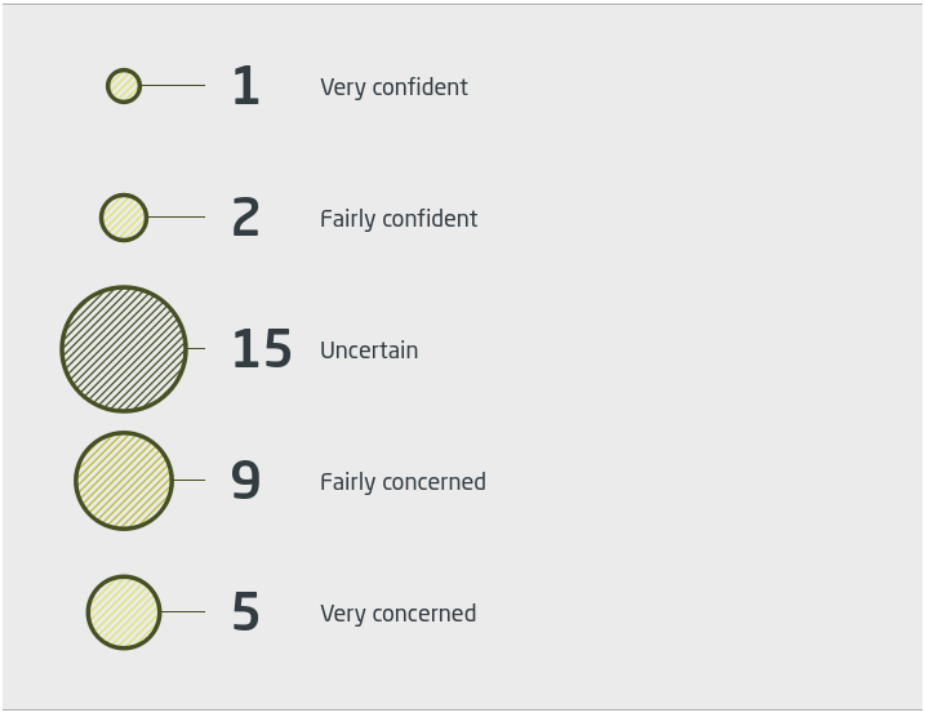
Figure 29: Looking ahead, how confident are you that your organisation will achieve financial balance in 2018/19?



27 CCG finance leads answered this question for the 32 CCGs they cover collectively.

Respondent comments

"Again this will only be on a non-recurrent basis and unless there is a change to funding policy 2018/19 will be the last year when we have any non-recurrent flexibility to support the bottom line."

– Fairly confident

"My organisation will not achieve financial balance in 2018/19, this is already a certainty."

– Very concerned

"Unless funding is diverted to the STP [sustainability and transformation partnership]."

– Very confident

"A lower QIPP target predicted but will have exhausted all 'menu of opportunity' options."

– Fairly concerned

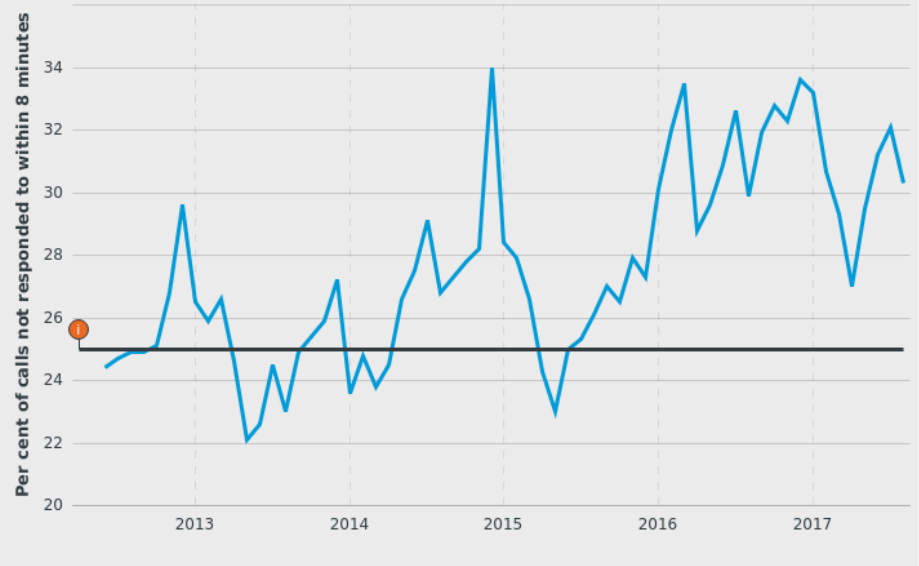
1. NHS performance dashboard

2. Urgent care

Ambulance services

- Since June 2012, ambulance trusts have been given eight minutes to respond to the most urgent cases and nationally no more than 25 per cent of these calls should be responded to outside of this time.
- This standard was met until 2013/14 but for all subsequent years has been missed. The most recent data shows performance remains challenged. Category A Red 1 calls are the most time-critical and immediately life-threatening category of ambulance calls – these cover conditions such as cardiac arrest. In August 2017, 69.7 per cent of Red 1 calls received a response within eight minutes (Figure 30).

Figure 30: Monthly performance of ambulance trusts in England for Red 1 calls

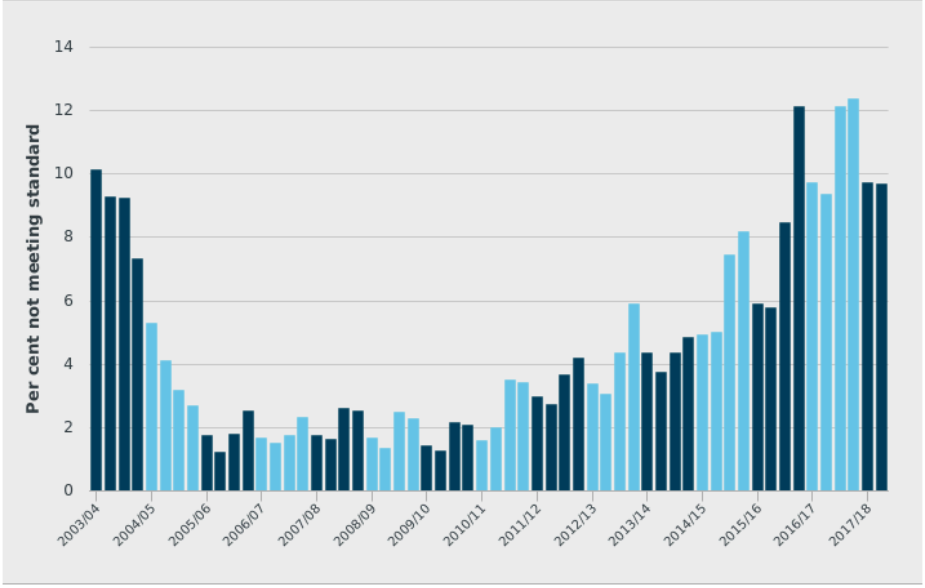


Data source: Ambulance quality indicators www.england.nhs.uk. From April 2016, changes under the Ambulance Response Programme mean response time data are unavailable on an equivalent basis for some ambulance trusts.

Accident and emergency

- In the first half of 2017/18, the percentage of patients waiting more than four hours from arrival to discharge, admission or transfer in all A&E departments was 9.8 per cent, showing some recovery against the 95 per cent standard compared to the second half of the previous financial year, but at a similar level to the same period in the previous financial year (Figure 31). Slightly more than 580,000 patients waited more than four hours on average during quarter one and quarter two this year.
- The four-hour standard has not been met in any month since July 2015.

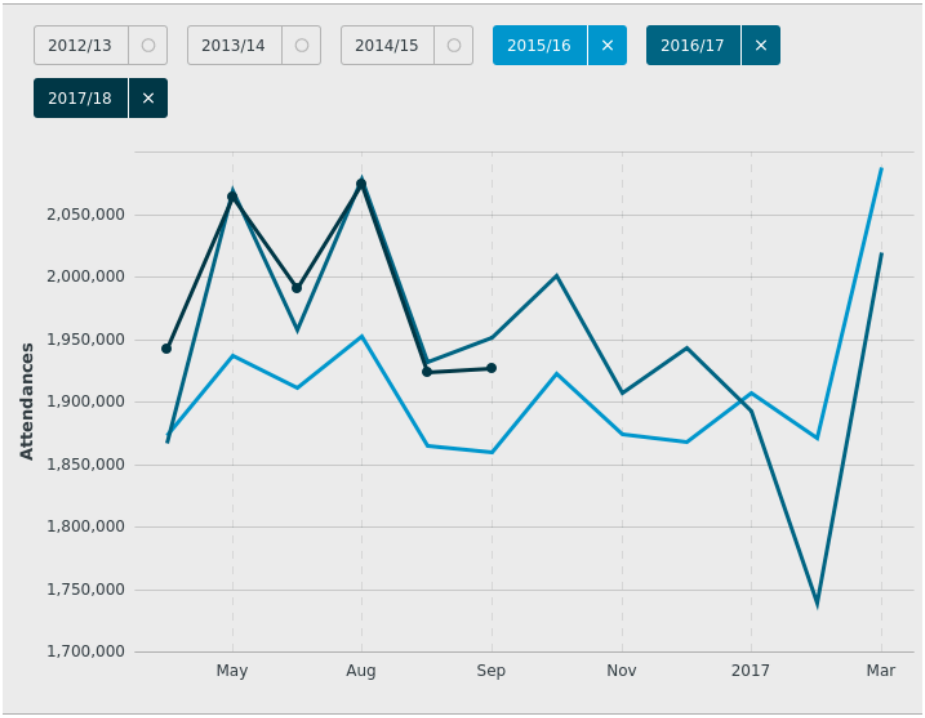
Figure 31: Percentage spending more than four hours in A&E from arrival to admission, transfer or discharge; quarterly data



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

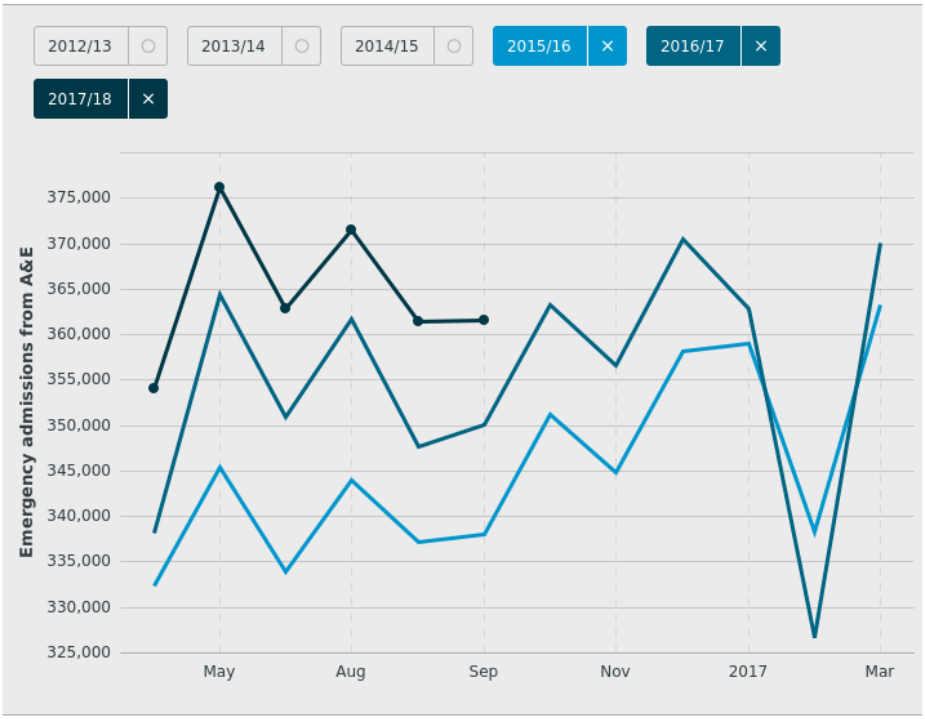
- The performance figures for the first half of 2017/18 are similar to those in the previous year: both the percentage of people seen in four hours and the number of attendances in quarters one and two of 2017/18 are similar to the same quarters in 2016/17 (Figures 31 and 32).
- This means that notably higher numbers of patients attended A&E in 2017/18 and 2016/17 compared to previous years: in quarters one and two of 2016/17 and 2017/18, attendances have been at least 6 per cent higher each month on average than in 2012/13.
- The most noticeable trend in the data from the first half of this year is in the number of admissions from A&E, which have been 4 per cent higher on average each month in 2017/18 than they were in 2016/17 (Figure 33). In some ways this is not surprising, as the number of admissions typically increases each year, but the size of the increase is particularly notable; the average increase in emergency admissions from A&E going back to 2003/4 is 1.4 per cent per year.

Figure 32: Total attendances at accident and emergency departments, monthly data



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

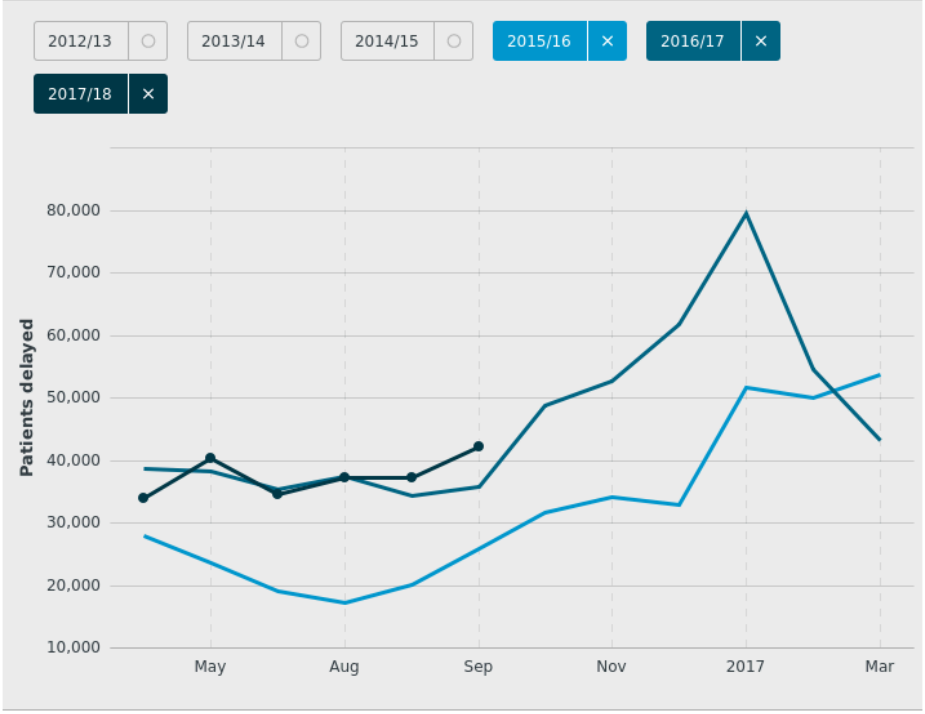
Figure 33: Emergency admissions from accident and emergency departments, monthly data



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 at a similar level to last year, with 109,000 and 118,000 patients waiting more than four hours in quarter one and quarter two 2017/18 respectively (Figure 34). However, the number of patients waiting longer than 12 hours has fallen, from 387 and 254 in quarter one and quarter two 2016/17 respectively to 311 and 211 in the same quarters in 2017/18.

Figure 34: Patients waiting more than four hours in A&E from decision to admit to admission, monthly data

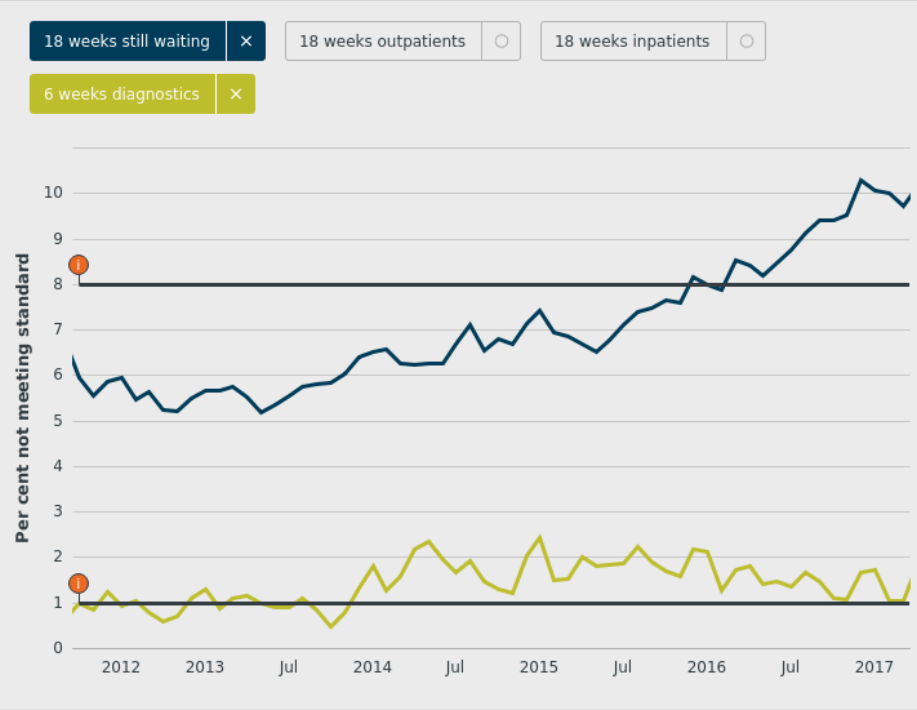


Data source: A&E attendances and emergency admissions www.england.nhs.uk.

3. Waiting times

- After showing some improvement in quarter four 2016/17, performance against the 18-week referral-to-treatment waiting time standard has worsened again, with more than 10 per cent of patients waiting more than 18 weeks for treatment for two months in a row for the first time since 2010/11. The standard has now not been met for 18 months.
- In August, for the first time since the standard was introduced, more than 400,000 patients were left waiting for more than 18 weeks for treatment, while the number of people waiting more than 12 months also increased to 1,729, the most since August 2012.
- The number of people waiting to begin treatment rose once again in the first half of 2017/18, with 14 per cent more people added to the waiting list between April and August 2017 (when 63,000 people were added to the waiting list) than in the same period in 2016 (when 55,000 were added to the waiting list).
- 2017/18 to date also represents the first period in which both diagnostic and referral-to-treatment waiting times have both worsened compared to their standards (Figure 35). Previously, one or both has improved or remained steady.
- The proportion of patients waiting more than six weeks for a diagnostic test has now missed its standard (1 per cent) every month since November 2013 (Figure 35).
- In each month between April and August 2017, the number of people waiting for a diagnostic test has been 3 per cent higher on average than the same month in 2016, with 875,000 people waiting for a diagnostic test by August 2017.

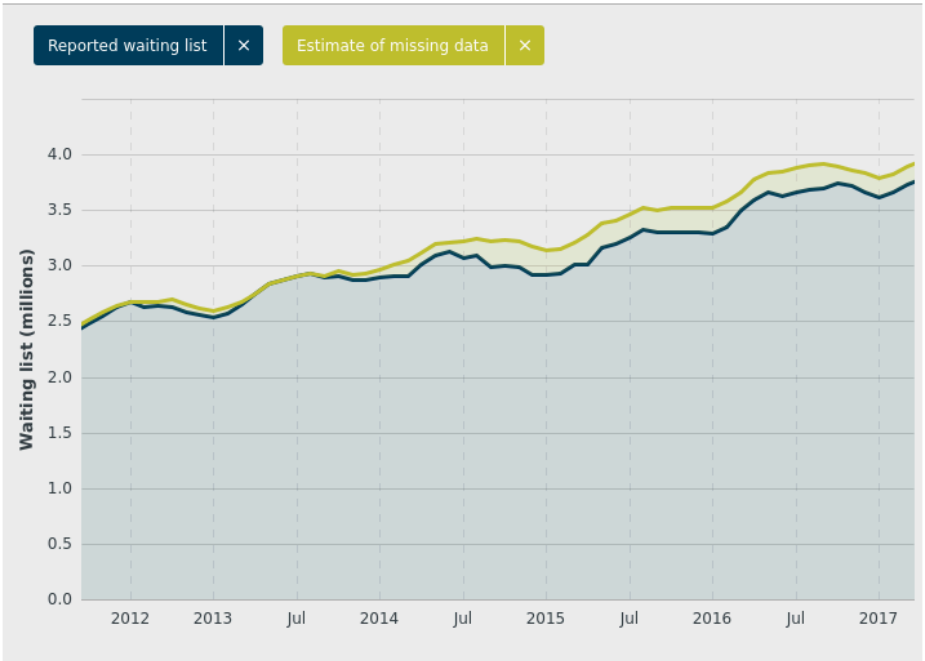
Figure 35: Per cent still waiting 18 weeks to begin treatment/having waited more than six weeks for diagnostics



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

- The reported total elective waiting list grew to 3.87 million in August 2017. This is 180,000 more patients than in August 2016 (Figure 36).
- This total, however, does not include data from several trusts that have not been reporting their waiting list size. Including these trusts, NHS England estimates that the true waiting list in August 2017 was more than 4.1 million patients (Figure 36). This is the first time the total number of people waiting for treatment has been more than 4 million since the same period in 2007.

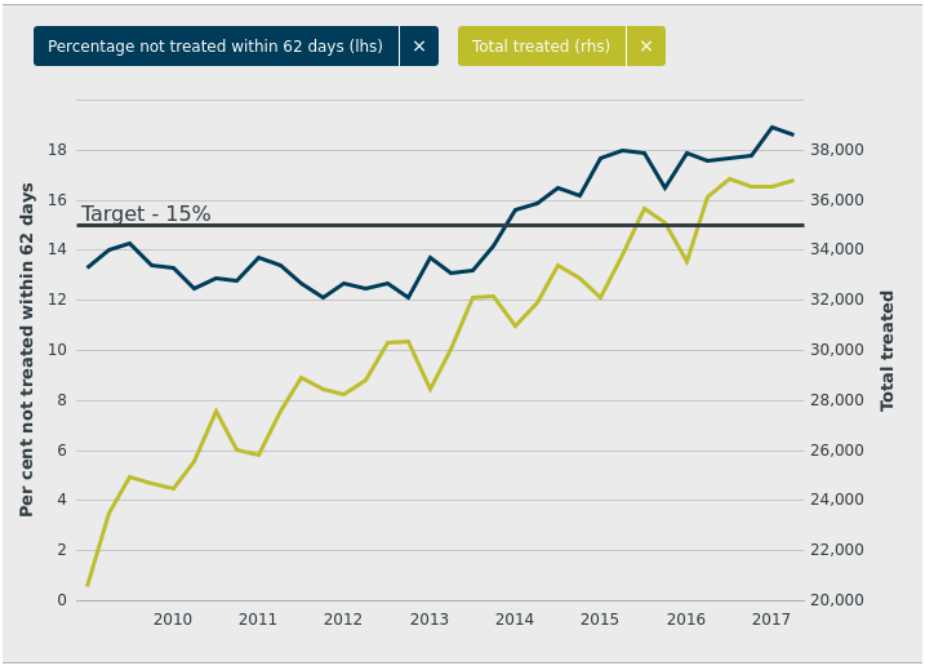
Figure 36: Referral-to-treatment total waiting list size in millions, England



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

- The overall waiting times standard for cancer treatment is that no more than 15 per cent of patients should wait more than 62 days from an urgent referral from their GP to receiving treatment for their cancer. This standard was met from quarter four 2008/9 until quarter four 2013/14, since when it has been missed in each quarter (Figure 37).

Figure 37: Maximum 62-day wait for first treatment: all cancers (urgent GP referral to treatment)



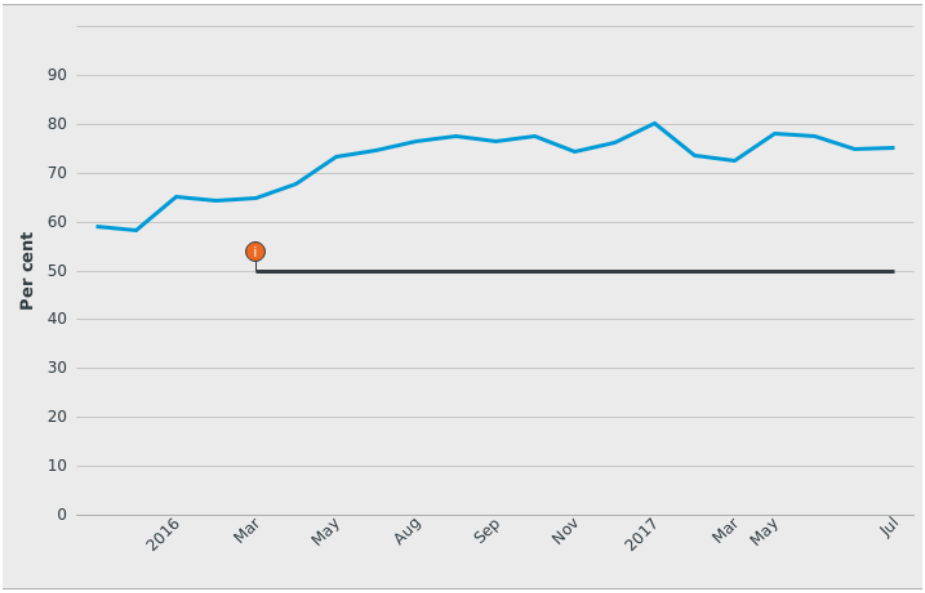
Data source: Provider-based cancer waiting times www.england.nhs.uk.

- For patients accessing mental health services, there are currently three waiting time standards: 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.

- For patients accessing psychological therapies, both standards were met for every month in 2016/17 (to date).
- Data from 2016/17 show that, during 2017/18 so far, 74 per cent of patients accessed early intervention in psychosis services within two weeks (Figure 38).

Figure 38: Per cent of patients accessing Early Intervention in Psychosis services within 2 weeks, monthly data

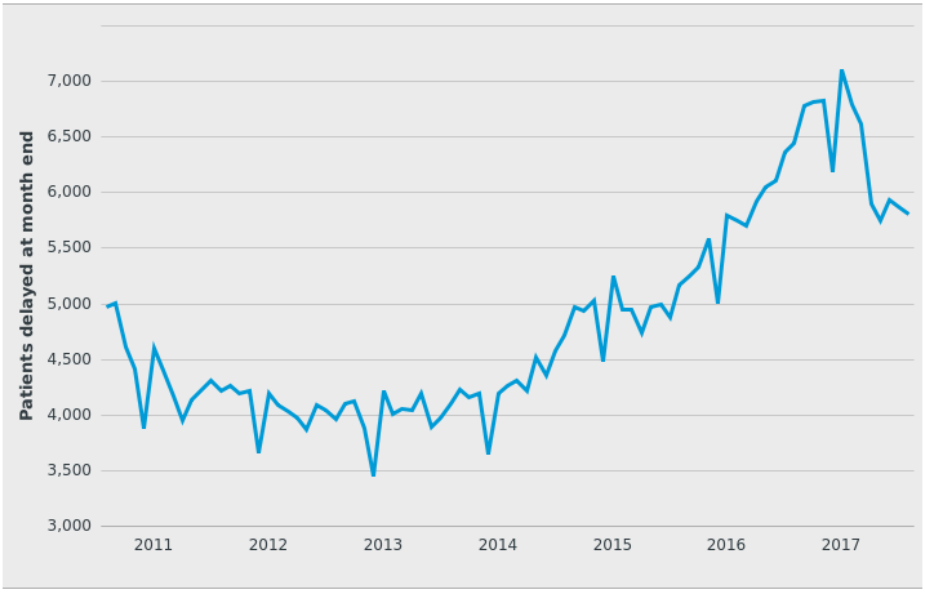


Data source: Early Intervention in Psychosis Waiting Times www.england.nhs.uk.

4. Delayed transfers of care

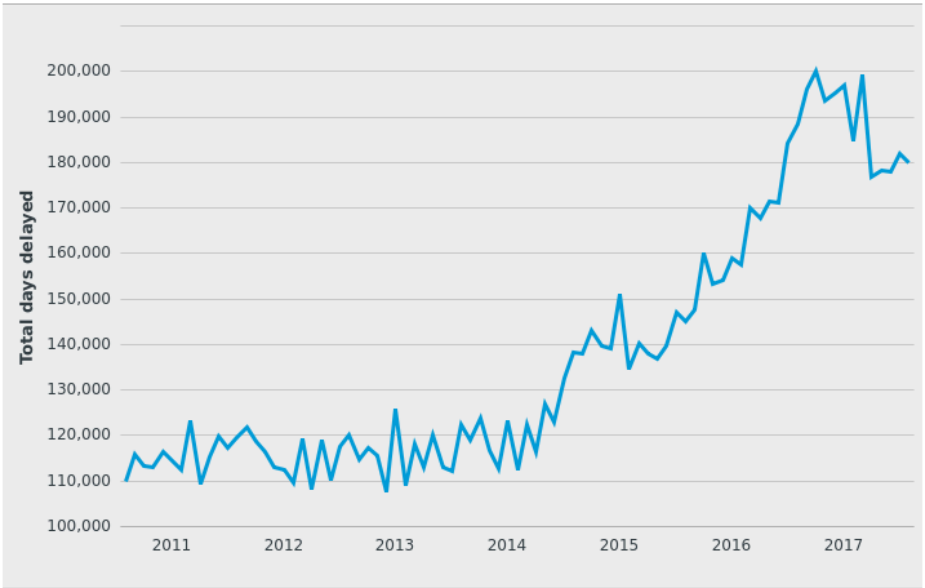
- After reaching a seasonal high in March, since this collection started, fewer people experienced delayed discharge from hospital between April and August 2017 compared to the same months in 2016. This is the first time that the number of patients delayed has fallen for more than two months in a row since 2012. The number of people experiencing a delay fell from 7,100 in January 2017 to 5,800 in August 2017 (Figure 39).
- The number of total days delayed has fallen during 2017/18 from 199,000 in March to 180,000 in August (Figure 40). The number of total days delayed in July and August were both lower in 2017 than in 2016, the first year-on-year monthly reduction since January 2014.

Figure 39: 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 40: Delayed transfers of care: total number of days delayed each month



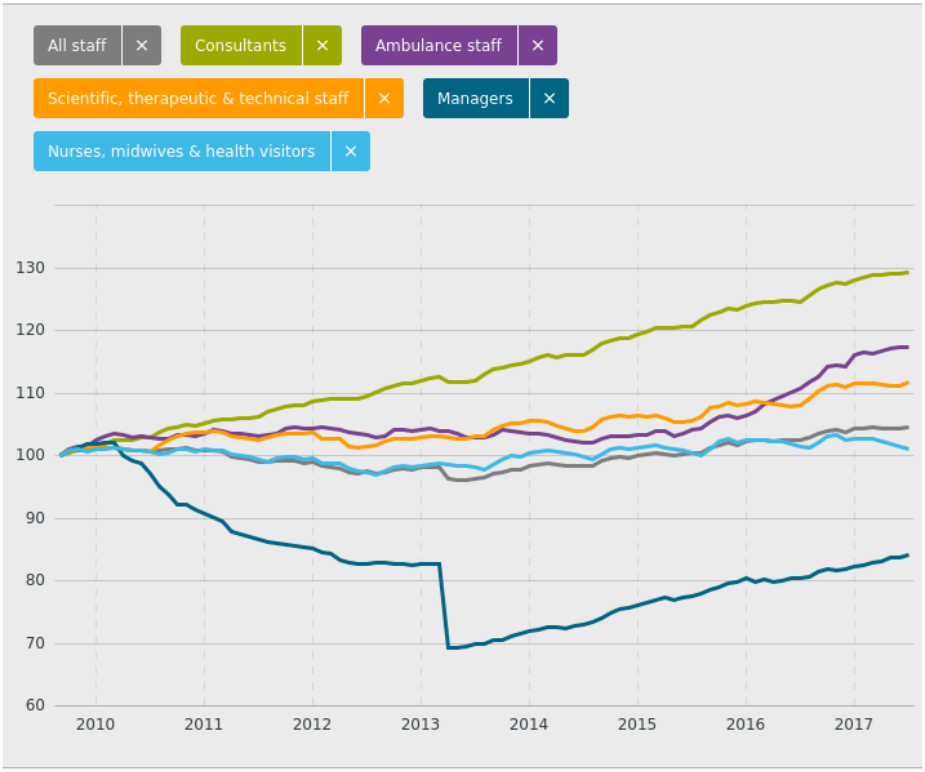
Data source: Acute and non-acute delayed transfers of care, total days delayed, 2016/17 www.england.nhs.uk.

5. Workforce

- The total amount of staff in the NHS has remained steady since November 2016, with 1.05 million full-time equivalent staff employed across England as of July 2017.
- Within this total, however, the number of nursing staff has fallen by 1.67 per cent since January (Figure 41), and has been lower year on year since April, the first time that the total amount of nursing staff in the NHS has fallen

year on year since the publication of the Francis Report in mid-2013.

Figure 41: Index change in NHS full-time equivalent staff: September 2009 - July 2017



Data source: Monthly NHS Workforce Statistics - July 2017, Provisional statistics.

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