

Performance Report

Chief Executive's overview

Personally and on behalf of our Board, I want to start by paying tribute to Sir Malcolm Grant, who later this year stands down as NHS England's founding Chair. Malcolm has both shaped and driven NHS England's mission as the independent steward of the National Health Service, and champion of the patients we serve. He will be greatly missed.

As this Annual Report shows, the past year has again been one of both progress and pressure.

Genuine and measurable advances have been secured in many critical services. We've had upgrades to cancer radiotherapy treatment, and steadily improving cancer survival rates. Mental health services are expanding, particularly for new mums and for young people needing specialist care. More patients are able to see a GP after work or on a weekend. Fewer frail older people are stuck in hospital waiting to go home. More people are getting advice from an NHS 111 clinician. Fewer people with learning disabilities are living in inappropriate institutions. More A&E patients are being looked after within four hours. Further gains have been secured in efficiency, with action to drive out ineffective or wasteful prescribing and procurement. This has all been underpinned by continued financial discipline, as NHS England has balanced its books and met or exceeded all financial goals set by the Government for the fifth year in a row.

But there has also been intensifying and inescapable pressure in other important areas. GP workloads are up, but GP numbers down. There were longer waits last year for A&E and routine surgery, and a particularly difficult winter. And financial deficits continued in some local NHS organisations.

So in November I spoke publicly about what would be needed if, in our 70th year, we wanted to sustain a well-functioning National Health Service. I explained that the compound effect of funding and staffing constraints since the 2008 economic crash meant that GPs, community and mental health services, hospitals and social care were under increasing strain. While NHS productivity has been rising far faster than the rest of the economy, over the past five years cumulatively the NHS has operated with £27 billion less than had it been funded at its long term trend funding growth. We are now spending a third less per person on our health services than Germany, on a like-for-like basis.

Against this backdrop, the Prime Minister's important decision in June this year now provides the NHS with the welcome certainty of a five year funding settlement. Working with patient groups, clinicians, frontline NHS leaders and our wider partners, we will use this opportunity to frame a realistic but appropriately ambitious plan for health and care improvement for the next decade.

Because as we turn to the years ahead, it is not just a question of 'keeping the show on the road'. We also need to continue and accelerate the fundamental changes we're embarked on to 'future proof' the health service for generations ahead. In doing so we have three particular advantages to build on.

First, our health service staff are outstanding. The past year has once again shown not only their skill and dedication day in, day out, but also how NHS staff respond in the most extraordinary way at times of national emergency. Survivors and relatives of Grenfell Tower, and

victims of terrorism in Manchester and London all bear witness to the care and compassion of the nurses, therapists, doctors, care assistants and countless others who were there for them at their time of greatest need. And in a year when we also mark the 70th anniversary of the Empire Windrush, we are reminded that the NHS has over seven decades benefited from the professional commitment of generations of staff from Britain and also from overseas.

Second, the NHS's own reform programme is beginning to bear fruit. GPs and local Clinical Commissioning Groups have begun to develop alternatives to hospital referral for conditions that don't need it, and new outpatient referrals each day actually fell by 1.6% over the past year. 12.5 million people across England are now covered by early stage 'integrated' care, and where GPs, community services and hospitals are working most closely together, emergency hospitalisations per person are now growing at under half the rate of the rest of the country. 12% fewer people are being admitted to hospital as emergencies than would have been five years ago, thanks in part to better support at home.

Third, the British people want us to succeed. I joined the NHS on its 40th birthday in 1988, and thirty years later as we mark its 70th birthday, public support for and satisfaction with the NHS is higher now than it was then. That is a testament to the enduring popularity of the founding principle of an NHS there when you need it, regardless of ability to pay. But it is also a recognition of the fact that, while by no means perfect, for most people most of the time, the NHS provides high quality and steadily improving care.



Simon Stevens

CEO of NHS England, and Accounting Officer

Performance Analysis

Our business plan for 2017-19 was published on 6 April 2017 as part of the Next Steps on the NHS Five Year Forward View, with a further update being made on 29 March 2018.

Next Steps on the NHS Five Year Forward View outlines national priorities for the NHS, and this report provides analysis of the following priority areas: **Urgent and emergency care** (p.16); **Primary care** (p.18); **cancer** (p.19); **mental health** (p.20); and **integrating care locally** (p.22).

These priority areas encapsulate the objectives set out in the Government's mandate to us for 2017/18⁸ and are underpinned by other national priority themes: funding and efficiency; harnessing technology and innovation; strengthening our workforce; and patient safety, all of which are addressed throughout this document. Further information on our performance against the mandate is available in appendix 1 on page 160.

Urgent and emergency care

A comprehensive urgent and emergency care programme has been delivered during 2017/18, covering GP urgent care, A&E departments, emergency ambulance services and NHS 111. This programme was developed to tackle the rising demands on urgent and emergency care, as well as clarify where patients can access services that best meet their urgent care needs.

Reforms are being introduced to NHS 111 which allow patients, whenever their condition requires it, to speak to a clinician as well as being able to book an appointment directly with a service that is right for them. NHS 111 online has been piloted and evaluated in a number of areas, with 34% of the population now able to access urgent and emergency care advice through this online portal. We aim to have NHS 111 online services in place across all areas this summer, with work being undertaken to develop greater integration with local services.

Record call volume is being successfully managed through NHS 111, and more patients than ever before are able to speak to a clinician about their urgent and emergency care needs when calling the service. 48.4% of calls now receive clinical input, which is expected to rise to half of all calls by the end of March 2019.

A number of strategies have continued to be developed to ease the pressure on hospitals, including extended access to primary care, with coverage of 55.4% of the population, and more Urgent Treatment Centres (UTC). There are now 85 UTCs that have been designated with the revised standard specification.

The recommendations of the Ambulance Response Programme have been implemented in mainland ambulance trusts across England.

By the end of March 2018, all eligible acute Trusts with Type 1 A&E had front-door clinical streaming services in place. This has resulted in more patients with minor illnesses being diverted to more appropriate services, helping to improve patient experience and health outcomes.

We have provided an additional £96.7 million to 105 Trusts to support the modification of their A&Es to separate serious medical and surgical cases from those needing urgent primary care treatments.

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692140/NHSE_Mandate__2017-18_revised.pdf

At the 'back door' of A&E 1,649 beds have been freed up as a result of reducing Delayed Transfer of Care (DToCs), and DToC delayed days have reduced consistently throughout the year. With the exception of December 2017, this is the lowest number of beds occupied DToC since August 2015. This means that there are now fewer patients occupying a hospital bed who could receive better and more appropriate care in their own home or a nursing or care home. This has been achieved through partnership working between health and social care at a local level, with 150 local council areas agreeing Better Care Fund (BCF) plans. In addition, there are now more assessments for patients' continuing healthcare needs taking place out of an acute hospital environment.

The NHS's plan for winter was more detailed and intensive than in previous years.

2017/18 performance was tracking the same as last year until December and January. Performance for February and March 2018 reflected much greater pressure, and as a result, year-end performance by hospitals on their four hour standard was at 88.4%, below 2016/17 performance of 89.1%. This downturn towards the end of the year reflected a more complex case mix, increased ambulance arrivals and the most severe flu season since 2010/11, with flu patients occupying over 2000 more beds at the peak than at the worst days in 2016/17. This was exacerbated by norovirus bed closures, which were up on the previous year. Bed occupancy, therefore, tracked higher than the same period last year.

Action for the year ahead includes:

- Continuing to focus developing NHS online, enhancing NHS 111, developing urgent treatment centres and completing the extension of extended access to GPs to the whole country.
- Continuing to develop patient streaming in A&E departments.
- Developing clinical pathways to optimise the use of emergency day care and identify more cohorts of patients who can be managed in this way.
- Reducing the number of patients whose length of stay exceeds 21 days (which amounts to around 20% of total bed occupancy), to create the capacity hospitals need.
- Working with Local Authorities and care home providers to help keep patients in their own homes and away from hospital unless really necessary.

In March 2018, the NAO published its report 'Reducing Emergency Admissions'. We have put in place a number of actions to address the recommendations made. In addition, jointly with NHS Improvement, we have requested local providers and commissioners to focus on reducing length of stay in the coming year, particularly for patients who have been waiting in hospitals over 21 days. A reduction in length of stay will support the increase in capacity required to manage the predicted emergency and elective demand over the course of the year.

For further information please see the urgent and emergency care pages of the NHS England website⁹.

Primary care

The Primary Care Programme continues to support the delivery of the General Practice Forward View (GPFV). The programme increases investment in primary care services, increases the number of people working in primary care and supports the improvement of access, services and premises. Responses to the GP Patient Survey give a patient view on how primary care is performing. In 2017, responses to the survey remained positive overall, with 84.8% rating their experience as good, and many would recommend their GP surgery to others (72.7%). However, the survey did reveal decreasing satisfaction with ability to contact their GP 'in-hours' and being able to get an appointment with a GP they prefer to see.

In response, we remain on track to deliver an additional £2.4 billion by 2021, increasing our investment in general practice to £12 billion per annum, as set out in the GPFV, with a particular focus on additional investment for primary care transformation. Investing in upgrading primary care facilities has continued, with 106 schemes completed in 2017/18 in addition to the 758 schemes previously completed. As well as this there are a further 972 active schemes at different stages of progress (427 in due diligence, 170 pre-project, and 375 in delivery).

We have surpassed the Government's Mandate commitment to achieve 40% access to evening and weekend appointments for general practice services, as more than half of the population are now able to access these extended services. The whole of the population will be able to access evening and weekend appointments by October 2018.

We continue to tackle challenges in GP retention and recruitment. In partnership with Health Education England, NHS England has a number of programmes that are seeking to maintain and increase numbers in line with the ambitions in the General Practice Forward View. These include a continued focus on boosting the number of new GPs and other professionals working in primary care. We now have the highest number of GP trainees ever recruited, as more than 770 additional GP trainees have commenced specialist training since 2015, bringing the current total to 3,157. Recruitment for the 2018 intake is now underway.

We have launched a programme to recruit international GPs to further strengthen our GP workforce. International GP recruitment has begun in the first three pilot sites in Lincolnshire, Essex and Cumbria. Humber Coast and Vale subsequently started during the latter stages of the pilots. The expanded recruitment programme is now also underway across 11 additional areas of the country, with further phases planned, and it is expected that the first candidates will be relocated to England by the Autumn. The GP Retention Scheme, offering financial and educational support to doctors who might otherwise leave the profession was launched in April 2017 and replaced the Retained Doctors 2016 scheme. There were 286 GPs being supported through these schemes at 31 March 2018, an increase of 80% since Sept 2015.

During 2017/18 nearly 34 million patients have benefitted from improved pharmacy services in a general practice setting. Against the current target of 2000 Full Time Equivalent (FTE) Clinical Pharmacists in post by 2020/21, as at March 2018 over 748 FTE Clinical Pharmacists were actively working in general practice, an increase of 550 since September 2015. Applications for a further 410 FTE Clinical Pharmacists have been approved to date.

Action for the year ahead includes:

- Actively encourage every practice to be part of a local primary care network, serving populations of at least 30,000 to 50,000.
- Ensure every practice implements at least two of the high impact 'time to care' actions.
- Continue to recruit and retain the primary care workforce via all available national and local initiatives.

For further information on our work with primary care, please see the primary care pages of the NHS England website¹⁰.

Cancer

Progress continues to be made on delivering world class cancer services as set out in the Next Steps on Five Year Forward View. We are developing services that increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond the disease. Cancer survival has never been higher. The latest figures published in November show one year survival at 72.3% for people diagnosed in 2015, amounting to a further 0.7% year-on-year increase.

We are shifting to earlier and faster diagnosis by increasing public awareness of the signs and symptoms of cancer, encouraging people to seek medical advice if they have concerns and making sure health services act swiftly to ensure rapid diagnosis. In 2017/18, we invested more than £37 million nationally through our Cancer Alliances to boost diagnostic services, including embedding the latest research on prostate diagnosis to avoid unnecessary biopsies and identify more cancers, and rolling out 'straight to test' pathways for colorectal cancer to speed up diagnosis and reduce the number of outpatient appointments. We also introduced ten new multidisciplinary rapid diagnostic and assessment centres to ensure patients with complex symptoms receive a rapid diagnosis.

We have continued to implement the largest radiotherapy upgrade programme in 15 years.

£46 million was spent in 2017/18 on 26 new radiotherapy machines in 21 hospitals and we are on track for 70 new / upgraded machines by Autumn 2018 at a cost of £130 million. We also consulted on a new radiotherapy service specification to ensure equity of access to the highest quality treatment across the country. The new specification will be rolled out in 2018/19.

In 2017/18, more than £18 million was spent nationally on additional capacity to support improvement against the 62-day Referral to Treatment Time (RTT) standard for cancer. Additional funding was made available to our Cancer Alliances by way of performance incentives for achievement of the RTT standard. During 2017/18, almost 140,000 patients received first treatments for cancer within 62 days of an urgent GP referral, 3% more than last year. Despite this progress, trusts remain short of their 85% target, and this will continue to be their focus so times are improved further in 2018/19.

10 <https://www.england.nhs.uk/gp/>

Fast track funding for the most promising new cancer drugs is being delivered by the new Cancer Drugs Fund, which has benefited nearly 15,700 patients since it opened in July 2016. 52 drugs across 81 different types of cancer have been made available, and around 5,000 patients have received treatment sooner due to new early access arrangements. There is a commitment from National Institute for Health and Care Excellence (NICE) to make a decision on cancer drugs within 90 days of their being licensed for use in England. In 2017/18, we have also invested more than £11 million through 10 of the 19 Cancer Alliances to transform personalised follow up after cancer treatment.

Action for the year ahead includes:

- Driving earlier and faster diagnosis through our Cancer Alliances, including implementing rapid diagnostic and assessment pathways for lung, prostate and colorectal cancer, and rolling out the use of low dose CT case finding for lung cancer.
- Introducing Faecal Immunochemistry Test (FIT) into the bowel cancer screening programme, and readying the system for the introduction of HPV screening in the cervical screening programme.
- Driving up standards in treatment and care, investing in radiotherapy equipment and networking and implementing personalised follow-up support.
- Enabling and reinforcing Cancer Alliances' leadership role to drive improvements for their populations and delivering a data, evidence and analysis service to ensure evidence based, local decision making.
- Making improvements to meet and sustain the 62 day referral-to-treatment standard and all other cancer waiting times standards, and deliver a new Cancer Waiting Times system.

For further information, please see the cancer pages of the NHS England website¹¹.

Mental health

Throughout 2017/18 we have been implementing the recommendations included in the Five Year Forward View for Mental Health (FYFV MH), published in February 2016, with more patients being seen and a number of other improvements.

Access to mental health services for people requiring psychological therapies has been improved for children and young people with eating disorders, and for individuals requiring early intervention in psychosis. All access targets are being met, and, where appropriate, are on track to be strengthened by 2020/21.

Integrating mental health services with the rest of our transformation agenda has been a key focus this year. £16.3 million was invested in 2017/18 in acute hospitals to support 74 areas to meet the 'Core 24' standard, which includes 24/7 mental health liaison teams as part of the commitment to invest £30 million by March 2019. 46% of acute hospitals are expected to meet the 'Core 24' standard by the end of 2018/19.

£48.7 million has been invested in 37 'early adopter' sites to progress the integration of

11 <https://www.england.nhs.uk/cancer/>

Improving Access to Psychological Therapies and Long term Conditions, to improve mental and physical health services. Early results from some of these sites show a marked decrease in use of primary and secondary care services.

We have also provided more physical health checks and interventions for patients with severe mental illnesses in secondary care, with 60% of people in inpatient settings and 42% in community mental health teams receiving this to date.

£18 million was also provided over the winter period to address mental health-related system pressures.

£18.6 million was invested in more than 20 areas in 2017/18 to develop perinatal community services. We comprehensively exceeded the target of 2,000 women being able to access specialist perinatal mental health services as 7,000 more women accessed specialist care in 2017/18.

New beds are helping to improve patient experience and reduce the travel for children and young people, and their families. An additional 113 have been implemented or re-purposed for specialist mental health services for children and adolescents (tier 4).

70 new or extended community eating disorder services have been funded and commissioned across the country.

The Mental Health Investment Standard was met both nationally and regionally in 2017/18, and we have required each CCG to meet the standard in 2018/19.

CCGs have continued to meet the dementia diagnosis standard, with a performance of 67.5% in 2017/18. A project to examine potential strategies to reduce unnecessary admissions and length of stay in acute hospitals for people with dementia has been established, and three STPs have been invited to participate. For further information, please see the mental health pages of the NHS England website¹².

We increased personalised care for people discharged from psychiatric hospitals who receive Section 117 aftercare under the Mental Health Act, working with more than 50 sites across England.

Action for the year ahead includes:

- Requiring all CCGs to increase investment in mental health services faster than the overall increase in their allocation this year.
- Expanding children and young people's mental health services so children and young people in need can access high quality care at the right time.
- Increasing access to the Individual Placement and Support Programme by 25% to support people with severe mental illness to gain and retain meaningful employment.

Integrating care locally

Throughout the past year, STPs have provided a framework for all local health and care systems to identify shared challenges and solutions. STPs in every part of England are now addressing the Five Year Forward View's triple aim of improved health and wellbeing, transformed quality of care and sustainable finances – as well as the priority areas set out in Next Steps on the Five Year Forward View.

The most mature partnerships are evolving further to become 'Integrated Care Systems'. Commissioners and NHS providers, working closely with GP networks, local councils and others, voluntarily agree to take shared responsibility for how they use their collective resources for the benefit of local populations in ways which are consistent with the existing statutory framework. Integrated care systems are crucial to improving health and care locally by:

- Putting GPs and primary care at the heart of the populations they serve, through the use of networks to provide at-scale and comprehensive services.
- Supporting the integration of services within the NHS and between health and social care, with a particular focus on people at risk of developing acute illness and hospitalisation.
- Providing more care through redesigned community and home-based services, including partnerships with social care, the voluntary and community sector.
- Ensuring a greater focus on prevention of ill health and population health outcomes, in partnership with communities.

During 2017/18 we signed a memorandum of understanding with eight ICSs¹³, setting out the expectations of delivery and resources and flexibilities that will be offered in recognition of their partnership working. This is complementary to the devolution agreements in place with Greater Manchester, Surrey Heartlands and London, with Greater Manchester and Surrey Heartlands playing a full role in the ICS programme. These systems have confirmed that the appropriate governance arrangements are in place to enable the release of delegated funding.

Further ICS areas were approved in June, so that 12.5 million people are now covered by this new way of working.

As the rest of the country moves in this direction, appropriate joint working with social care will be important, as described by the NAO in their study on the adult social care workforce.

For further information please see the system changes pages of the NHS England website¹⁴.

13 <https://www.england.nhs.uk/accountable-care-systems/>

14 <https://www.england.nhs.uk/systemchange/>

Our priorities for 2018/19

Progress continues to be made on delivering the Five Year Forward View. The Next Steps on the NHS Five Year Forward View, published in 2017, set out key priority areas and 'NHS England Funding and Resources 2017-19', as an annex to the Next Steps, detailed how funding will be distributed and staff used to achieve the ambitions stated in the Next Steps. 'NHS England Funding Resource 2018/19' updates the annex and contains information about NHS England's funding in 2018/19.

Our priorities for 2018/19 are those set out in the Next Steps and focus on transforming urgent and emergency care, cancer, mental health, primary care and integrating care locally, so that in the NHS's 70th year we can continue to deliver world class healthcare now and for future generations.

Our plans for 2018/19 reinforce the role of STP and ICS leadership in population health, coordinating and strengthening the delivery of the Five Year Forward View across their respective geographies. To deliver excellent treatment and care, we rely upon local healthcare professionals, working in partnership with their patients and communities, to inform us of services they need. We will continue to empower these local areas so they can access the best and most appropriate services.

We will also concentrate on building an effective model of joint working with NHS Improvement. We will work in a much more streamlined way in order to set consistent expectations of commissioners and providers and deliver forms of support and oversight that best help local systems to meet shared goals.

How we supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

NHS England responded to a number of potential threats to patient and public safety during the year, drawing on its considerable experience and expertise in EPRR.

The resilience capability of the NHS has been clearly demonstrated throughout 2017/18, with a number of terror attacks across the UK for the first time in many years. The attacks at Westminster Bridge, Manchester Arena, London Bridge, Salisbury, Finsbury Park and Parson's Green have all required an emergency response from the NHS. The EPRR team led the coordination of the immediate health responses to these incidents and will continue to work towards improving future emergency responses. In the months since these occurred, there has been much focus on sharing invaluable learning from these incidents, to help ensure emergency preparedness for similar future incidents. The EPRR team continues to cooperate with partners in the wider cross-government response to the Grenfell Tower fire in June 2017.

Following the outbreak of Ebola in West Africa, our High Consequence Infectious Disease Programme Board has continued its work to develop the UK's health response to outbreaks of infectious diseases posing a high threat.

The global attack of the 'WannaCry' virus in May 2017 affected many NHS organisations and caused significant service disruption. The health response required to restore impacted NHS IT systems and ensure protection against future cyber attacks was led by the national EPRR team. A number of CCGs, GP practices and NHS Trusts were affected, with services disrupted. Expert teams in the CSUs were part of the first wave response to that attack, in many cases responding out of hours and across the weekend. Their work was instrumental in preventing the attack from spreading and had a positive impact on maintaining services. Since this cyber attack, the EPRR team has contributed to the development of plans for the NHS for its response to any future attack.

In October 2017, The National Audit Office published a report¹⁵ that investigated the NHS's response to the WannaCry cyber attack. The investigation focused on the ransomware attack's impact on the NHS and its patients, why some parts of the NHS were affected; and how the DHSC and NHS national bodies responded to the attack.

The national breast cancer screening incident

On 2 May 2018, the Secretary of State for Health and Social Care informed the House of a serious incident in the national Breast Screening Programme in England, overseen by Public Health England, which resulted in thousands of women aged between 68 and 71 not being invited to their final breast screening appointment due to the misapplication of a computer algorithm dating back to 2009.

Public Health England has contacted 195,565 women registered with a GP in England who have been affected to offer them a screening appointment. Public Health England are leading

15 <https://www.nao.org.uk/wp-content/uploads/2017/10/Investigation-WannaCry-cyber-attack-and-the-NHS.pdf>

the incident response and NHS England has taken major steps with local areas to expand the capacity of screening services so that women who wish to be screened can be offered an appointment within six months.

Life sciences and innovation

NHS England has an important responsibility in promoting the opportunity for life sciences and innovation and supporting the spread of innovations. In 2017/18 we provided £37.9 million funding to Academic Health Science Networks (AHSN) to deploy innovation at pace and scale.

Over the last five years, the AHSNs estimate they have supported the spread of 332 innovations across 11,000 locations, benefiting 22 million patients.

The AHSNs have also: leveraged £330 million to improve health and support NHS, care and industry partners; supported contracts awarded to more than 450 Small and Medium-sized Enterprises (SMEs); and helped create more than 500 new jobs¹⁶.

The Innovation and Technology Tariff (ITT) was launched in April 2017 to incentivise the adoption of transformational innovation in the NHS. Since the launch of the ITT:

- 56,382 patients are benefitting from being able to self-manage their severe or very severe Chronic Obstructive Pulmonary Disease (COPD) symptoms.
- Reusable angled episiotomy scissors have been used on over 6,625 occasions, reducing the likelihood of injuries to women in labour.
- 1,578 ventilation tubes that are specifically designed to reduce the incidence of Ventilator Associated Pneumonia are in use in hospitals.
- 13,748 devices that prevent injection of fluids into an artery are being used, improving patient safety.

At our Board in November, we published Twelve Actions to support and apply research in the NHS. We have undertaken significant engagement with key stakeholders and partner organisations to progress work on solving excess treatment costs, commercial contract research and NHS England's research needs. NHS England is working with the Office for Life Sciences and Department for Business, Energy and Industrial Strategy (BEIS) on the Review of the Innovation Landscape. The review provides an opportunity to simplify and enhance how we deploy proven innovations and will help to create the conditions for these to be generated in the first place.

We coordinate and lead the NHS response to the Life Sciences Industrial Strategy, a report from the Life Science sector and Professor Sir John Bell, and we are an active partner in the Accelerated Access Collaborative (AAC). The AAC is a partnership between Government, industry and the NHS, tasked with implementing proven and affordable innovations.

During 2017/18, NHS England created a stronger focus on life sciences and innovation by establishing a new dedicated life sciences and innovation group.

16 The Academic Health Science Networks, Impact Report 2017, May 2017;
http://www.ahsnnetwork.com/wp-content/uploads/2017/06/AHSN-Network-Impact-Report-2017_Web_spreads.pdf

Personalised care

Evidence shows that supporting patients to be actively involved in their own care, treatment and support can improve their outcomes and experience. Personalised care can also potentially yield efficiency savings for the system through approaches that support people to stay well and manage their own conditions better. NHS England has made a commitment to involve patients and their carers by giving people the power to manage their own health and make informed decisions about their care and treatment and by supporting people to improve their health and give them the best opportunity to lead the life they want.

We delivered 28,040 Personal Health Budgets (PHBs) in 2017/18, significantly exceeding our target of 20,000. We are increasingly rolling out PHBs by default for people receiving continuing healthcare (CHC) and expanding local PHB offers to support people with learning disabilities. In July 2017, NAO published the findings of its investigation into NHS Continuing Healthcare. NHS England and the DHSC are working at providing more consistent access to CHC funding and supporting CCGs to make efficiency savings. We introduced an expanded Personal Wheelchair Budgets model to 18 CCGs and providers in 2017/18. We also delivered significantly in excess of our commitment of 10,000 Personal Maternity Care Budgets (PMBs), supporting 18,905 pregnant women in their choice of maternity care.

More than 70,000 personalised care and support plans have been created by people with long term conditions in partnership with professionals through the Integrated Personal Commissioning Programme.

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. During 2017/18, we have completed in the region of 47,000 Patient Activation Measurement assessments and around 70,000 since the programme began. This far exceeds the 50,000 commitment by March 2018, supporting more people to develop their knowledge, skills and confidence to manage their health, improving health outcomes and patient experience.

We also launched a national shared decision making collaborative, working with 13 CCGs to support people with MSK conditions to make more informed decisions about their care.

Meeting our Public Sector Equality Duty (PSED)

NHS England has developed a proactive response to the public sector equality duty and the associated specific equality duties. We have published a comprehensive report¹⁷ which demonstrates that meaningful action is being taken across NHS England that supports compliance with the Equality Act 2010 generally and the PSED specifically. The report also lays a foundation for future developments and for an exploration of the interface between addressing the PSED and the health inequalities duties arising from the Health and Social Care Act 2012. It sets out how NHS England has embraced the requirement to publish equality objectives every four years and equality information annually. Our equality objectives are supported by key targets, and progress in relation to both the equality objectives and the targets are set out in our latest response to the specific equality duties¹⁸.

NHS England's gender pay report¹⁹ was published in March 2018. This complies with the

17 <https://www.england.nhs.uk/about/equality/objectives-16-20/>

18 <https://www.england.nhs.uk/wp-content/uploads/2017/03/nhse-response-to-the-specific-equality-duties-of-the-equality-act-2010.pdf>

19 <https://www.england.nhs.uk/publication/nhs-england-gender-pay-report/>

requirement to publish monitoring information in relation to gender pay gap. Further information can be found on page 79 of our staff report.

Our equality objectives for 2016 to 2020, set out below, address our role as an NHS system leader and our own role as an employer:

Equality objective 1: To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the Public Sector Equality Duty and duties to reduce health inequalities introduced by the Health and Social Care Act 2012.

Equality objective 2: To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.

Equality objective 3: To improve the experience of LGBT patients and improve LGBT staff representation.

Equality objective 4: To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety.

Equality objective 5: To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the Public Sector Equality Duty in relation to patients, service-users and service delivery.

Equality objective 6: To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

During 2019/20 we aim to engage with stakeholders to review our equality objectives in order to publish updated objectives by March 2020.

Sustainability

The Five Year Forward View describes the importance of a sustainable NHS to ensure the continued provision of wide-ranging, high quality care. The sustainable development strategy for the NHS, public health and social care is led by the Sustainable Development Unit (SDU) and describes the vision and goals to support sustainable development, reduce emissions, save money and improve the overall health and wellbeing of communities.

Our Sustainability report describes NHS England's progress and approach to sustainable development and is presented in Appendix 6 from page 177.

Maternity services

Despite the growing challenges faced by maternity services, as the complexities caused by age, weight and the number of co-morbidities of service users increases, the NHS continues to deliver improvements in the outcomes it achieves:

- Between 2010 and 2016 the NHS delivered a 14% reduction in stillbirth, a 6% reduction in neonatal death and a 17% reduction in maternal death.

- The CQC maternity experience survey, published in March 2018, showed improvements in most areas, including choice, emotional support, postnatal care, and with fewer women being left alone at a time that worried them.

Key Deliverables:

- By April 2017, 44 Local Maternity Systems (LMS) were formed, co-terminous with STP footprints, bringing together commissioners, providers and service users to provide local leadership and place-based planning for maternity.
- Over the past year, these LMS have set out proposals and have begun to implement Better Births, the national maternity review (launched in 2016), in their areas.
- To help them do this, every LMS has been provided a bespoke offer of support, setting out the guidance and assistance they can expect from a national and regional level, and from their local strategic clinical network. From a national perspective, support in 2017/18 has included the following publications:
 - Implementing Better Births: A resource pack for LMS (March 2017) provided advice to LMS on how to approach their initial plans for Implementing Better Births.
 - Implementing Better Births: Continuity of Carer (Dec 2017) sets out two models for implementing continuity of carer, and provides practical guidance to LMS on how to develop a continuity of carer model within their services.
- The Saving Babies' Lives care bundle (SBLCB) is now being implemented by the majority of maternity care providers and all will be implementing by March 2019. The evaluation of the SBLCB is expected in the summer of 2018.
- Every NHS trust with a maternity service is taking part in National Maternal and Neonatal Health Safety Collaborative, 44 Trusts recruited for Wave 1 (2017/18), 45 Trusts recruited for Wave 2 (2018/19) and 45 Trusts recruited for Wave 3 (2019/20).
- Personal Maternity Care Budgets featured in the FYFV Next Steps and had an April 2018 target for 10,000. The end of year figure was 19,241, exceeding this target by 92%.
- Decision Aids have been published to support the 'choice discussion' with women about place of birth.
- Perinatal mental health: On the 8 May 2018, NHS England announced that new and expectant mums will be able to access specialist perinatal mental health community services, in every part of the country, by April next year. We have also published perinatal mental health care pathways²⁰.

20 <https://www.england.nhs.uk/publication/the-perinatal-mental-health-care-pathways/>

Learning disabilities

In 2015 we announced that we would reduce the number of people with learning disabilities, autism or both living in long stay specialist hospitals by 35-50% and ensure they received the right care in the right setting, close to home. Since March 2015, we have reduced the number of people living in specialist hospitals by 18%. In the last year significant progress has been made; over 1,600 people have been discharged from hospital, including 180 people who had been in hospital for over 5 years or more. The programme has also been working to prevent avoidable admissions, and the number of people receiving community/pre-admission Care, Education and Treatment Reviews (CETRs) continues to improve, with 42% more pre-admission CETRs undertaken in 2017/18 than in 2016/17 and 79% of these leading to a decision not to admit into inpatient care.

Commissioned by Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and led by the University of Bristol, the Learning Disabilities Mortality Review Programme continued to roll out a review process for the deaths of people with learning disabilities. In early May 2018, the University of Bristol published its annual report on this topic. The report found that, compared with the general population, the median age of death for people with a learning disability is 23 years younger for men and 29 years younger for women. The most common individual causes of premature death were pneumonia, sepsis and aspiration pneumonia; NHS England is feeding these early lessons into hospital and community services' work, including early detection of the symptoms of sepsis, pneumonia prevention, and the management of constipation and epilepsy, as well as developing work with RightCare to create optimal pathways for people with learning disabilities.

We remain committed to ensure more people with a learning disability receive an annual health check, and in 2017/18 the number of people who had an Annual Health Check increased by 10% in comparison with 2016/17.

In 2016/17 we launched the STOMP project (Stop Over Medicating People) to tackle inappropriate prescribing of psychotropic medication. Now over 230 organisations who support people with learning disabilities, autism or both have signed up to a STOMP Pledge, supporting over 55,000 people.

Elective care

The number of patients being referred for elective care by their GP has reduced by 1.6% this year, compared with a 1.5% increase in 2016/17.

Total referral growth in 2017/18 was at 0.3%, a reduction from 2% growth in 2016/17.

This reduction of demand represents a very significant achievement by primary care in redesigning pathways to avoid unnecessary hospital referrals and ensure that patients receive the care they need in the most appropriate location. Without this work, the impact on patients of hospital capacity constraints could have been much greater.

We continue to focus on reducing avoidable demand for elective care to ensure that patients who can have conditions treated in an alternative setting are not referred into hospital. In 2017/18, we have delivered:

- The Elective Care Development Collaborative (ECCR) to support improvements in the design of services, starting with gastroenterology and musculoskeletal (MSK)/orthopaedic services and progressing to diabetes, dermatology, ophthalmology and ear, nose and throat, cardiology, and urology. Our Elective Care Speciality Handbooks for MSK/orthopaedics and gastroenterology were published in November 2017. Further guides will be published in 2018/19.
- MSK triage to ensure that patients are seen by the most appropriate healthcare professional and, if required, a hospital consultant. By February 2018, 158 out of 197 CCGs had established compliant MSK triage services. We anticipate this increasing to 166 by the end of March 2018.
- Clinical peer review where GPs assess each other's new referrals to provide constructive feedback in a safe learning environment. By the end of March 2018 we anticipate that 35 CCGs, peer review, will have adopted this in at least half of their GP practices.
- Advice and guidance to support management of patients in a primary care setting where appropriate in lieu of outpatient referral. A non-mandated price structure has been developed and will undergo consultation through the NHS Improvement Tariff engagement process in early 2018/19.
- Capacity alerts via the e-referral system (e-RS) seeking to spread demand away from providers with the longest waiting times and help ensure the NHS is making best use of elective capacity across the country. Pilot sites have shown capacity alerts on e-RS can steer referrals, for certain specialties, from hospitals with limited capacity to those more able to meet the demand. National roll-out of capacity alerts is underway.

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2018 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 207 CCGs, consolidated through the Integrated Single Financial Environment (ISFE), a financial accounting and reporting system encompassing all of the organisations concerned.

NHS England was required to limit its revenue spending to £110,002 million in 2017/18. We are responsible for using this money wisely and fairly to secure the best 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.

Operational performance

The NHS England Group has delivered a managed underspend of £970 million (0.9% as a percentage of allocation) against its £109,536 million budget for in-year operational expenditure²¹.

£640 million of this underspend came from the release of the system risk reserve and other contingencies. The system risk reserve was an amount set aside in our allocation in case of need across the NHS system. It was made up of the following elements:

- Half of the 1% non-recurrent investment planned by CCGs (£360 million).
- £200 million set aside centrally by NHS England.

A further £80 million was added to this reserve from other sources during the course of the year, and all three elements were released at the end of the financial year to offset overspends by hospitals and other NHS service providers.

For 2018/19 NHS England and CCGs will not be holding any national risk reserve beyond normal operating contingencies. £650 million has instead been allocated to expand the Provider Sustainability Fund from £1.8 billion this year to £2.45 billion next year and thereby enable the provider sector to plan for and deliver a balanced financial position.

21 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.

The key features of the 2017/18 financial position are shown in more detail in the following table:

Financial performance - RDEL general (non-ring-fenced)

Financial performance	2017/18		2016/17		2015/16		2014/15		2013/14			
	Expenditure		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan		Under/ (over) spend against plan			
	Plan	Actual	£m	%	£m	%	£m	%	£m	%		
CCGs	80,964	81,177	(213)	(0.3)%	154	0.2%	(15)	0.0%	70	0.1%	89	0.1%
Direct Commissioning	24,439	24,216	223	0.9%	296	1.2%	82	0.3%	(12)	0.0%	(365)	(1.4)%
NHS England Admin/ Central Progs/ Other	4,133	3,171	962	23.3%	439	13.2%	340	21.4%	193	12.2%	679	34.4%
Historical Continuing Healthcare Claims administered on behalf of CCGs	-	2	(2)	0.0%	13	8.6%	192	67.7%	33	35.4%	(77)	0.0%
Total	109,536	108,566	970	0.9%	902	0.9%	599	0.6%	285	0.3%	326	0.3%

CCG performance

CCGs have delivered an unprecedented level of efficiencies, equivalent to 3.1% of their allocations, and have generally performed well in taking appropriate action to manage unprecedented pressures. £349 million of CCG cost pressures relate to the impact of significant issues with generic drug pricing set by DHSC, which are outside the control of local NHS organisations. This pressure has been partially offset by an £80 million prior year rebate on Category M drugs which was passed back to CCGs at the end of the year for release as part of the system risk reserve (see above).

There were overspends in 124 CCGs, with 65 CCGs overspent by more than 1%. Releasing the 0.5% risk reserve reduced this to 75 CCGs with an overspend, and 57 with an overspend of more than 1%.

Most of the underspend in Direct Commissioning comes from Specialised Commissioning, reflecting improvements in financial management processes and controls over the last two years.

Management took action early in 2017/18 to cover the emerging overspends by CCGs, including the impact of the concessionary drug pricing pressures described above. Underspends against central budgets are a mixture of non-recurrent, central running and programme cost underspends, mainly due to vacancy management, and the deferral of some transformation expenditure. Whilst necessary to deliver our contribution to the overall NHS financial position in 2017/18, deferring expenditure on transformation priorities in particular is neither sustainable nor consistent with our Five Year Forward View ambitions.

£25 million of the central underspend relates to winter funding attributable to the provider sector but not allocated to individual organisations.

Performance against wider financial metrics

Within the Mandate, the DHSC sets a number of technical financial targets for the NHS England Group, including the core operational limit (general RDEL) described above. These limits are ringfenced, which means that underspends on the other revenue limits cannot be used to support core patient services covered by the general RDEL limit.

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

2017/18 Performance against key financial performance duties

	Target				Underspend as % of Mandate
	Mandate Limit £m	Actual £m	Underspend £m	Target met	
RDEL - general	109,536	108,566	970	✓	0.9%
RDEL - ring-fenced for depreciation and operational impairment	166	123	43	✓	25.9%
Annually Managed Expenditure limit for provision movements and other impairments	100	18	82	✓	82.0%
Technical accounting limit (e.g. for capital grants)	200	55	145	✓	72.5%
Total Revenue Expenditure	110,002	108,762	1,240		1.1%
Administration costs (within overall revenue limits above)					
Total administration costs	1,805	1,583	222	✓	12.3%
Capital limit					
Capital expenditure contained within our Capital Resource Limited (CRL)	247	228	19	✓	7.8%

Allocations

NHS England has responsibility for allocating NHS funding agreed with the DHSC as part of our Mandate. We are required 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.

The November budget set by Government made an additional £337 million available in the 2017 Mandate for the management of 'winter pressures' and confirmed that 2018/19 revenue for NHS England would grow by £1.6 billion over the 2015 Spending Review figure. The DHSC subsequently agreed to make available a further £540 million for 2018/19.

As set out in our Board paper on allocations in February 2018 we are using this funding to:

- ensure that existing care is funded, recognising the current deficits in the provider and CCG sectors;
- cover the additional costs of emergency care improvements and growth in line with Mandate commitments;
- build on the progress made in 2017/18 and protect investment in mental health, cancer services and primary care; and
- enable carefully chosen investments in other local and national priorities in line with available resources and agreed plans.

The Government has also committed to provide additional funding in 2018/19 to cover the impact of its recent announcements on pay rises for NHS staff.

Future financial sustainability

The 10-point plan for efficiency was published as part of the Next Steps on the NHS Five Year Forward View and forms the blueprint for implementing the joined up national and local efficiency improvement initiatives required to ensure financial sustainability over the coming years.

The ten areas of focus being pursued across the NHS are:

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.

In 2018/19 local systems are expected to build on their success to date in implementing the priority efficiency programmes within the 10 Point Efficiency Plan. We expect all STPs to continue to identify and implement system-wide efficiency opportunities, such as reducing avoidable demand and unwarranted variation and sharing clinical support and back office functions.

The recently announced five-year funding settlement for the NHS, designed to support a 10-year strategy created on the platform of the Five Year Forward View, provides an important opportunity, in its 70th year, to put the NHS on a sustainable financial footing and create the foundations required to capture the opportunities of the decade ahead.



Paul Baumann

Chief Financial Officer