Summary

1. This report and its annex focus on the operational and financial performance of 238 providers at Quarter 1 (Q1) 2016/17. All results are based on the combined performances of 156 licensed NHS foundation trusts and 82 NHS trusts operating during this period, unless otherwise stated.

Overview

2. Faced with a further sharp increase in demand for services, providers are making concerted efforts to stabilise and improve their operational performance. Despite missing several national targets, A&E and diagnostic performances started to improve. However, significant operational challenges remain.

3. The introduction of the Sustainability and Transformation Fund (STF) in 2016/17 allowed the provider sector to stabilise and move to a more sustainable financial footing. For the first three months of this year, the sector reported a year-to-date deficit of £461 million, £5 million ahead of plan.

4. In July, NHS Improvement and NHS England published *Strengthening financial performance and accountability in 2016/17*, which outlines a suite of targeted improvement actions. These actions, combined with the control measures introduced last year, will help trusts achieve the required financial controls in 2016/17 and secure financial sustainability for the future.

Operational performance

_Urgent and emergency care_

5. Quarter 1 2016/17 saw A&E demand rising to a record 5.34 million attendances, 6.3% higher than the same quarter last year on a like-for-like basis. NHS providers managed to treat, admit or discharge 89.31% of A&E patients within four hours. Although this performance was well below the national target of 95%, performances in May and June 2016 showed signs of recovery. This
performance relates to A&E services provided by NHS FTs and Trusts only. Figures released for Q1 by NHS England confirm that 90.26% of patients were seen within 4 hours, which is slightly higher than the NHS provider performance as it also includes the performance of minor injury services managed by independent sector providers.

6. The number of A&E patients requiring further in-hospital treatment also rose. Major (Type 1) A&E departments alone saw a 6.4% year-on-year rise in A&E admissions. Bed constraints due to delayed transfers of care (DTOCs) continued to have an adverse impact on patient experience: 112,117 patients waited longer than four hours on a trolley for a bed, an increase of 60.7% compared to the same period last year. NHS Improvement is working with several trusts to improve patient flow through the ‘SAFER’1 patient flow bundle, reducing inpatient bed occupancy and length of stay.

7. Ambulance services in aggregate failed to achieve all key response time targets against Red 1 (time-critical), Red 2 (life-threatening) and Category A calls, as both Red 1 and Red 2 calls rose by 5.9% and 15.5% respectively compared to the same period last year (on a like-for-like basis). The rollout of a dispatch-on-disposition pilot has continued to affect both Red 2 and Category A call response times as the pilot allows call handlers extra time to triage calls, resulting in different clock start times.

Elective care

8. The waiting list reached the highest recorded level of 3.45 million, leading to trusts’ continued underperformance against the 92% referral-to-treatment incomplete target. Trusts in aggregate reported a performance of 91.27%. NHS Improvement and NHS England have started a programme to reduce elective demand and ease pressure on trusts’ stretched capacity.

9. Despite not meeting the 1% target for diagnostic waiting time, the percentage of patients waiting longer than six weeks for a diagnostic test fell from 1.88% at June last year to 1.50% in June 2016. This was partly due to work by a national programme team from NHS Improvement and other national bodies, which reduced the number of patients waiting longer than six weeks for endoscopy procedures.

10. In contrast, trusts continued to experience difficulties in providing first treatment to more than 85% of urgent GP referrals for suspected cancer within 62 days. They achieved 82.34% in Q1 2016/17. Work with the National Cancer Taskforce has begun to reduce delays by increasing capacity for specific tumour groups at the most challenged trusts. In time, we expect the 62-day cancer target performance to improve.

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1 The ‘SAFER’ patient flow bundle refers to senior review; all patients will have an expected discharge date and clinical criteria for discharge; flow of patients; early discharge; and review by multidisciplinary team.
Financial performance

11. After one of the toughest financial years, the sector is addressing its financial challenges. To help trusts move to a more sustainable financial footing, a £1.8 billion Sustainability and Transformation Fund (STF) has been introduced for 2016/17. Providers are eligible to access it if they can meet a ‘financial control total’ and an agreed trust-specific plan for certain waiting-time standards.

12. ‘Financial control totals’ set the minimum level of financial performance for both the sector and individual trusts. By early July 2016, 214 out of 238 trusts had accepted their individual control totals and planned to achieve a full-year financial position either equivalent to or better than their control totals.

13. The sector reported a year-to-date deficit of £461 million, £55 million better than planned. Compared to a year-to-date sector deficit of £930 million at Q1 last year.

14. Of the 214 trusts that accepted their control totals, 185 met their Q1 funding targets, which allowed them to receive their first quarter’s STF payments.

15. The Q1 2016/17 financial performance reveals that many trusts are making progress in stabilising and improving their financial positions. This is shown in falling monthly agency staff costs since April 2016, while control measures introduced last year are embedded. Trusts are currently on course to reduce their combined annual agency staff costs by £1 billion this year and the aggregate paybill (including agency costs) was £9.8 million better than plan at Q1. In addition, the number of trusts reporting a year-to-date deficit reduced from 190 at Q1 2015/16 to 153, another indication of trusts’ progress.

16. However, further work is required especially on non pay costs and efficiency. Non pay spend continues to be the biggest area of overspend with drugs and clinical supplies overspending against plan in the first quarter by £44 million (60% of the total non pay overspend). This overspend is driven by a combination of cost and volume factors. To help providers tackle the non pay overspend NHSI will be rolling out a Purchasing Price Index Benchmarking Tool to providers shortly which will enable providers to share information, benchmark prices transparently and facilitate the NHS to negotiate the best price or switch suppliers going forward. So far providers have collectively shared purchasing information covering £6.5 billion of expenditure and we expect the tool to help providers realise material non pay savings in the second half of 2016/17.

17. Urgent remedial action is also required to address the cost improvement plan (CIP) shortfall of £45 million that the sector reported at Q1 2016/17. In July, NHS Improvement wrote to all trusts asking them to focus on:

- tackling excess pay bill growth;
- taking forward Lord Carter’s recommendations on back office and pathology consolidation;
- consolidating unsustainable services that rely on locum and agency staff.

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18. In the same month, NHS Improvement and NHS England jointly published *Strengthening financial performance and accountability in 2016/17* outlining further targeted actions to help trusts achieve in-year and long-term financial balance. These include:

- a new oversight framework with a strong focus on financial performance
- tackling financial failure through special measures
- launching a two-year NHS planning and contracting round for 2017/18 and 2018/19

19. These actions have obviously not impacted on Q1 results. Some organisations are indicating that their outturn could be worse than either their accepted control total or, where they have not accepted, their proposed plan results in a worse financial position than NHSI assessed they could achieve. Before the further action this would have the impact of increasing the aggregate planned provider deficit of £580m by £64m to £644m for 2016/17.

20. A set of follow up actions are now in train where there is a variance to plan including:

- Ensuring consistency of forecasting and approach which is work in progress and will be improved when we introduce the Single Oversight Framework we have recently consulted on the Finance Special Measures policy we recently launched;
- All organisations indicating downside deficit in their outturn positions at Q1 are being engaged with by regional finance teams to determine corrective actions;
- The implications of the improvement actions set out in paragraphs 16 and 17 have yet to be worked through individual organisational positions;
- We are engaging with a small cohort of organisations to determine upside opportunities to increase their surplus delivery, where this is possible there is the potential to
- The continued engagement with specific organisations to address particular issues where providers required support and/or advice.

21. It is acknowledged that Q1 financial performance is an early indicator of financial performance for 2016/17 and that the provider plan profile has a challenging trajectory for the remainder of this year but it should also be recognised that many providers are making demonstrable financial progress and this is a promising start for the sector. Indeed it is noticeable that the sector's achievement of meeting its aggregate financial plan for the quarter bucks the trend of recent periods of being significantly off plan at Q1 recent periods.

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Public Sector Equality Duty:
NHS Improvement has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In drafting this report consideration has been given to the impact that the issues dealt with might have on these requirements and on the nine protected groups identified by this Act. It is anticipated that the issues dealt with in this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Act because this paper is primarily provided for information rather than for decision.

Exempt information:
None of this report is exempt under the Freedom of Information Act 2000.