PERFORMANCE REPORT

Simon Stevens
Accounting Officer
3 July 2017

Chief Executive's Overview

Increasing treatment and care for a growing and aging population mean that pressures on the NHS in 2016/17 were arguably greater than they have ever been. But on most objective measures, treatment outcomes are far better – and public satisfaction higher – than ten or twenty years ago. And as reflected in the NHS Five Year Forward View, there is now an underlying consensus about how care needs to evolve to help 'future proof' the NHS.

In 2016/17 NHS England made good progress in the first phase of implementing agreed national blueprints for cancer, mental health, maternity, learning disabilities and GP services, backed by targeted initial investment. Cancer survival is at a record high, and the first ever waiting times targets for mental health treatments were introduced and met, as was the new dementia diagnosis target. Patient experiences of care remained strong, as reflected in national patient surveys.

The first phase of fundamental care redesign under way through integrated 'vanguard' new care models began to show results, with the rate of per person emergency hospitalisation growth slowing by up to two-thirds. CCGs' work to constrain inappropriate demand meant that the growth rate in referrals to hospital, and the growth in the waiting list for routine operations, both also fell by two-thirds compared with the year before. NHS England produced strong financial performance during 2016/17, with a managed underspend of £902 million, beating our goal of £800 million, and substantially up on our 2015/16 managed underspend of £599 million.

However, despite increased acute hospital beds, delays in being able to discharge patients needing community health, home care or care home places put A&E waiting times under pressure. Last winter was particularly difficult. The NHS was also confronted with some difficult choices within its available funding – for example about the relative priority of ending years of relative neglect of primary care and mental health versus increasing investment in non-urgent elective procedures. While the NHS and

the Government remain committed to short waits, our new mandate for 2017/18 recognises these trade-offs mean that further improvements in waiting times will have to be phased.

For the year ahead we have detailed our plans and approach in our Next Steps on the NHS Five Year Forward View, available at https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/.

It necessarily takes as its starting point the current legislative framework, and the current funding the NHS has been allocated. Future decisions on both are for government and Parliament. The Next Steps plan sets out clear accountabilities for delivering local goals and key national milestones – including better A&E performance, improvements in cancer, mental health and primary care services, and local financial control totals supported by action on major efficiency programmes.

Of course significant risks to delivery remain, such as workforce supply and staff support, the hospital bed occupancy challenge, the resilience of GP services and social care, capital requirements and residual financial gaps. NHS England and NHS Improvement are working with the Department of Health and local health partners to help address these. Doing so will require continued acts of unparalleled leadership across the NHS, at a time of leadership renewal and change. Above all the NHS only succeeds thanks to the dedication and professionalism of our staff.

A fair conclusion from the NHS' recent history is therefore that we have a viable and agreed strategic direction, and progress has been made. But we have a Health Service under real pressure from inescapably rising demand within a tight funding envelope.

Over the last seven decades of the NHS' life, growth in NHS funding has closely followed the ups and downs of wider economic cycles. Since the recession of 2008 the economic picture has again become more challenging. Despite real terms protection, NHS funding growth is much slower than either the historic long term trend or the Office for Budget Responsibility's forecast of what will be needed going forwards.

Next year the NHS turns 70. The Health Service's founding principles of care for all, on the basis of need not ability to pay have stood the test of time. That is unsurprising because the case for the NHS is straightforward. It does a good job for individual patients, offering high quality care for an ever-expanding range of conditions. It reduces insecurity for families, especially at times of economic uncertainty and dislocation, because access to care is not tied to your job or your income. And as one of the world's most cost-effective health systems, it directly contributes to the success of the British economy.

We are determined to play our part in ensuring that it does so in as strong a position as possible. There can be little doubt that that is what our patients, staff and taxpayers all want to see.

Simon Stevens, Chief Executive

Performance Analysis

How we have delivered against our corporate priorities for 2016/17

Our Business Plan for 2016/17 was published on 31 March 2016 and set out our 10 business priorities for the year, detailing how we will improve health and secure high quality healthcare for the people of England, now and for future generations. The priorities reflect the main themes of the mandate and are grouped under themes which embody the agenda of the Five Year Forward View (FYFV): improving health, transforming care and controlling costs.

Improving health – closing the health and wellbeing gap

The 2016/17 business plan set out four priorities under the improving health gap:

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Improving the quality of care and access to cancer treatment	20
Upgrading the quality of care and access to mental health and dementia services	24
Transforming care for people with learning disabilities	28
Tackling obesity and preventing diabetes	31

Throughout 2016/17, work on achieving these priorities was driven forward through a strong focus on prevention, delivering care more locally, and empowering patients to take more control over their own care and treatment. An emphasis on dissolving the divides between physical and mental health, health and social care, and prevention and treatment underlies each of the priorities under the Improving Health section.

Transforming care – closing the care and quality gap

NHS England focused on five main priority areas throughout 2016/17 geared towards closing the care and quality gap:

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Strengthening primary care services	33
Redesigning urgent and emergency care services	36
Providing timely access to high quality elective care	39
Ensuring high quality and affordable specialised care	45
Transforming commissioning: new care models	48

2016/17 has seen increased focus on personalised and co-ordinated health services for patients. NHS England has made demonstrable progress in the integration of primary and acute care to bring services together for local populations that are integrated around the patient. Significant investment has been made in priority services, improving care as well as the patient experience.

Controlling costs and enabling change – closing the finance and efficiency gap

The FYFV set out a roadmap and financial strategy for the period to 2020/21. Resolute action on efficiency is now required to secure the sustainable services we require for the future.

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Delivering value and financial sustainability through a step change in efficiency	58
Developing leading edge science and innovation	61
Transforming care through harnessing information and technology	65
Developing the capability and infrastructure for transformational change	See Accountability Report
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Throughout 2016/17 NHS England has worked with NHS Improvement to implement the recommendations of the Carter Review[3], delivering trust deficit reduction plans and reducing spending on agency staff, as well as working to ensure the delivery of our contribution to the NHS efficiency target. We have recently published in Next Steps on the NHS Five Year Forward View a more detailed efficiency blueprint for the coming years in the form of a 10 point plan for implementation across the NHS.

We have worked with our partners, patients, and local communities on developing new ways of delivering services, making better use of technology, further developing leadership and supporting scientific research and innovation.

3. Operational productivity and performance in English NHS acute hospitals: unwarranted variations https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf.

Cancer

Our 2016/17 commitments:
In April 2016, we will launch an integrated cancer dashboard of outcomes. By March 2017, we will agree an approach for collecting data on long term quality of life for inclusion in the dashboard.
From September 2016, we will begin to roll out a national system of Cancer Alliances.
By December 2016, we will develop a plan for a modern national radiotherapy network, with a revised radiotherapy service specification.
From April 2016, we will support NHS providers and NHS Improvement to achieve the 62-day maximum wait from receipt of urgent GP referral to start of first treatment.
By March 2017, in five local health economies, we will develop and test a new waiting times standard of 28 days from referral to definitive diagnosis, for roll out from early 2017/18.

More people are being treated for cancer than ever before and the standard of care has risen. The latest survival figures show an estimated 7,000+ more people surviving cancer after successful NHS cancer treatment compared to three years prior. Early diagnosis and prompt intervention are the best defence against the disease and give the greatest chance of cure. Over 1.7 million urgent referrals for investigation were made by GPs during the year and the proportion of cases diagnosed as an emergency fell to one in five, the lowest ever recorded.

We are upgrading radiotherapy equipment to create a modern, sustainable service over two years backed by a £130 million investment. The first 23 hospitals have received new or upgraded equipment in 2017, and over 50 new radiotherapy machines in at least 34 hospitals will be rolled out over the next 18 months, subject to HM Treasury approval of the capital business case.

We have established 16 Cancer Alliances and three cancer vanguard sites to lead local implementation of the recommendations of the independent Cancer Taskforce, which recommended an upgrade in prevention, a focus on earlier diagnosis, improved patient experience, better care, extra investment and reformed commissioning. Alliances will take a whole population, whole pathway approach to improving outcomes across their geographical ‘footprints’, building on their relevant STPs.

They are the 'cancer work stream' of STPs. Alliances have developed delivery plans for implementation of independent cancer taskforce recommendations locally.

In 2016/17, the NHS met seven out of the eight cancer waiting times standards. In 2016/17, 119,798 patients referred urgently by their GP with cancer received treatment within 62 days, an increase of 5,902 (5.2%) on 2015/16. However, this equated to national performance for the full year of 82%, against a target of 85%. NHS England and NHS Improvement are working with NHS providers and CCGs to improve speed of care during 2017/18. A national Performance and Delivery Group will oversee implementation of regionally driven recovery plans.

We launched 30 projects across the country to test more efficient pathways to speed the diagnosis of cancer. These included increasing the number of patients who receive a test at their first appointment, managing patients in the most clinically appropriate and efficient manner and increasing the amount of testing that can be processed immediately on site. The work was supported by the National Diagnostics Capacity Fund announced in May 2016.

We began testing a new standard that patients should receive a diagnosis or ruling out of cancer within 28 days in five test sites across the country.

We launched a new integrated Cancer Dashboard in May 2016 to provide a single, high level measure of patient outcomes in local areas to help improve the speed and quality of services. We also commissioned research on the best way of introducing a Quality of Life indicator for cancer patients, working with Macmillan Cancer Support.

East Lancashire Hospitals NHS Trust: Faster Diagnosis for Suspected Cancer Patients

East Lancashire Hospitals NHS Trust (ELHT) has been chosen by NHS England as one of the five test sites developing the 28 day standard.

ELHT receives a high number of referrals for suspected lung and upper gastrointestinal (GI) (oesophageal and gastric) cancers, but less than a third of these will turn out to have cancer.

The trust is working in partnership with local CCGs to test the policy and explore the service changes needed to meet the 28 day target. Initially this will be for patients referred by their GP with suspected lung cancers and upper GI cancers.

Redesigning pathways is crucial. Since November 2016 the trust has been testing and evaluating ways to shorten the pathway initially for patients referred with suspected lung cancer on a two week wait referral into the trust. From January 2017, the trust has been reviewing the pathway for upper GI.

ELHT is making two key changes to the pathways which lung and upper GI cancer patients go through.

For lung cancer patients the trust has created a 'virtual clinic'. When a patient is referred by their GP with suspected lung cancer, a Lung Physician and a Consultant Radiologist conduct a 'virtual clinic' to view the GP letter, x-ray and CT scan results (if available) and decide the next steps before the patient attends their first outpatient appointment. Clinicians are speedily brought together in the virtual clinic and can agree the next steps much quicker and diagnostic tests can be requested earlier. This results in the first outpatient appointment being more effective and efficient.

For upper GI cancer patients the trust is working closely with colleagues in the Endoscopy and Radiology Units to look at the feasibility of booking patients in for a CT scan who need one within two to three days of having their scope. This will lead to a faster diagnosis.

TrueNTH UK Supported Self-Management and Follow-Up

Five NHS trusts are participating in the TrueNTH Supported Self Management and Follow Up Care Project, which was set up to develop and test a new model of follow up care for prostate cancer focusing on self management and remote monitoring.

Men who are identified as suitable to take part in the project do not have to attend clinic appointments unless they have a Prostate Specific Antigen (PSA) rise or other significant issue that requires face-to-face intervention by the clinical team. Instead, they have access to a computer system to support them to self manage aspects of their care. They are monitored remotely by the clinical team via the system and have access to a support worker. They are also invited to attend a workshop to give them the confidence to self manage aspects of their care.

Between June 2014 and December 2016 over 2,000 men were enrolled on the new model of follow up care and 191 workshops were delivered. Feedback from patients and clinical teams has been very positive.

An evaluation is now underway to compare the new model of follow up care with clinic based follow up care. The final evaluation report will be available in August 2017.

Mental health and dementia

Our 2016/17 commitments:
Develop and implement a new national implementation programme for mental health to 2020/21, building on the recommendations of the independent Mental Health Taskforce and the Dementia Implementation Plan.
From April 2016, at least 50 percent of people experiencing a first episode of psychosis should commence treatment with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral, with the aim of increasing to 60 percent over the next five years.
By April 2016, we will work with mental health providers to ensure that 75 percent of people referred to psychological therapies begin treatment within six weeks, and 95 percent within 18 weeks, securing a minimum of 50 percent recovery rate from treatment, with the aim of increasing access to 25 percent over the next 5 years.
From April 2016, maintain a minimum of two-thirds diagnosis rates for people with dementia, whilst agreeing an affordable implementation plan to deliver more consistent access to effective treatment and support.
By March 2017, we will support CCGs to begin implementing plans to improve crisis care for all ages, including investing in places of safety.
By March 2017, we will work with partners to increase provision of high quality mental health care for children and young people to ensure an extra 70,000 have access by 2020, including prevention and early intervention.
By March 2017, we will set out how areas will ensure that children and young people with an eating disorder commence treatment with NICE approved care within clear waiting times for both urgent and routine cases.

We made progress in improving the care of people with mental health problems who in the past have received poorer services than people with physical health problems, suffered worse outcomes and endured stigma and discrimination.

We published the Five Year Forward View for Mental Health by an independent taskforce in February 2016 which recommended new investment in crisis care, psychological therapies, liaison services, children's services and suicide prevention. In July 2016 we published an implementation plan to help an extra one million people receive support, backed by extra investment rising to £1 billion annually by 2020/21. In February 2017, to mark the anniversary of the publication of the Five Year Forward View for Mental Health, we published the One Year On report, which highlights the progress made in the first year of the programme.

We introduced a waiting time standard for a first episode of psychosis from April 2016 to ensure at least 50% of patients are treated within two weeks of referral. The latest performance data (March 2017) show 73.7% of patients were treated within two weeks.

The waiting time standards for psychological therapies under the Improving Access to Psychological Therapies (IAPT) programme were consistently met. The programme has expanded significantly, providing help to more than 3.5 million people since 2008. In February 2017, 89.3% of people began treatment within six weeks of referral to the programme against the 75% standard, and 98.7% within 18 weeks against the 95% standard. The Children and Young People IAPT programme is a shared responsibility with HEE. In 2016/17 the programme worked with services covering 90% of 0-18 year olds in England.

In November 2016 we invited bids from acute hospitals to increase the proportion providing 24/7 liaison psychiatry services in A&E departments from 10 to 20%, with £30 million of funding over two years from within the additional investment set out above. Our ambition is to raise the proportion to 50% by 2020/21.

We achieved the NHS mandate commitment on dementia that two-thirds of those with the condition will be diagnosed. This ambition has been met and sustained since July 2016 and the National Estimated Diagnosis Rate was 68% in March 2017[4].

We are committed to reducing the number of people suffering mental health issues who are taken to police cells as places of safety. We announced 88 projects in autumn 2016 to improve access to health-based places of safety and community-based alternatives. Police figures show the use of police cells fell sharply in 2015/16, accounting for 1,764 (8%) of all Section 136 detentions, down from 3,996 (17%) the previous year. Data for 2016/17 confirming further progress will be available in the autumn of 2017.

We worked to improve early access to care for children with eating disorders. We launched a National Quality Improvement and Accreditation Network for Community Eating Disorder Services and supported CCGs to establish 61 Community Eating Disorder teams to improve early access to National Institute for Health and Care Excellence (NICE) concordat care for children and young people.

We supported CCGs to create Children and Young People's Mental Health Local Transformation Plans setting out how local areas will improve access to services.

4. The level of dementia in the over 65 population that we use to assess the rate of diagnosis uses the Cognitive Function and Ageing Study estimate.

In April 2016, the NAO recognised the progress we had made in setting priorities and national leadership and we are working to overcome the challenges it identified. These included implementing access and waiting times standards, building workforce capacity and capability, and better integration of mental and physical health. ('Mental health services: preparations for improving access', NAO, April 2016).

Stockport CCG - Improved Dementia Diagnosis Service

Stockport CCG had a dementia diagnosis rate of 40% and large increases in waiting times and referrals to memory services, with a need to improve post-diagnostic support.

The CCG implemented a shared care pathway where the management of stable patients with dementia was conducted in primary care with support from a memory service. This meant that there was early recognition and initial diagnosis in primary care with final diagnosis and medication initiation via the memory service. Additional resources were brought in from the third sector to support this pathway.

As a result of this action, the diagnosis rate increased dramatically to over 72% by summer 2016. Additionally, waiting times for memory services were reduced, with 95% of referred patients being diagnosed within 6 weeks and all patients now receiving two dementia reviews each year.

Durham and Darlington Children's and Young Person's Mental Health Services Crisis, Liaison & Intensive Home Treatment Team

The Durham and Darlington Children's and Young Person's Mental Health Services Crisis, and Liaison team (CYPMHS) conducted 1833 assessments between May 2014 and March 2017. Of these around 85% of presentations were seen for assessment in less than three hours therefore greatly relieving the strain on front-line emergency services and offering faster access to mental health care for the patients.

The CYPMHS crisis and liaison team have an open-access service that offers telephone support as well as access to other health professionals including the children's workforce and an out-of-hours response.

The initial comprehensive mental health and risk assessment appointment aims to commence within one hour (four hour maximum) of the referral being received by the service. This is followed up by intensive support within the home, or appropriate setting, for up to 72 hours or until the risks are contained.

Updated information for the service covering the period May 2014 to March 2017 showed that overnight paediatric bed use reduced by approximately 1032 admissions, A&E attendances reduced by around 600 as well as a reduction in waiting times.

40% of CYPMHS crisis assessments now take place in community settings.

Learning Disabilities

Our 2016/17 commitments:
During 2016/17 we will increase the number of people with a learning disability living in homes in the community and reduce the numbers in hospital, to achieve an overall reduction of 35-50 percent by 2020.
During 2016/17 we will increase the number of people with a learning disability who are registered with, and known to, a GP.
During 2016/17 we will increase the number of people with a learning disability having an annual health check.
During 2016/17 we will strengthen the monitoring of the quality of services accessed by people with a learning disability and their mortality rates.
During 2016/17, we will help NHS employers to employ more people with learning disabilities. We will also set an example ourselves by finding good opportunities to include people with learning disabilities within NHS England.

In 2015 we announced that we would reduce the number of people with learning disabilities, autism or both living in long stay specialist hospitals and ensure they received the right care in the right setting, close to home.

Between March 2016 and March 2017 we reduced the number of people living in specialist hospitals from 2,750 to 2,510.

We are now working to deliver a further reduction of around 35% from the March 2017 total over the next two years and we are working with partners such as local government to tackle the barriers to progress identified by the NAO in their recent report. ('Local support for people with a learning disability', NAO, March 2017).

The public consultation relating to the future of secure services in the North West ended at the end of February 2017, and it has been confirmed that a decision has been made to close the Mersey Care Whalley site (formerly known as Calderstones Partnership NHS Foundation Trust), re-providing services in a better way.

To ensure people do not stay in hospital longer than they need we are investing in a whole range of services and support, including a family based initiative to provide support to people in their own homes. Called the Shared Lives model, this provides a carefully matched carer to share their lives with someone with a learning disability.

People with a learning disability suffer poor physical health and die on average 16-25 years earlier than the rest of the population. During 2016/17 we began rolling out the local mortality reviews of all deaths of people with a learning disability, in order to understand and act on these differences. We have worked with 13 organisations to improve the quality of health services and co-design and implement Always Events®[5] and develop two further NHS Quality Checking toolkits, giving seven in total, allowing people with a learning disability to assess the quality of services they use.

As a key step towards reducing the mortality gap, we strengthened the learning disability annual health check process by providing a new standardised template. We also commissioned the Royal College of General Practitioners, Mencap and the National Development Team for Inclusion (NDTI) to support people to receive an annual health check.

In 2016/17 we launched the STOMP project (Stop Over Medicating People) to tackle inappropriate prescribing of psychotropic medication. The Royal Colleges of GPs and Psychiatrists and the Royal Pharmaceutical Society have launched projects of work to support STOMP.

We are improving systems to ensure people with learning disabilities are identified on GP records and their needs met by, for example, exploring using a flag on Summary Care Records to ensure reasonable adjustments can be made.

We are committed to improving employment opportunities for people with learning disabilities in the NHS. The NHS Learning Disability Employment Initiative is designed to support and increase the number of people with learning disabilities employed by the NHS.

At March 2017, 113 NHS organisations had pledged to employ more people with a learning disability, exceeding the original target of 100. Of these 36 were already employing people with a learning disability, with others offering internships or planning to do so in 2017/18.

5. Always Events® are described as "aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time". The learning disability programme has been working with a number of services to co-produce Always Events® with people with a learning disability and their families as a basis of an improvement programme for that service.

People with a learning disability are employed by the NHS England Learning Disabilities programme, which published guidance for NHS Employers and commissioned a more accessible version of the NHS Jobs application form. In November 2016 NHS England participated in the learning disability work experience week organised by Mencap.

Case study

David from Cambridgeshire is someone who left hospital with all the right standards in place. The Intensive Support Team (IST) assisted with David's move from a community hospital to supported living. For the last two years, David has lived in his own place and works at a charity shop three days a week and two days a week at an allotment.

David organises his week to get everything done including shopping, cooking, cleaning and going to the gym. Through regular planning meetings, David was involved in developing his own goals and had increased access to the community without staff and took part in problem solving sessions and was able to address concerns and anxieties, and work out other ways of coping. David went from having 24-hour staff support to having no staff and has been supported to attend education courses in order to get a paid job. He would like to work in car sales. In his own words, David said he "now lives in the real world."

Diabetes and obesity

Our 2016/17 commitments:
By April 2016 we will have the first contracts in place locally for the delivery of diabetes prevention services.
By March 2017 we will have made available to at least a further 10,000 people at high risk of developing Type 2 diabetes support to help modify their diet, control their weight and become more physically active through the prevention programme.

Rising rates of obesity have been accompanied by a rapid increase in Type 2 diabetes. The numbers affected are projected to increase to over 4 million by 2030, causing widespread suffering and putting an immense burden on the NHS.

Since April 2016, the NHS Diabetes Prevention Programme (NHS DPP) has been rolled out to 27 areas, covering nearly half of England's population. The programme targets people at high risk with help to modify their diet, control their weight and become more physically active. The aim is to slow the rise in incidence of the disease and reduce the burden of heart, stroke, kidney, eye and foot problems (and associated mortality) related to it.

The first 27 areas to join the programme began to refer people to the new services between June and December, and at the end of March 2017, total referrals stood at over 30,000, exceeding the 10,000 target set in the NHS mandate.

Building on the success of the NHS DPP in 2016/17, we have expanded the programme for 2017/18 in 13 new STP areas. NHS DPP Framework providers bid through a competitive process during February 2017 and contracts were awarded in March 2017.

For people with Type 1 diabetes, we are working with partners to develop an online resource to support self-management. It will aim to ensure that when someone is newly diagnosed, they have a single, online point of access all of the information and support they need to manage their condition.

In December 2016, we announced £40 million Transformation Funding for Diabetes Treatment and Care and invited CCGs to submit bids. The funds are available to improve multi-disciplinary foot care teams, increase diabetes inpatient specialist nursing capacity, increase the achievement of NICE-recommended treatment targets and improve access to structured education.

Luis, age 40, South London

It was a routine appointment to see the GP which led to 40 year old Luis, from South London, being told his blood sugar levels were high. It's also where he first heard about the Healthier You NHS Diabetes Prevention Programme. After meeting with the Healthier You team and taking another blood test, which confirmed he was at risk of developing Type 2 diabetes, Luis signed up to the programme.

"Because of my medical history, I wasn't that surprised when I learned I might be at risk of developing Type 2 diabetes", said Luis: "I've had cancer before, and my dad has Type 1 diabetes. I have a young family and I'm young too. I want to take good health with me into my old age so I can be involved in my children's lives."

"I was playing basketball twice a week for two hours and I also used to swim about a kilometre every week. So I was quite fit, but my GP advised me to stop playing and exercising for a period of time due to a different health issue."

"This has meant that my cholesterol and sugar levels have shot up in the past 18 months."

However thanks to the Healthier You programme, Luis has recently been told that he can start to be more active again and says "The changes we're making are achievable and sustainable. It's not about dieting and eating less, it's about healthy alternatives and small lifestyle changes...I really do feel better!"

Primary care

Our 2016/17 commitments:
By the end of March 2017, as part of our commitment towards achieving a seven day NHS, we will offer ongoing evening and weekend access to general practice for at least 20 percent of people across England.
By the end of March 2017, we will have accelerated investment in primary care estates and rolled out workforce measures to improve return to work processes for doctors working in general practice, which contributes to securing 5,000 doctors by 2020.
By the end of March 2017, we will conclude contract negotiations for 2017/18 for general practice and pharmacy, and develop an alternative contract option for general practice as part of the new care models programme.

Primary care services are the bedrock of the NHS. They receive around 300 million patient visits a year, which account for most of the contact that patients have with the NHS. But a growing, ageing population and the rise of people with multiple conditions requires both more capacity and new ways of providing care. To meet the rising demand, in April 2016 we set out a multi-billion pound investment and reform plan, the General Practice Forward View, to improve access to general practice services, to invest in new forms of provision, and to increase the workforce.

The GP Access Fund has continued to improve patient access to general practice services, with over 17 million patients (30% of the country) in over 2,500 practices benefiting. We are building on this by providing additional funding to CCGs to commission and fund extra capacity across England to ensure sufficient routine and same-day appointments are provided at evenings and weekends to meet local demand, alongside effective access to urgent and other care services.

The Estates and Technology Transformation Fund is a multi-million pound, multi-year investment in GP buildings. In 2016/17 198 schemes were completed, 169 were in delivery and 656 were in the identified pipeline for potential investment subject to due diligence checks and approval. These schemes are in addition to 560 schemes already completed by the end of 2015/16.

In February 2017, along with the Government and the British Medical Association's General Practice Committee, we reached agreement on changes to the general practice contract in England to benefit patients and GPs. The new contract, to take effect from April 2017, will see investment of around £238 million going into the contract for 2017/18.

A new £30 million national General Practice Development programme has been established, supporting practices to develop new ways of meeting demand and improving the experience for patients.

Over 1,000 practices are able to access support to help them develop under the new £40 million Practice Resilience Programme.

To support the workforce, we now have an easier route to return to practice for doctors who have left general practice, for a career break or to raise a family, through the Induction and Refresher scheme. We have also supported the recruitment of GP trainees to areas where there have traditionally been shortages, through the Targeted Enhanced Recruitment Scheme.

In January 2017 we launched the NHS GP Health Service, a new confidential service which offers support to those suffering stress or mental health issues.

These measures will help us meet the challenges to increasing the GP workforce identified in the NAO report published in January 2017 'Improving patient access to general practice'.

An additional 491 clinical pharmacists were recruited to 650 practices across the country by December 2016. Applications for the next phase of the Clinical Pharmacy Scheme have now been considered; as a result over 200 more pharmacists will be supporting over 700 practices. The number is expected to rise to 1,500 by 2020, backed by an extra investment of £112 million. Roll-out has also begun of mental health therapists working in primary care.

Increasing the number of doctors in general practice

NHS England and Health Education England's revamped Induction and Refresher scheme to attract family doctors back to practice makes it easier than ever to return to the profession.

The first time Dr Frances Clement tried to come back to general practice after a 10-year break she was faced with bureaucracy and gave up in frustration. But thanks to the revamped scheme to attract GPs back, she has returned to work as a salaried GP in Derbyshire, having been supported and funded through retraining.

The 49 year old, who now works seven sessions a week for Royal Primary Care in Chesterfield, admitted: "I'm absolutely delighted by what I have achieved. It's obviously the right thing for me at my stage in life. But if you had asked me two years ago, I would not have been able to imagine how I would be able to make this choice." From gaining a place on the Induction and Refresher scheme to starting her current job took only 11 months.

The newly-simplified GP I&R scheme aims to make it easier for GPs to return to practice after taking time to have children, work abroad or following a change in profession. The hope is to attract an extra 500 doctors into the NHS through this scheme by 2020/21.

Estates and Technology Transformation Fund

More than £320,000 is being invested into Roxbourne Medical Centre at South Harrow, Middlesex. A ground floor extension will provide a new wing to the practice, consisting of additional consulting, rehabilitation and clinical support space. It will be used primarily as a community cardiopulmonary rehabilitation unit.

With major housing developments underway in the area there is potential for an increased list size and requirement for additional clinical space. It is the intention of the practice to work with the local hospital-based cardiology and respiratory teams to develop and run a rehabilitation service for Harrow patients to aid recovery and prevent further admissions.

Urgent and emergency care

Our 2016/17 commitments:
By March 2017 we will deliver the integrated urgent care model described above to at least 20 percent of the country, offering a single all hours telephone number (111) for all urgent care needs, with access to a clinician and, where possible, to an individual's health records when required.
By March 2017 the emergency ambulance service will provide a 999 response that best meets a patient's clinical needs.
By March 2017, we will support hospitals to roll out seven day emergency hospital services to 25 percent of the population, across nine parts of the country. These services will comply with the four clinical standards that have been identified as having the most impact.

Demands on the urgent and emergency care service have been rising steeply for years. Many patients are uncertain about where to get help and how to choose between GP urgent care, the A&E department, the emergency ambulance service and NHS 111.

Next Steps on the Five Year Forward View, published in March 2017, set out our plans to improve the system to provide a modern responsive service to deliver the right care to patients in the right place at the right time.

We have introduced reforms to the NHS 111 service which will allow patients, whenever their condition requires it, to speak directly to a clinician and/or be directly booked into an appointment with the service that is right for them. In the past, callers may have had their symptoms assessed by call handlers to determine their severity before being signposted to their GP or A&E for further advice or treatment. Now, clinicians will give advice and either complete on the phone or refer to the most appropriate point of care. Patients will increasingly have direct access to a greater range of more senior clinicians. This is already the case for 30% of callers, up from 22%, and will continue to increase.

We are trialling changes to the emergency ambulance service, to help meet rising demand from a population with changing needs and expectations. The changes are aimed at reducing wasted journeys to patients with less serious conditions and involve providing callers to 999 with telephone advice, treatment at the scene, or conveyance to hospital or elsewhere, as clinically appropriate. This means ambulance staff will be able to allocate calls more accurately and deliver the right resource to the right patient at the right time, with improvements in efficiency and performance.

We developed a set of 10 clinical standards to improve the quality of emergency care, four have been prioritised as most likely to have the greatest impact in tackling variation in quality and safety and experience of hospital care and improve patient flow through a hospital. The four priorities to be met, whatever the day of the week, are: being assessed by a specialist consultant soon after admission to hospital; having necessary tests promptly; having emergency treatments without delay; and being reviewed by specialists daily in high dependency areas. In early 2017 more patients should be receiving care that meets these standards seven days a week. By November 2017 the standards should be met for all patients at all times in five urgent specialist services – major trauma, paediatric intensive care, hyperacute stoke, emergency vascular surgery and STEMI heart attacks.

The Next Steps on the Five Year Forward View sets out an expectation that Trusts and CCGs will be in line with the Government's 2017/18 mandate to the NHS, ensure that:

1. in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours. This compares with 89.1% for 2016/17

2. the majority of trusts meet the 95% standard in March 2018, and the goal that

3. the NHS overall returns to the 95% standard within the course of 2018.

During winter 2016/17, hospital inpatient beds actually increased, but elective capacity fell as a result of sharp increases in 'delayed transfers of care'. The single most important operational dependency for improved A&E waiting times in 2017/18 will therefore be the extent to which additional social care investment helps hospitals free up inpatient beds for emergency patients. By the end of 2017/18, all trusts will have implemented co-located primary care streaming into their emergency departments to support treatment of minors. Thus far 98 trusts have had capital funding made available to them to support any capital development needed to implement this service in time for winter 2017/18. Hospitals will speed up the assessment process and ensure that patients are able to return home as soon as possible and if home is not the best place for their immediate care, they will be transferred promptly to the most appropriate care setting for their needs. We will standardise access to 'Urgent Treatment Centres' through booked appointments via NHS 111. These facilities will be open 12 hours a day, staffed by clinicians, with access to simple diagnostics.

Urgent Response Assess at Home pathway

A patient with Multiple Sclerosis was admitted to hospital with a broken leg; as a result, she had high care needs and was not to put weight through her leg for 6-12 weeks whilst it healed.

Hospital therapists liaised with the community Urgent Response team who booked a 'discharge to assess pathway', which included equipment and a home care package.

When the patient arrived home, it was identified that the equipment was unsuitable for her environment and that three carers were needed for each visit. An urgent therapy assessment at home facilitated more suitable equipment that reduced the care package back to two carers and re-enablement subsequently reduced this further to one carer visiting twice a day.

This pathway helped the patient's rapid discharge from hospital as well as helping to prevent further crisis or re-admission to hospital or a care home as well as more appropriate commissioning of lower intensity longer term care. Overall, patients on this pathway are discharged from hospital sooner with a 25% reduction in long term care needs. 20% of patients are independent within 6 weeks.

Elective care

Our 2016/17 commitments:
By April 2016 we will begin to implement the maternity review.
By March 2017 we will ensure that commissioners are commissioning the care needed to achieve recovery of the NHS Constitution standards for elective care and support providers and NHS Improvement to help hospitals deliver them.
By March 2017 we will have set out significant improvement in the patient referral process and patient journey to better meet patient needs, deliver genuine choice and manage demand for elective care, for wider adoption by providers and commissioners.

The number of patients treated by the NHS continues to rise and during 2016/17 there was substantial progress made in slowing the rate of referral into hospital care. Referral growth fell by two-thirds compared with 2015/16. However, capacity constraints in acute hospitals linked to extended emergency inpatients stays meant hospitals struggled to expand their elective operations. The combined effect of these two variables – much better CCG demand management but with hospital capacity constrained – was that waiting lists rose, but by two-thirds less than in 2015/16. At the end of March 2017, 90.3% of all patients on the waiting list for non-urgent treatment had been waiting less than 18 weeks, compared to the 92% standard.

The number of treatment episodes (Referral to Treatment [RTT] pathways) completed each day increased by 4.7% in 2016/17 compared with 2015/16.

In 2016/17 we added resources to the regions to support elective care redesign and published a demand management guide, listing actions CCGs should consider implementing locally, particularly to reduce unnecessary outpatient appointments. These include peer review of referrals, shared decision making and alternatives such as group or nurse-led consultations.

We designed new ways to deliver specialist care and tested them in pilot sites as part of the Elective Care Rapid Testing Programme. We are now providing further support to new vanguard sites.

Renal e-clinics in Tower Hamlets

Tower Hamlets Together has created a single pathway from primary to secondary care, with rapid access to specialist advice provided by consultant led e-clinics which has transformed the way the renal outpatient service is delivered.

GPs refer patients to an e-clinic, which is run by a community based nephrologist, who reviews patient notes and provides advice back to the GP via the EMIS web system. E-clinics are coupled with an education package with clear guidelines for GPs and multi-disciplinary teams on how to manage this process. In a six week pilot phase across 19 practices in Tower Hamlets, 50% of referrals were managed without the need for an outpatient appointment.

Tower Hamlets have successfully enabled joint access to patient records, which is a key factor in the success of this model. Though this has been done in renal services, the principles can be applied to other specialities. Local transformation teams are currently working to spread this model across all other specialities in the health system.

Bedford Musculoskeletal disorders (MSK) Referral Management Centre

Bedford Referral Management Centre (RMC) has implemented a model where 95% of all musculoskeletal disorders (MSK) referrals go through the RMC. Referrals are triaged by extended scope physiotherapists within 24 hours, and trust consultants are also integrated into this hub, enabling shared decision making for major surgery. The remaining 5% of referrals not managed through the hub equates to 18% of secondary care activity.

Benefits from this model are numerous; for instance, up to 30% of GP decisions are changed so that the patient receives the most appropriate treatment and is not routinely directed to secondary care. It also shows a significant difference in performance between providers that are contracted by the RMC and those that are not (92% vs. 83% RTT performance for Trauma and Orthopaedics respectively). Contracted providers are able to direct referrals to the right consultant, reducing the risk of a referral being rejected or an inappropriate referral being made.

Bedfordshire CCG is now among the 10 CCGs in the country with the lowest inpatient activity per 1,000 of population and has seen a more significant decrease in inpatient activity than similar, benchmarked CCGs. Finally, there has been an improved utilisation of community care through this initiative.

Maternity care

Following the launch of the National Maternity Review Report 'Better Births' in February 2016, we established the Maternity Transformation Programme (MTP) to ensure all women get high quality maternity care regardless of their circumstances or where they live. The MTP will give women greater control and more choice, as well as making care safer, by providing information and support based around their needs and circumstances, and those of their babies.

As recommended in Better Births we have brought local providers, commissioners and other stakeholders together by forming 44 Local Maternity Systems (LMS), based on STP geographies, across England. These LMS will ensure that by October 2017 every part of England has a plan in place to implement Better Births. A LMS resource pack to support implementation of Better Births was published in March 2016.

From January 2017 early adopters have been working to implement key elements of Better Births including improved postnatal care, choice, personal care planning, safer care, continuity of carer, electronic patient records, bringing services together and closer to users through community hubs and new models of care co-designed with service users.

In May 2016 NHS England established seven Maternity Choice Pioneers who are working to extend the choices available to women including through the introduction of Personal Maternity Care Budgets (PMCBs). All of the pioneers have now launched their PMCBs. By March 2017, 81 women had benefited from a PMCB and by the end of 2017/18 10,000 women will have been offered a PMCB.

In February 2016 the Maternal and Neonatal Health and Safety collaborative was launched and the 44 Trusts who are taking part in wave 1 were announced. The collaborative will work with providers and commissioners to improve clinical practices, reduced unwarranted variation and support delivery of the Secretary of State's ambition to halve neonatal mortality, still-birth, serious brain injury and maternal mortality by 2030. During 2016/17 we supported the roll out of the Saving Babies Lives Care bundle which sets out evidence based priorities and actions for reducing still-birth. Over 90% of all NHS Maternity Providers are implementing activity across all four elements of the care bundles to reduce smoking in pregnancy, better detect foetal growth restriction, raise awareness of reduced foetal movement and effective foetal monitoring during labour.

In December 2016 we provided £2 million to CCGs with the highest rates of smoking at time of delivery to invest in proven interventions to reduce smoking during pregnancy.

In August 2016 the specialist perinatal mental health community services development fund was launched to promote service development and quality improvement and increase the availability of high-quality care for women and families. 20 proposals have been selected for wave 1 covering 90 CCGs and all four NHS regions. In 2017/18 we will set out further plans to expand specialised perinatal mental health services including additional Mother and Baby Unit capacity.

Birmingham and Solihull United Maternity and Newborn Pathway (BUMP) Early Adopter

Birmingham and Solihull United Maternity and Newborn Pathway (BUMP) is one of seven maternity Early Adopters which are being supported to test key recommendations from Better Births, the report of the National Maternity Review.

BUMP focuses on providing women with a single point of access with midwives as their first point of contact. This will ensure that women are supported by a midwife throughout their journey and helped to make informed choices about their care.

The service aims to increase the number of women choosing to give birth in midwifery led units or home births. It also aims to provide a multidisciplinary community maternity team which will provide continuity of carer to women and their families and increase provision of community antenatal care. This will help to improve outcomes in areas such as infant mortality, experience of care and the ability to deliver care closer to home.

BUMP is working to create a single maternity Electronic Patient Record for all pregnant women and to commission new care providers to enhance the portfolio of providers.

North East London Choice and Personalisation Pioneer

Waltham Forest, as part of the North East London Pioneer project, have increased their choice offer to women in each part of the maternity pathway by introducing a new provider, Neighbourhood Midwives, who offer a continuity of carer model to women on a standard pathway. The Maternity Choice and Personalisation Pioneer programme will work with Waltham Forest and Neighbourhood Midwives to understand the learning from this in relation to pricing, commissioning, outcomes and the local maternity system and will share this learning through the wider maternity transformation.

Specialised care

Our 2016/17 commitments:
By January 2017, we will articulate and communicate the overall strategic vision and strategy for specialised commissioning over the next five years.
By March 2017 we will implement new arrangements for the Cancer Drugs Fund.
During 2016/17 we will continue to invest in Proton Beam Therapy which will see the first patient treated in the UK in August 2018.
By March 2017 we will have completed at least seven national service reviews to improve value and quality for patients.
During 2016/17 we will give CCGs stronger leadership of collaborative commissioning of specialised services.
During 2016/17 we will embed an Integrated Quality Surveillance Programme for specialised services and cancer services and establish a rolling programme of peer reviews for services where there are variations in quality of care.
By March 2017 we will have developed and delivered a new high cost drugs and devices procurement approach.
By March 2017, as part of our ongoing Improving Value programme, we will have delivered Quality, Innovation, Productivity and Prevention (QIPP) project plans for national schemes that will deliver benefits in the 2017/18 contracting round.

The demand for new, innovative and often expensive treatments is rising rapidly. To meet these challenges, we have developed and tested a new strategic framework which sets out our overall vision for specialised commissioning, in line with the FYFV.

Following consultation, we implemented a new process for prioritising new investments in specialised services and strengthening clinical leadership and patient and public involvement through a refreshed clinical reference group structure for the six National Programmes of Care: internal medicine, cancer, mental health, trauma, women and children, and blood and infection.

We implemented a new operating model for the Cancer Drugs Fund (CDF), working with the National Institute for Health and Care Excellence (NICE), under which 25 drugs treating 42 indications are currently being accessed by patients. This has been effective in containing spend in the total CDF budget.

The first Proton Beam Therapy Centre in England is due to open in 2018, in line with the prime ministerial commitment, and in the meantime we are continuing to fund treatment overseas for those patients who are clinically appropriate.

Our programme of National Service Reviews has included congenital heart disease services, specialised children and adult mental health services, medium and low secure adults' mental health services and perinatal mental health services

During 2016/17 the National Oversight Group (NOG) for High Secure Hospital Services has focused on the work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which inspected secure hospitals last year and compliance with the Mental Health Act 1983 Code of Practice; paying particular attention to the number and circumstances around patients being in long term segregation and seclusion. This work continues into 2017/18 with the reporting arrangements to NOG changing to reflect this key area. The review into the High Security Psychiatric Services (arrangements for Safety and Security) Directions 2013 continues and we expect to consult on the revisions later this year. This work is being led by the Department of Health, working with colleagues at the high security hospitals and NHS England, with the aim of ensuring the Directions reflect more contemporary clinical and security best practice.

In December 2016, we announced an expansion of the HIV prevention programme to provide access to Pre-Exposure Prophylaxis through a large scale clinical trial.

To help tackle variations in care across the country, we have established an Integrated Quality Surveillance Programme under which 200 peer reviews have been completed to support providers to meet published standards in specialised services and cancer services.

We have developed a new approach for procuring high cost devices which is on target to deliver substantial savings through economies of scale. We are implementing a new national approach to purchasing medical technology devices with all hospitals using a single national online catalogue. This means the NHS national purchasing clout secures substantial savings allowing us to reinvest substantial resources in patient care. We also reshaped the Identification Rules (IR) for specialised services to more accurately reflect the content of the Specialised Service manual and supporting service specification. Business intelligence reporting has been developed to facilitate discussion with STPs about specialised commissioning in their area.

Rolling out new oral treatments for Hepatitis C

The largest single investment in new treatments in the year was for new oral Hepatitis C treatments. We now have evidence that this investment and the approach to manage access through operational delivery networks who prioritise those in greatest need has reduced deaths and liver transplants within the first year of introduction. By end of March 2017 we are on target to have treated approximately 16,000 patients, which amounts to more than 10% of the total infected population. Since we have followed NICE guidance to focus on those at greatest clinical need, this has led to a rapid reduction in death rates (by 11%) and a reduction in transplantation for Hepatitis C Virus of 50%.

Transforming commissioning: new care models

The national bodies are committed to enabling new care models and are working together to deliver the following:
During 2016/17 we will track progress in the vanguards using clear national and local measures.
During 2016/17 we will support the design and delivery of the sustainability and transformation planning process to enable the spread of new care models.
By June 2016, we will have developed and published common frameworks for MCPs, PACS and enhanced health in care homes.
During 2016/17, we will start testing new payment approaches, including whole population budgets, as well as approaches to gain and risk share that align financial incentives across local health systems.
By September 2016, we will work with the vanguards to co-produce frameworks for the new organisational forms that will help other areas to deliver new care models.
By March 2017 we will be testing a new contract for MCPs and PACS, for use in 2017/18.
Over 2016/17, we will enable and support MCPs and PACS, as well as Greater Manchester and the North East, to contribute to system-wide changes in 15 to 20 percent of the country.
During 2016/17, we will work with 10 new towns and developments to 'design in' health and healthy environments, and to create health services delivered making the most of technology and patient engagement.

NHS England has worked closely with other health sector bodies including NHS Improvement, Care Quality Commission (CQC), Health Education England (HEE), National Institute for Health and Care Excellence (NICE) and Public Health England (PHE), to develop solutions to the multiple challenges the NHS faces by transforming the way care is delivered, following the strategy set out in the FYFV.

As part of this effort, the programme was launched in March 2015 to develop new ways of working that will act as blueprints for the future. The new care models (NCM) programme received £148 million of funding in 2016/17 to bring together best practice and support the development and spread of new models of care.

A further £100 million transformation funding has been allocated to existing vanguards for 2017/18 to demonstrate implementation of the new approaches at scale, support their spread and ensure the wider NHS learns from their experience.

The vanguards are led by front line clinicians, managers and patients and are testing new approaches by creating networks of care, breaking down the barriers between hospital, community services, primary and social care.

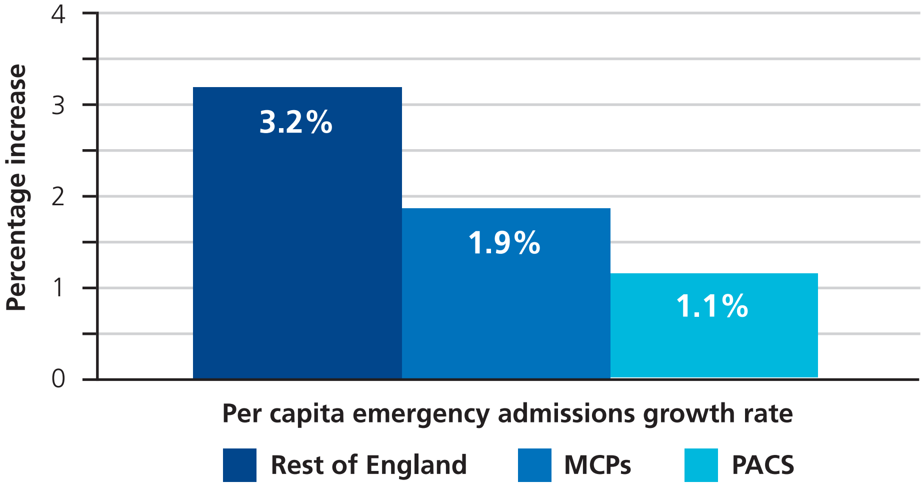
Vanguards have aligned their work to published frameworks for the multispecialty community provider (MCP), integrated primary and acute care system (PACS), and enhanced health in home care vanguards, whilst continuing to respond to the needs of their local communities.

We have worked intensively with vanguards, including those in Greater Manchester and the North East, to develop new arrangements for commissioning and assuring services under the MCP model last published in February 2017. A draft version of the contract was published in December 2016 for a period of engagement, and we will shortly publish an updated version of the contract which is ready for use by commissioners to help inform the early stages of their procurement processes.

We have been working closely with a number of vanguard areas across the country to co-develop a whole population budget methodology, which will focus on outcomes rather than activity, and incentivise prevention. An initial version of the 'Whole population models of provision establishing integrated budgets handbook' will be published in the coming months for a period of public engagement and feedback.

Compared to their 2014/15 baseline both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England. Given sample sizes and duration it is important not to over-interpret the data currently available. However, comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%.

MCP and PACS vanguards have seen lower growth in per capita emergency hospital admissions than the rest of England



NB: This chart compares the most recent 12 months for which complete data is available (January-December 2016) with the twelve months prior to the vanguards commencing (the year to September 2015).

Alternatively taking the full financial year April 2014-March 2015 before the vanguards were selected as the baseline period, per capita emergency admissions growth rates were: PACS 1.7%, MCPs 2.7% and rest of England 3.3%. Vanguards such as Morecambe Bay, Northumberland and Rushcliffe are reporting absolute reductions in emergency admissions per capita. As intended, the benefit has been greatest for older people. The Care Homes vanguards are also reporting lower growth in emergency admissions than the rest of England, and meaningful savings from reducing unnecessary prescribing costs.

The New Care Models programme has continued to support the 25 integrated care pioneer sites that are testing new ways of joining up health and social care services across England. We started work with a further cohort of 22 small district general hospitals to test new ways of improving their quality, efficiency, and effectiveness in order to sustain smaller local district hospitals in their communities.

We supported the National Association of Primary Care to develop the Primary Care Home (PCH) model, which is being tested in 92 'community of practice' sites covering a total population of around four million. The programme is aimed at developing a new model of primary health care for a population of 30,000 to 50,000 centred around the needs of local communities, with multidisciplinary teams delivering personalised and comprehensive care.

East and North Hertfordshire CCG Vanguard - Enhanced health in care home

East and North Hertfordshire CCG vanguard (enhanced health in care home) has employed pharmacists to work with GPs, care home staff and other healthcare professionals to provide in depth medicine reviews for residents. Improved IT also means they can now access patients' records using laptops in the care home, allowing a more thorough review alongside each resident's care plan and medicines record. Working with 25 care homes, the vanguard has already seen over 901 patients and reviewed the use of 8,183 medicines. 1,015 medicines have been stopped, including 198 which could have increased the risk of falls. The direct cost savings are estimated to be around £160,000 or £181 per patient.

Fylde Coast Local Health Economy

Fylde Coast Local Health Economy vanguard (multispecialty community provider) has created a new 'extensive care service' which brings together different health professionals who offer dedicated, targeted support for older patients with multiple conditions. National vanguard funding means the care model is being rolled out across the entire Fylde Coast with every GP practice able to refer eligible patients. Early indications from their figures show a 13% reduction in A&E attendances, 25% reduction in non-elective admissions and 18% reduction in outpatient appointments. Most notably, there has been a 37% fall in planned visits to hospital among patients receiving support.

The Better Together Vanguard

In mid-Nottinghamshire, the Better Together vanguard (integrated primary and acute care system) includes a total of eight joined-up community teams who work with patients, their families and carers to provide physical, mental and social care support to ensure people are cared for at home wherever possible. The vanguard has reported a reduction in acute bed days and reductions in long term admissions to care homes. They have also reported a 5.4% reduction in avoidable patient attendances for 18-79 year olds and 20.5% for patients aged 80 years and above (compared to 2015/16).

Healthy New Towns

We supported 10 demonstrator sites to form partnerships across the NHS, local government and housebuilders to produce detailed delivery plans that re-think how health and care services can be delivered and shape the health of their communities. We helped them design new care models and engage patients in developing them, embed health-improving interventions in the technical town planning process and pilot new models to support people to lead healthier lives.

The ten sites formed collaboratives to address common problems and share expertise – focusing on the built environment, new care models, community engagement and evaluation – and we are inviting global innovators to enter a competition to design a practical healthy new town.

Transforming commissioning: Personalisation and choice

Our 2016/17 commitments:
By October 2016 we will develop a detailed strategy and delivery plan to ensure we are able to meet the mandate commitment to increase the number of personal health budgets and integrated personal budgets to between 50-100,000 by 2020/21.
By June 2016 we will launch a programme to improve choice for women during maternity, in at least three test sites.
By March 2017 we will promote and support the implementation of a Choice Commitment to improve choice in end of life care.
By March 2017 we will develop a robust operational structure to enable national roll out of Integrated Personal Commissioning.

The NHS is moving from a 'one size fits all' approach to care which is increasingly personalised to the individual. Since September 2014, people with long term complex conditions who receive NHS Continuing Healthcare (CHC) have had a legal right to have a Personal Health Budget (PHB), enabling them to tailor the care they receive to better meet their needs.

We have been implementing Integrated Personal Commissioning (IPC) in Demonstrator sites since April 2015, a new model of care for people with complex needs that includes blending health and social care funding and offering people integrated personal budgets that give them more control over how resources are used for their care. In 2016/17, we extended the roll-out of IPC through an additional set of early adopter sites and also across Greater Manchester, so that 40 CCGs are now actively implementing IPC.

In 2016/17, we made personal health budgets available to a wider range of other people who would benefit from personalised services, such as people who use wheelchairs, mental health services, and end of life care services, people with a learning disability, and children and young people.

By the end of March 2017, 15,811 people were benefiting from a personal health budget; more than double the number in September 2015. Since November 2016, every CCG in England has been working towards robust trajectories for the number of personal health budgets they will deliver, putting us firmly on track to achieve the mandate commitment of 50,000 to 100,000 by 2020/21.

To support this delivery, we have published a comprehensive set of practical delivery support materials for IPC and PHB, including the IPC Operating Model and these have been co-developed with key stakeholders across the system.

In May 2016, we established seven Maternity Choice and Personalisation Pioneers, involving 36 CCGs, to improve choice and control for women in maternity, including through Personal Maternity Care Budgets (PMCBs). By the end of March 2017, 81 women were benefitting from a PMCB, and Pioneers are putting in place plans to provide 10,000 PMCBs by March 2018.

Following the DH's July 2016 response to the Review of Choice in End of Life Care, we launched a national programme to promote the changes necessary for the NHS to meet the Government's End of Life Care commitment of consistently high quality, personalised care, and are developing PHBs in End of Life Care in five areas with the aim of promoting their adoption across the country.

In August 2016, NHS England and NHS Improvement jointly published 'Securing Meaningful Choice: Choice Planning and Improvement Guide', a self-assessment framework for CCGs to improve patients' choice over where and how they receive their care. CCGs have begun to adopt the guide, and we are now working with a range of CCGs to demonstrate improvements and the resultant benefits to patients and the NHS as we aim to ensure that all CCGs are fully compliant with choice standards by March 2019.

Personal health budgets improving end of life care in Warrington

NHS Warrington CCG is working with a local hospice to offer personal health budgets (PHBs) to people receiving end of life care within the hospice, as well as those who choose to remain at home.

Hospice staff identify suitable recipients for PHBs through the Fast Track funding process and have been trained to co-develop personalised support plans and identify health outcomes with patients.

Four months into the pilot, 17 people have received PHBs, which have been used for a range of services to support health outcomes, such as pain management and mental health care. Traditionally, the home care and support package consists of four visits per day and three overnight stays. All recipients of PHBs in the pilot have opted for alternative care and support to this traditional offer, with a fully tailored package and plan put in place that includes services and support the individual may be accessing in the community.

Each of the PHBs has resulted in a more efficient use of resources. Work is now in progress to offer PHBs to people not accessing the hospice service, in order to secure equity of access and support across the locality.

Seeing the financial benefits of Integrated Personal Commissioning in the South West

North, East and West (NEW) Devon has been part of the Integrated Personal Commissioning (IPC) programme since 2015, and joined the programme as a fully-fledged demonstrator site in 2016.

Strong links have been made into local Transforming Care and Special Educational Needs and Disability (SEND) programmes as well as with other associated programmes such as the Better Care Plan, the Success Regime and with Integrated Care Exeter. Here, IPC is seen as the foundation for the development of new models of care to support people with long-term conditions and complex needs.

NEW Devon is working towards making personal health budgets (PHBs) a routine offer for patients within Continuing Healthcare (CHC), and for jointly funded packages of care. The PHB 'offer' will be extended to cover people with mental health problems, learning disabilities and autism plus people with multiple long term conditions.

NEW Devon's work with around 100 people eligible for CHC who are in receipt of a PHB has built local confidence that PHBs improve health outcomes and deliver services more efficiently. NEW Devon has estimated that traditional health and care spending for these people would have been around £7.3 million in 2016/17, and that the provision of PHBs has resulted in efficiencies of around £1.3 million (20%).

Commissioning development

Our 2016/17 commitments:
During 2016/17 we will continue to oversee integration of health and social care through the Better Care Fund.
During 2016/17 we will support the roll out of full co-commissioning of primary care to the majority of CCGs.
During 2016/17 we will enable CCGs to have stronger leadership and influence of collaborative commissioning of specialised services.
By April 2017, we will ensure that every commissioner has access to excellent commissioning support, including leading edge business intelligence and analytics, through completing the nationwide roll out of the Lead Provider Framework.

Strong commissioning is vital to the future of the NHS and we have worked to ensure it continues to evolve with the changing role of CCGs.

A key objective is integration of health and social care. The Better Care Fund was established in 2013/14 to provide a partially pooled budget for the NHS and local government. In 2016/17, the third year of its operation, the budget for the Better Care Fund rose to £5.9 billion. Of 150 Health and Wellbeing Boards, voluntary contributions to 119 were more than the minimum.

Through the roll out of delegated commissioning, CCGs take on responsibility for commissioning primary care services to promote and develop integration, aligned to wider CCG plans and STPs for improving health services. We have seen benefits in terms of improved quality of care, improved access to primary care, greater local ownership of development of primary care services, increased clinical leadership and more local decision making, greater involvement of patients and a more sustainable primary care service for the future.

Progress on the roll out of delegated commissioning is set out on page 135 of this annual report.

We have strengthened support services for NHS commissioners through the Lead Provider Framework which was established to drive up the quality of services and the value for money for taxpayers. At the end of March 2017, 109 CCGs had launched procurements for external support worth over £480 million, including population health analytical solutions, demand management and capacity planning support, and ICT transformation.

Financial sustainability

Our commitments for 2016/17:
By November 2016 we will roll out RightCare to the first wave of 60 CCGs, followed by the remaining 150 CCGs starting in December 2016.
By March 2017 we will achieve planned reductions in spending through RightCare, and ensure NHS England's contribution to the overall efficiency agenda across other programmes.
During 2016/2017 we will drive the transformation of services by rolling out new methods of assessing value in investment and developing payment systems and tariff structures.

The NHS faces very significant challenges in terms of controlling costs and improving care in order to achieve financial sustainability, as highlighted by the NAO in their report, Financial sustainability of the NHS, published in November 2016.

The RightCare programme, which compares performance across the country in order to reduce unwarranted variation and secure the best value for money, is a key part of this drive.

In 2016/17 we rolled out NHS RightCare to all 209 CCGs in England. Each CCG has agreed a timeline for identifying planned savings under the programme, based on comparing their performance with ten similar health economies, and will report against them. Typically, it takes around nine months for a first cycle of change but there are already examples of positive progress and tangible improvements to outcomes and value. One such example is Slough CCG, which introduced a new complex care case management service that has reduced targeted demand on A&E by 24% and non-elective admissions by 17%.

The RightCare approach is focused on capturing opportunities to reduce unwarranted variation and increase value, securing agreement among stakeholders for change and a plan of action, and reaching agreement on measures to monitor its impact on a quarterly basis to 2020.

Cumbria CCG's Pain Management Service

The NHS RightCare Commissioning for Value 'Where to Look' pack highlighted musculoskeletal (MSK) services as one of Cumbria CCG's key opportunities for improvement, with the pain service as a key component. Cumbria CCG had a high spend for back pain injections compared to their most similar 10 CCGs.

The CCG brought key players together to design an optimal care pathway and the outcome was the persistent physical symptom management service (PPSS). It was introduced in April 2016 and offers GPs a single point of access to a biopsychosocial symptoms management service, whatever the patients' diagnosis. Early evaluation shows the new service is helping to improve access, has high patient and GP satisfaction, and highlights a reduction in drug prescribing. There is also a positive improvement on core measures for IAPT, depression and quality of life outcomes.

North Kirklees CCG over the counter medicines

As a wave 1 CCG, North Kirklees used Commissioning for Value data as a starting point to identify areas of unwarranted variation in the local health economy. One area that was quickly prioritised for action and capable of yielding improvements was prescription of analgesia.

The data identifying unwarranted variation was reviewed by the clinical strategy group. This was essential in driving clinical engagement, and provided an opportunity for a wide range of clinicians in the geography to challenge, understand and ultimately buy into the view that there was an opportunity to improve prescribing spend. The group also reviewed evidence of where similar CCGs had introduced successful interventions, including over-the-counter (OTC) schemes.

A number of clinically-led interventions were developed, with an OTC scheme approved as a priority to drive better value quickly. The CCG led a campaign aimed at encouraging patients to not ask for cheaper, generic medicines such as ibuprofen or paracetamol on prescription therefore linking the associated costs and savings to other services where the funding could be better used such as community nurses, breast cancer treatment and cataract operations.

In 2017/18 we will be progressing the 10 point plan for efficiency, which has been published as part of the Next Steps on the NHS Five Year Forward View document and forms the blueprint for implementation of the joined up national and local efficiency improvement initiatives required to ensure financial sustainability over the coming years. Further detail is included in the CFO report on page 75.

The NHS and, where appropriate, local councils have come together in 44 areas across England to develop joint plans for health and care, strengthen local leadership and agree how to improve services within the total resources available, focusing on the needs of the populations they serve rather than of individual organisations. STPs represent a shift in how the NHS commissions and delivers services, with the focus on closer integration of health and social care and place-based planning.

The plans vary in their levels of detail and ambition, reflecting the strength and length of local relationships. Regional and local teams will work with the STP leadership teams to ensure they develop and implement good quality plans, with the aim of making services easier to access, keeping people healthier for longer, reducing avoidable demand growth for acute hospital care and promoting co-operation between health and social care.

Science and innovation

Our 2016/17 commitments:
During 2016/17 we will continue to develop our strategy for a Personalised Medicine service, encompassing underpinning diagnostic services.
During 2016/17 we will deliver the NHS contribution to 100,000 Genomes project.
During 2016/17 we will continue central funding of the Small Business Research Initiative and seek external investment and experience to promote products for priority areas.
During 2016/17 we will support our Academic Health Science Networks to help drive the uptake of innovation in the NHS at local and regional level.
During 2016/17 we will continue to sponsor Healthcare UK, the international brand for the UK healthcare industry, jointly with the DH and UK Trade and Investment.
During 2016/17 we will produce a research plan, developed with our partners, setting out our programme of work to identify research priorities, help increase patient recruitment into trials, and continue to address concerns about excess treatment costs.
By January 2017 we will deliver interim results on the innovations being trialled in the seven real world test beds we have established for evaluating new technologies and approaches that offer better care at the same or lower overall cost.

Our continued investment in science and innovation has contributed to UK economic growth and supported the NHS in its aims of improving patient outcomes and experience. We have taken the first step in defining how we will commission future research to meet the needs of the NHS and set the groundwork for delivering radically different diagnostics of cancer and rare diseases which will positively impact the treatment of thousands of patients.

Personalised medicine

Across the world, scientific discoveries and technological advances in genomics, informatics, analytics and bio-nanotechnology are transforming our ability to more precisely diagnose illness and target treatment of disease.

The concept of tailoring interventions is not new, but never before has it been possible to identify the underlying cause of disease, predict how each of our bodies will respond to specific interventions, or determine which of us is at risk of developing an illness.

In September 2016, we published Improving Outcomes through Personalised Medicine which sets out our intention to support the NHS to embed genomic medicine into routine care, to lay the foundations for personalised treatments and interventions.

100,000 Genomes

By the end of 2016/17, the 13 NHS Genomic Medicine Centres established to collect samples and engage patients and family members in the programme had collected over 25,000 rare disease and over 4,000 cancer samples. Over 20,000 whole human genomes have been sequenced. By sequencing the genomes in these samples not only can we better understand these diseases, but we can also target specific treatments at the patients who will benefit most from them. The main cancer programme of the project is live and multi-disciplinary teams have been set up to handle the return of sequencing data and the validation of results. This is a world leading project, preparing the NHS to embed genomics as part of routine NHS care where it is clinically and cost effective to do so.

Test beds

Since announcing the seven test beds in January 2016, the programme has facilitated the formation of seven public-private partnerships, in which NHS organisations have partnered with around 40 digital technology companies. A conservative estimate is that the programme has leveraged £15 million (this is about three times more than the £5.1 million NHS England has invested).

All seven test beds have transitioned from design and mobilisation in year 1 to delivery in year 2; for example Lancashire and Cumbria Innovation Alliance is testing digital tools (wearables and sensors) with 1,600 people living with a long term condition identified through their redesigned vanguard patient pathways. The programme will be developing tools for others to use.

National Innovation Accelerator

The scheme supports individuals to develop innovations for the NHS. It recruited a further eight fellows in 2016/17, bringing the total to 25. The themes pursued by the new fellows were prevention, earlier intervention and long-term condition management.

The initial cohort of 17 fellows, appointed in 2015/16, have secured £20 million of additional funds to support the development of their ideas. These include digital health innovations which focus on reducing health inequalities, such as Patients Know Best, an online patient engagement system which empowers patients to take control of their medical records, MyCOPD, providing online rehabilitation for patients with Chronic Obstructive Lung Disease at home, and DrDoctor, an online platform allowing patients to book and cancel appointments. These innovations are being evaluated and rolled out in 419 NHS organisations.

Exemplar Clinical Pathways

In late 2015 NHS England began work with the Academy of Medical Colleges, to co-develop exemplar Clinical Pathways. The Pathways demonstrate how personalised medicine approaches could be built into the diagnosis and treatment of significant diseases. The work of the Academy culminated in Roundtable meetings throughout the following year, which brought together key stakeholders including academia, NHS, industry and research funders.

The first Roundtable mapped out a high-level clinical pathway for monogenic diabetes, which accounts for 2-3% of patients diagnosed with diabetes before 30 years of age, and is an area where personalised clinical pathways are not yet widely implemented.

The second Roundtable addressed clinical pathways for cardiovascular disease, including Familial Hypercholesterolaemia, and inherited cardiac conditions, Hypertrophic Cardiomyopathy and Long QT Syndrome. They can lead to serious consequences including heart disease and sudden cardiac death, and so there are tangible benefits to implementing a stratified approach to these patient pathways.

The Academy made recommendations covering commissioning; awareness; education and training; and health economics; addressing the challenges to implementation and the practical steps required to put these pathways into practice.

The reports were published in October 2016, and are being used to support NHS England's programmes of work to build the evidence base, encourage clinical change in the NHS and build the appetite for the introduction of personalised medicine approaches.

The benefits are: earlier and more precise diagnosis; better prognosis; identification of predisposition markers to predict disease before onset / symptoms'; better disease prevention; avoidance of adverse drug reactions; and more precise assessment of the likely clinical effectiveness of treatment and avoidance of futile prescribing.

Information and technology

Our 2016/17 commitments:
By June 2016 local health communities will develop roadmaps setting out the steps to be taken to achieve a paper-free NHS.
By March 2017 we are incentivising CCGs and providers to make 80 percent of relevant elective referrals electronically using NHS e-Referrals, up from 50 percent today.
By March 2017 we will ensure 10 percent of patients are registered for primary care services online.
By March 2017 all ambulance trusts, all community pharmacies, NHS 111 and two-thirds of A&E departments will have access to patients' Summary Care Records.
By March 2017 we will publish five new scorecards about hospital quality on the MyNHS website.
By March 2017 we will publish revised national data on mental health and learning disabilities.

During 2016/17 we aligned the Personalised Health and Care 2020 information strategy with the Five Year Forward View to ensure that information technology is delivering the right capabilities at the right time to help deliver improved health, improved care, and improved efficiency. In June 2016, 73 Local Digital Roadmap footprints were developed to set out the steps to achieve a paper-free NHS. These have now been aligned with the 44 STPs, to ensure that the ten domains of activity in the national IT strategy are delivering support to the service developments described in the STPs.

In September 2016 we announced the first 12 Global Digital Exemplar acute trusts. These organisations are the most advanced IT hospitals in the NHS and have committed to work to become world class exemplars from which the rest of the NHS can learn.

Development of the NHS e-Referral system for elective referrals is continuing. The user interface has been improved and a facility introduced to flag specialties within hospitals where waiting times are particularly long. The bi-monthly Hospital Activity Data shows utilisation currently at 54% and the programme has been charged with increasing this to 100% by October 2018.

As of January 2017, 95% of GPs offer patients online appointment booking, repeat prescriptions and access to their Summary Care Record. Overall, 10.4 million people are now registered for online services, exceeding the 10% target set out in the NHS England Business Plan. 9 million have registered for repeat prescriptions, and 5 million for their summary information record. In January 2017, 1.1 million appointments were booked or changed online and 1.9 million repeat prescriptions were ordered online.

As at March 2017, 100% of NHS 111 and 92% of ambulance trusts could access extended patient data through the Summary Care Record (SCR). 85% of A&E departments have access to GP records, which is significantly more than forecast in the NHS England Business Plan. It is estimated that 40% of urgent treatment centres are enabled to access SCR or a local care record sharing service. These combined developments ensure safer clinical care, improved speed in transitioning care between services and an improved patient experience.

The national mental health services dataset is being updated to better capture data to monitor improvement across the service. Key performance measures are published quarterly in the FYFV Mental Health Dashboard, with the first dashboard published in October 2016.

The roll-out of free Wi-Fi to GP surgeries for patients and professionals has started and as of March 2017 covered approximately 1,000 surgeries in 20 CCG areas.

NHS Patient Online - Hugh's story

Hugh is visually impaired, registered blind. He also has asthma and a number of different health conditions.

Before Hugh had online access to his patient records he managed his healthcare in a "very random and unprivate way." He had to ask people to read things to him, and didn't feel very in control of what he was doing when having to use the telephone system to book appointments.

Hugh's GP receptionist spoke to him about Patient Online and typed the login information to Patient Online into Hugh's laptop for him, to keep it confidential.

Hugh is able to access the system by listening to it through his smartphone or laptop, and a screen reader. Listening through his earphones keeps his information completely confidential.

Patient Online has made a huge difference to Hugh as he can directly read information through his talking device. It has helped him understand and stay in control of his healthcare.

"It just frees you from having to ask anybody else for help, you can do it for yourself and I think that's so important when you're managing your own health - that it's something that you're in control of, that you're reading, it's your information and ultimately it's about you managing your own health and being a good patient.

I think Patient Online is the best thing I've used in terms of accessing information about my healthcare…"

How we supported the wider NHS

Emergency preparedness, resilience and response

NHS England responded to a number of potential threats to patient and public safety during the year, drawing on its considerable experience in emergency preparedness, resilience and response (EPRR).

We tested EPRR plans for a series of scenarios including chemical attacks and the treatment of burns victims. Following the 2014-16 outbreak of Ebola in West Africa, we continued to develop the UK's health response to outbreaks of infectious disease posing a high threat.

We made sure the NHS continued to deliver safe care during the 2016 junior doctors' industrial dispute, working with key partners through our national incident control centre.

In July 2016, we worked closely with Public Health England to ensure the safe treatment of over 100 victims of an e-coli outbreak in the south west of England, associated with contaminated salad leaves.

In November 2016, the EPRR team were instrumental in ensuring more than 50 people injured in a train crash in Croydon received an NHS emergency response.

The resilience capability of the NHS has been clearly demonstrated in a number of incidents in recent months. March 2017 saw the first mass casualty terror attack on UK soil for many years, when a vehicle was driven into tourists along Westminster Bridge in London killing and injuring members of the public.

In Manchester in May 2017, members of the public were killed and injured by a suicide bomber in a terrorist attack at a music concert at the Arena, with many of those affected being children and young people.

In early June 2017, three men drove a vehicle into crowds on London Bridge and launched a knife attack on people in the Borough Market area. Once again, as a result of this atrocity members of the public were killed and injured.

A raging fire ripped through Grenfell Tower block in North Kensington, London in June 2017, resulting in significant injuries and loss of life. A number of people were transferred to hospital as part of the rescue operation, with many more seeking advice and treatment for the effects of smoke inhalation.

All 999 services, including health, responded to this series of exceptional incidents with dedication, professionalism and bravery – both in the immediate deployment of emergency resources and in delivering the ongoing healthcare requirements for many of the individuals affected. The importance of our investment in specialist trauma centres and networks was reinforced during these events. The EPRR team led co-ordination of the immediate health response, ensuring access to NHS services for all those affected by this tragic event. The team also participated in the wider cross-government response for victims who experienced such traumatic and life changing events.

Equality and Meeting our Public Sector Equality Duty

We are committed to ensuring that all those using the NHS have fair and equitable access to high quality services that are appropriate and in proportion to their needs. In addition we have a specific focus on those with protected characteristics (by reason of age, membership of disadvantaged groups or living in disadvantaged areas).

We trained more than 150 commissioners, policy leads, managers and other staff in their Public Sector Equality Duty and their duty to reduce health inequalities, and are continuing to roll out the programme and evaluate its success. An assessment of how we have acted to address health inequalities, as required by the Health and Social Care Act 2012, is set out in Appendix 4 from page 256.

As leaders of the NHS Equality and Diversity Council (EDC), we have worked to promote equality as a system leader throughout the NHS. See Appendix 4 for more information.

Our report detailing the work we have done to promote equality under the Equality Act 2010, and setting out our objectives for 2016-20, can be viewed at www.england.nhs.uk/about/equality/.

Inclusion health and lived experience

An inclusion health and lived experience sub group of the EDC was set up to help improve access to, and outcomes of, healthcare services for disadvantaged groups, people with lived experience of inequalities and those with protected characteristics.

In 2016/17 we:

- delivered a 'Quick Wins' programme targeting barriers to primary care
- strengthened the capacity of EDC member organisations to identify and address health inequalities
- produced leaflets explaining the new principles designed to make it easier for patients from Inclusion Health groups to register with GP practices
- organised a presentation to demonstrate the power of lived experience to improve the planning, commissioning and delivery of integrated health care, ensuring the voice of the marginalised is heard, to the Heads of Digital Inclusion, Equality and Health Inequalities at Expo 2016.

Community Languages Information Standard

We are committed to reducing language barriers for individuals and groups who need NHS services but may suffer worse access or outcomes or whose safety may be at risk because of communication difficulties. A scoping exercise on the development of a community languages information standard has been created for consultation. The intention is to ensure alignment with interpreting and translation principles. Moving forward, during 2017/18 we plan to consult further and assess next steps subject to sponsorship and resources being available.

Unified Information Standard

We commenced work to develop a scoping exercise to examine how to map the quality and extent of equality information cross-system to enable compliance with the Pubic Sector Equality Duty (PSED) in relation to patients, services users and services. This work to scope how to develop a Unified Information Standard will be completed in 2017/18. As part of our work to develop a Unified Information Standard, we are considering how best to address definitional issues around the monitoring of protected characteristics.

Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) mandates the NHS to tackle less favourable treatment of black and minority ethnic staff. Our first report on the WRES, published in June 2016 showed gaps in the progression and treatment of BME staff compared with their white counterparts. In London, 69% of NHS trusts had a higher proportion of BME staff complaining of being harassed, bullied or abused by patients, relatives or members of the public. All trusts in London reported lower proportions of BME staff who felt their employer offered equal opportunities for career progression compared to elsewhere in England.

We have challenged NHS trusts and independent providers to meet their WRES commitments. To ensure a consistent approach, trusts are required to demonstrate that they are collecting data against the nine WRES indicators, analysing for evidence of discrimination, and implementing action plans to close the gaps in line with their Public Sector Equality Duty.

The WRES has become part of the 'well led' domain of CQC inspections. The 2016 WRES report was published in the first quarter of 2017 and included workforce data from the NHS staff survey. We will use this data to identify good practice and drive improvement. The programme will require sustained effort over several years.

Workforce Disability Equality Standard

We introduced the Workforce Disability Equality Standard (WDES) to improve the representation, treatment and experience of disabled staff in the NHS and to promote the theme of 'disability as an asset'. Employing people with lived experience of disability or long term health conditions helps the NHS to increase the quality of its services and attract diverse talent. The WDES will be mandated in England from April 2018.

Sustainability

The Five Year Forward View highlights the importance of a sustainable NHS in order to continue providing comprehensive, high quality care. The sustainable development strategy for the NHS, public health and social care system is led by the Sustainable Development Unit (SDU), and sets a vision and goals to aim for by 2020 to support sustainable development, reduce emissions, save money and improve the health and resilience of people and communities. The strategy can be viewed on the SDU's website at http://www.sduhealth.org.uk/policy-strategy/. Our sustainability report is presented in Appendix 5 from page 264.

Our priorities for 2017/18

Our continuing contribution to delivering the FYFV is set out in Next Steps on the Five Year Forward View, published in March 2017.

As an annex to the Next Steps document, we published 'NHS England Funding and Resource 2017-19' which sets out how we will, through the distribution of funding and our people, support the next steps on the NHS Five Year Forward View to transform local health and care systems.

Over the past two years, national improvement blueprints have been developed with key partners for urgent and emergency care, cancer, mental health, primary care, learning disabilities, and maternity. 2017/18 will support the delivery and implementation of these key priorities and work will continue on accelerating service redesign locally through STPs and Accountable Care Systems.

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2017 are presented later in this document and show the performance of both the consolidated group – covering the whole of the commissioning system – and NHS England as the parent of the group.

The group comprises NHS England and 209 CCGs, consolidated through the Integrated Single Financial Environment (ISFE), a financial accounting and reporting system covering all of the organisations concerned.

NHS England had a revenue resource limit of £106,528 million in 2016/17. We are responsible for using this money wisely and fairly to secure the best possible outcomes for both patients and taxpayers. As shown later in this report, the group has again fulfilled all of the financial duties set out in its mandate from central government, covering revenue spending, administration costs and capital expenditure.

Although not legally responsible for securing financial balance across the NHS or for ensuring that the DH meets its overall Revenue and Capital Departmental Expenditure Limits, the NHS England Group has, in addition to meeting its own financial duties, held back the risk reserve specified in the NHS Planning Guidance for 2016/17 and ultimately deployed it to help offset provider deficits.

Operational performance

The NHS England Group has delivered a managed underspend of £902 million (0.9% as a percentage of allocation) against its £105,702 million budget set for in-year operational expenditure.[6]

The most significant factor in this underspend is the release of the system risk reserve. As set out in the 2016/17 NHS Planning Guidance, commissioners were required to hold a 1% risk reserve, created by setting aside the monies they would otherwise have spent during the year. This was intended to be released for investment in FYFV transformational priorities to the extent that evidence emerged of risks across the system not arising or being effectively mitigated through other means.

6. The core measure for the financial performance of NHS commissioners included here is the non-ring-fenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL.

In the event, however, the position across the provider sector has been such that NHS England has been unable to allow the 1% non-recurrent monies to be spent, and therefore all CCGs and NHS England direct commissioning teams were required to release their share of the reserve to the bottom line. This was delivered in full, resulting in a contribution of £799 million (of which £707 million is included in CCG positions and £92 million in direct commissioning) towards our overall surplus of £902 million.

The key features of the 2016/17 financial position are shown in more detail in the following table and set in the context of the pattern of small managed underspends delivered in the three previous years since the creation of NHS England and CCGs:

Financial performance	2016/17				2015/16		2014/15		2013/14	
	Expenditure Plan	Expenditure Actual	Under/(over)spend against plan		Under/(over)spend against plan		Under/(over)spend against plan		Under/(over)spend against plan	
	£m	£m	£m	%	£m	%	£m	%	£m	%
CCGs	76,630	76,476	154	0.2%	(15)	0.0%	70	0.1%	89	0.1%
Direct commissioning	25,610	25,314	296	1.2%	82	0.3%	(12)	0.0%	(365)	-1.4%
NHS England Admin/ Central Progs/ Other	3,312	2,874	439	13.2%	340	21.4%	193	12.2%	679	34.4%
Historic continuing healthcare claims administered on behalf of CCGs	150	137	13	8.6%	192	67.7%	33	35.4%	(77)	0.0%
Total	**105,702**	**104,800**	**902**	**0.9%**	**599**	**0.6%**	**285**	**0.3%**	**326**	**0.3%**

The figures above are on a non-ring-fenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL.

2016/17 has been a year of unprecedented challenges for NHS commissioners. The creation of the risk reserve in 2016/17 has placed significant pressure on the commissioning system, requiring an increase in the level of savings that commissioners needed to make from an average of 2.2% of allocations in 2015/16 to 3.0% of allocations in 2016/17 plans. In addition, the NHS England Group has absorbed a number of material financial pressures this year, including most significantly a £190 million increase in the rates set by DH for funded nursing care. NHS England's systematic process for continuous evaluation of financial exposure enabled us to identify the level of commissioner risks from the start of the year and take appropriate mitigating action both with individual CCGs and in relation to central budgets.

In general, CCGs have risen well to the challenge. Commissioner efficiencies delivered by CCGs have risen from £1.5 billion in 2015/16 to £2.0 billion in 2016/17, and the measures to improve CCG resilience, which we commenced in 2015/16, were further developed and widely deployed in 2016/17. The majority of CCGs delivered their planned financial position in addition to the release of the risk reserve. 24 CCGs reported further underspends totalling £17 million, and there was a £34 million underspend against the budget set for Quality Premium. However, 85 CCGs reported operating overspends totalling £607 million, leading to an aggregate overspend of £556 million (0.7%) before allowing for the reserve release.

Within direct commissioning, specialised services teams achieved an underspend of £58 million on their operational performance, reflecting the significant programme of measures undertaken over the last two years to improve management processes and controls. In addition, a new approach to prioritisation and financial management of drugs within the Cancer Drugs Fund (CDF) was introduced in July 2016, which has been effective in containing spend within the total CDF budget, contrasting with the £126 million overspend in the previous financial year.

In the light of the operational finance risks identified at the start of the year we took early action to reduce the programme and running cost expenditure of NHS England directorates while freezing contingencies and banking a number of small one-off gains. This led to a combined underspend of £439 million. However, it should be noted that most of these variances relate to non-recurrent budgets and income available to NHS England in 2016/17, and the recurrent elements have generally already been reflected in reduced central budgets for 2017/18. We have now largely completed the programme to deal with historic claims in relation to continuing healthcare, with expenditure in the year slightly below the amount set aside in our plans.

Performance against wider financial metrics

Within the mandate, the DH sets a number of technical financial targets for the NHS England Group, including the core operational limit (general RDEL) described on the previous page. These limits are ring-fenced, which means that underspends on the other revenue limits cannot be used to support core patient services covered by the general RDEL limit.

£150 million of the total £237 million savings against the administration limit are relevant to the general RDEL limit, the remainder being depreciation-related. This underspend has helped to offset the significant operational pressures highlighted above while maximising funding available for frontline services.

Delivery against NHS England's full range of financial performance duties is summarised in the table below:

Revenue Limits			Target		
	Mandate limit	Actual	Underspend	Target met	Underspend as a % of mandate
	£m	£m	£m		
RDEL - general	105,702	104,800	902	√	0.9%
RDEL - ring-fenced for depreciation and operational impairment	166	96	70	√	42%
Annually Managed Expenditure limit for provision movements and other impairments	300	(308)	608	√	202.6%
Technical accounting limit (e.g. for capital grants)	360	71	289	√	80.4%
Total Revenue Expenditure	**106,528**	**104,659**	**1,869**		**1.8%**
Administration costs (within overall revenue limits above)					
Total administration costs	**1,832**	**1,595**	**237**	√	**12.9%**
Capital limit					
Capital expenditure contained within our Capital Resource Limit (CRL)	**260**	**227**	**33**	√	**12.7%**

Allocations

NHS England has responsibility for the allocation of NHS funding agreed with the DH as part of our mandate. Funding objectives contained within the mandate require NHS England to operate a transparent allocation process to ensure equal access for equal need. The Health and Social Care Act 2012 also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare.

In December 2015 the NHS England Board approved allocations for the commissioning sector for the next five years, 2016/17 to 2020/21, with firm allocations for the first three years and indicative allocations for the final two years. As reported last year, these allocations were intended to achieve the following goals:

- Faster progress towards our strategic goals, particularly through:
  - higher funding growth for GP services
  - increased operational and transformational investment in mental health and
  - the establishment of a Sustainability and Transformation Fund of £2.14 billion for 2016/17 and £2.86 billion for 2017/18, of which £1.8 billion is deployed to support provider sustainability and the remainder for transformation in other key areas, prioritised within the FYFV.
- Greater equity of access, by bringing allocated funding closer to target levels, with no CCGs more than 5% under target for CCG commissioned services and no CCG areas more than 5% under target for the total commissioning streams for their population
- Closer alignment with population need through improved allocation formulae, including improvements to inequalities adjustments and a new sparsity adjustment for remote areas and
- Better visibility of projected total commissioning resources by locality to stimulate and support the development of place-based commissioning and stronger long-term collaboration between commissioners and providers.

Subject to minor adjustments, mainly to reflect specific changes to commissioning responsibilities between CCGs and NHS England, the decisions made by the Board have been reconfirmed in relation to 2017/18 and 2018/19.

Future financial sustainability

The FYFV set out how, in the absence of further annual efficiencies in the NHS, a combination of growing demand from an ageing population, increases in the costs of running the NHS and constrained funding growth would produce a significant mismatch between the growth in resources available and the funding required to deliver what patients need.

The 2015 Spending Review provided additional real-terms funding of £8.4 billion to reduce an estimated £30 billion resource gap by 2020/21 and provide resources for sustainability and transformation investments. In parallel with this, the NHS has been developing and implementing STPs across 44 local areas to demonstrate how commissioners and providers, and local authority partners can work together to deliver the goals set out in the Forward View within the resources available to each locality.

A 10 point plan for efficiency has also been published as part of the Next Steps on the NHS Five Year Forward View document and forms the blueprint for implementation of the joined up national and local efficiency improvement initiatives required to ensure financial sustainability over the coming years. In this context, NHS England and NHS Improvement will work closely together and with other arm's length bodies to support concerted action in the following areas:

1. Freeing up hospital bed capacity
2. Improving staff productivity, including further action on temporary labour costs
3. Leveraging the NHS's procurement opportunities
4. Securing best value from medicines and pharmacy
5. Reducing avoidable demand and meeting demand more appropriately
6. Reducing unwarranted variation in clinical quality and efficiency
7. Action on estates, infrastructure, capital and clinical support services
8. Cutting the cost of corporate services and administration
9. Improving cost recovery from non-UK residents
10. Ensuring financial accountability and discipline in all NHS organisations.

The profile of funding growth in the Spending Review settlement means that 2017/18 and 2018/19 present a particular challenge for local health economies in balancing the significant and growing operational pressures facing the service with the need to invest confidently in transformational programmes in the key priority areas set out in the Next Steps document. In many places this will involve difficult choices on where to invest and disinvest, and partners in every STP area will need to use the 10 point efficiency plan to build on and substantially accelerate progress made in 2016/17, if they are to square this very challenging circle.

Long term expenditure trends from the establishment of NHS England in 2013/14 are set out below, detailing expenditure on CCGs, direct commissioning and NHS England's central programme and running costs. The increase in central costs is driven by the establishment of £1.8 billion deployed to support provider sustainability within the Sustainability and Transformation Fund (STF).

Financial performance - RDEL general (non-ring-fenced)	**Expenditure**				**Expenditure (%increase)**		
	2013/14 £m	**2014/15 £m**	**2015/16 £m**	**2016/17 £m**	**2014/15 %**	**2015/16 %**	**2016/17 %**
CCGs	65,427	66,775	72,259	76,476	2.1%	8.2%	5.8%
Direct commissioning	27,407	29,364	26,687	25,314	7.1%	-9.1%	-5.1%
NHS England Admin/ Central Progs/ Other	1,294	1,387	1,245	2,874	7.2%	-10.2%	130.8%
Historic continuing healthcare claims administered on behalf of CCGs	77	61	92	137	-21.2%	50.9%	49.5%
Total RDEL - general	**94,205**	**97,587**	**100,283**	**104,800**	**3.6%**	**2.8%**	**4.5%**