Board Meetings held in Common

Meeting Date: 27 June 2019

Agenda item: 4

Report by: Julian Kelly, Chief Financial Officer

Report on: Month 12, 2018/19 Finance Report

Decision Making Responsibility:

NHS England	☐
NHS Improvement	☐
NHS England and NHS Improvement	☐
N/A - joint discussion	☒

Introduction

1. This paper provides the following a summary of the financial position across the NHS as a whole and the commissioner and provider sectors for the 2018/19 financial year.

Context

2. This report shows an aggregated financial position for both the commissioner and provider sectors based on current reporting practices. The commissioner sector figures are presented on a non-ringfenced RDEL basis and include NHS England central and corporate budgets. The provider sector figures are reported using Generally Accepted Accounting Principles on an adjusted financial position basis. They include the Provider Sustainability Fund (PSF) within provider results where earned, and centrally in other cases. The positions reported only include the aggregate of individual providers. NHS Improvement corporate budgets are not included as they are considered outside of the NHS ringfence and are also non-material to the overall financial position. The commissioner and provider sector figures are based on the final accounts position.

Summary of the year-end financial position

3. Table 1 shows an aggregated position for the commissioner and provider

sectors based on current reporting practices.

4. In summary, the year-end financial position across the NHS is a **revenue underspend of £89m** (para 5 onwards) and a **capital overspend of £330m** (para 14).

Table 1

Suplus / (Deficit)		Month 12 Outturn			
		Plan	Actual	Under/(over) spend	
		£m	£m	£m	%
Commissioner Sector					
	Clinical Commissioning Groups	48.2	(155.0)	(203.2)	(0.2%)
	Direct Commissioning	120.0	315.4	195.4	0.8%
	NHSE Running & central programme costs	96.8	713.2	616.4	14.3%
	Other including technical & ringfenced adjustments	0.0	42.6	42.6	
Commissioner Sector Total - non-ringfenced RDEL		**265.0**	**916.2**	**651.2**	**0.6%**
Provider Sector					
	NHS Providers	(1,048.0)	(867.2)	180.8	0.2%
	Technical adjustments incl. uncommitted PSF	654.0	296.0	(358.0)	(0.4%)
Provider Sector Total - including PSF		**(394.0)**	**(571.2)**	**(177.2)**	**(0.2%)**
Total combined position		**(129.0)**	**345.0**	**474.0**	
Total combined position - exc. exceptional technical adj*		**(129.0)**	**89.0**	**218.0**	

*accounting treatment of Carillion PFI part-donated assets

5. For the year to 31 March 2019, the provider sector reported a headline deficit of £571 million, a variance to plan of £177m. This includes a £256m benefit from the accounting treatment of Carillion PFI part-donated assets which are not recognised for RDEL reporting purposes, the key measure for departmental reporting (see paragraph 9 for further detail). Excluding this adjustment, the provider position shows an overspend of £827m. At the year-end, the overall position for NHS England is a managed underspend of £916m against the planned underspend of £265m, a positive variance to plan of £651m. ***This gives a combined underspend for the NHS for 2018/19 of £89m.***

6. Table 2 shows the number and value of CCGs and NHS providers who ended the financial year with overspends and underspends against plan.

Table 2

	Month 12 Outturn			
	Overspend		Underspend	
	#	£m	#	£m
Clinical Commissioning Groups	33	(291.2)	27	27.0
NHS Providers (incl. PSF)	70	(973.4)	159	1,154.1
NHS Providers (excl. PSF)	80	(778.8)	145	305.3

7. By the end of the financial year 70 providers had overspends, of which 33 were over £10m. If the PSF is excluded, there are 80 providers with overspends, of which 29 were over £10m. These 29 providers have an aggregate variance to

plan of £569m which is 120% of the sector headline variance to plan excluding PSF.

8. Key factors cited by providers as contributing to overspends include:
   - difficulties in achieving planned efficiency savings;
   - operational cost pressures relating to temporary staffing;
   - substantive workforce pressures including the extent to which the Agenda for Change pay awards are fully funded;
   - unplanned investments required to maintain or improve service quality; and
   - unplanned emergency activity displacing elective income.

9. The year-end provider position includes the benefit of a £256m exceptional technical adjustment. As a result of the liquidation of Carillion, two PFI hospitals were brought onto providers' books as part-donated assets. This results in the affected providers recognising additional income. The accounting treatment – recognising donated assets as income - is consistent with previous years, follows HM Treasury rules for donated asset accounting in local bodies, and has been agreed with the Department of Health and Social Care. However, the income and bottom line gain are not recognised for RDEL reporting purposes, the key measure for departmental reporting.

10. CCGs have overspent by £264m against their plan, with 33 CCGs ending the year with an overspend against plan. The CCG position is partially offset by £61m of the centrally held Quality Premium budget, which is the amount that has not been earned by commissioners.

11. Managed underspends in NHS England direct commissioning budgets are mainly driven by Specialised Commissioning, particularly management of drugs budgets.

12. The positive position on NHS England central budgets includes savings from vacancy control, and income from GP rates rebates and counter fraud receipts. In addition, during the year NHS England acted to ensure delivery of the overall financial position by holding back investment that would otherwise have been used to fund transformation and service improvement.

13. Material financial pressures that have been absorbed within the commissioner sector financial position for 2018/19 include:
   - increased prescribing costs relating to No Cheaper Stock Obtainable (NCSO) designations on certain drugs;
   - increased costs as a result of the Government's GP pay awards; and
   - the loss of the savings expected from DHSC's renegotiation of community pharmacy fees that DHSC did not secure.

14. The NHS England capital outturn position reported expenditure of £221m against a mandate of £255m - an underspend of £34m. For the provider sector, the actual CDEL expenditure at Month 12 final accounts is £3.93 billion, an

underspend against the provider plans of £711 million. The Department of Health and Social Care set a provider sector budget for capital resource of £3.56 billion in 2018/19. The actual Month 12 expenditure exceeds this budget by £378 million.

APPENDIX A

NHS ENGLAND FINANCIAL PERFORMANCE
Summary of Expenditure by Area of Commissioning

	Month 12 Outturn			
	Plan £m	Actual £m	Var £m	Var %
Local Net Expenditure				
North	25,348.5	25,360.1	(11.6)	(0.0%)
Midlands & East	24,710.9	24,776.1	(65.2)	(0.3%)
London	13,526.3	13,641.1	(114.8)	(0.8%)
South West	7,974.2	7,974.1	0.1	0.0 %
South East	12,740.5	12,812.9	(72.4)	(0.6%)
Quality Premium[1]	60.7	0.0	60.7	0.0 %
Total Local Net Expenditure	**84,361.1**	**84,564.3**	**(203.2)**	**(0.2%)**
Direct Commissioning				
Specialised Commissioning	17,314.2	17,183.9	130.3	0.8 %
Armed Forces	57.8	57.8	0.0	0.0 %
Health & Justice	585.6	579.0	6.6	1.1 %
Primary Care & Secondary Dental	5,672.6	5,644.8	27.8	0.5 %
Public Health	1,087.1	1,056.8	30.3	2.8 %
Total Direct Commissioning Expenditure	**24,717.3**	**24,522.3**	**195.0**	**0.8 %**
NHS England Other (excluding depreciation & technical)				
NHS England Running Costs (excl. depreciation)	466.0	449.6	16.4	3.5 %
NHS England Central Programme Costs (excl. depreciation)	892.1	792.9	99.2	11.1 %
CSUs net margin	7.1	7.1	0.0	0.0 %
Other Central Budgets (including provider STF)[2]	2,951.0	2,450.0	501.0	0.0 %
Total NHS England Other (excluding depreciation & technical)	**4,316.2**	**3,699.6**	**616.6**	**14.3 %**
NHS England depreciation charges	136.0	109.4	26.6	
Remove ringfenced under/(over) spend (depreciation and impairments)	(166.0)	(132.1)	(33.9)	
Remove AME/Technical items	(8.8)	(58.9)	50.1	
Total non-ringfenced RDEL	**113,355.8**	**112,704.6**	**651.2**	**0.6%**

Note 1 - Quality Premium is added to the planned expenditure (and income) of CCGs in the lines above when earned. This line shows the element of annual quality premium budget which has not yet been earned.

Note 2 - Expenditure relating to awards under the provider element of the Sustainability Fund (PSF) is assumed to be in line with the full allocation of £2.45bn. The related income for trusts is fully accounted for in the provider position reported by NHS Improvement - either within individual organisations' results and forecasts or as a separate line to the extent that it is either not yet allocated or not earned under the relevant award criteria.

Based on the draft accounts position, 33 CCGs have ended the financial year with overspends. The most significant overspends were in 2 CCGs in the North (£13.9m), 3 CCGs in Staffordshire (£64.6m), 5 CCGs in Kent & Medway (£43.3m) and 13 CCGs across London (£130.3m). The main reasons for CCG overspends were QIPP under-delivery and acute contract pressures.

The 2018/19 plan included £90m that was initially held centrally for CCG Quality Premium and then added to CCG budgets when earned. We ended the year with a £61m underspend against this budget due to a high proportion of CCGs failing to deliver the relevant performance and/or financial targets in 2017/18.

Direct Commissioning underspends related to central specialised commissioning budgets, dental budgets and slippage on the Bowel Scope Screening programme in line with the revised implementation profile. Community Pharmacy pressures associated with the reduction in pharmacy fee savings in 2018/19 were managed non-recurrently across all regions.

The underspend on NHS England central budgets was largely due to vacancies, income from GP rates rebates and counter fraud receipts not included in the operating plan, plus the release of contingencies and reserves that were not required. The outturn position also reflects greater pressure than expected from the impact of the technical and ringfenced adjustments relating to provision movements and

NHS ENGLAND FINANCIAL PERFORMANCE
Summary of Efficiency Performance by Area of Commissioning

	Commissioner Efficiency Outturn						2017/18		Percentage Increase	
	Plan £m	As % of Allocation	Actual £m	As % of Allocation	Var £m	Achieved %	Outturn £m	As % of Allocation	Planned %	Outturn %
Local										
North	675.6	2.7%	586.9	2.3%	(88.7)	86.9 %	630.1	2.6%	7.2%	(6.9%)
Midlands and East	903.6	3.7%	822.4	3.3%	(81.2)	91.0 %	855.6	3.6%	5.6%	(3.9%)
London	522.4	3.9%	427.0	3.2%	(95.4)	81.7 %	410.8	3.2%	27.2%	3.9%
South West	253.7	3.2%	240.7	3.0%	(13.0)	94.9 %	589.1	3.0%	8.3%	(0.6%)
South East	384.2	3.0%	344.8	2.7%	(39.4)	89.7 %				
Total Local	**2,739.5**	**3.2%**	**2,421.8**	**2.9%**	**(317.7)**	**88.4 %**	**2,485.6**	**3.1%**	**10.2%**	**(2.6%)**
Direct Commissioning										
Specialised	523.9	3.0%	513.3	2.9%	(10.6)	98.0 %	413.9	2.5%	26.6%	24.0%
Armed Forces	0.0	0.0%	0.0	0.0%	0.0	100.0 %	0.0	0.0%	0.0%	0.0%
Health & Justice	3.7	0.6%	3.7	0.6%	0.0	100.0 %	3.5	0.6%	6.8%	6.8%
Primary Care and Secondary Dental	57.3	0.9%	48.3	0.7%	(9.0)	84.3 %	110.9	1.7%	(48.3%)	(56.5%)
Public Health	3.6	0.3%	3.6	0.3%	0.0	100.0 %	7.5	0.8%	(51.7%)	(51.7%)
Total Direct Commissioning	**588.5**	**2.3%**	**568.9**	**2.2%**	**(19.6)**	**96.7 %**	**535.8**	**2.2%**	**9.8%**	**6.2%**
Total Commissioner Efficiency	**3,328.0**	**3.0%**	**2,990.7**	**2.7%**	**(337.3)**	**89.9 %**	**3,021.4**	**2.9%**	**10.1%**	**(1.0%)**
Of which transformational	1,531.2	1.4%	1,169.9	1.1%	(361.3)	76.4 %	1,208.0	1.2%	26.8%	(3.2%)

CCGs delivered 88.4% of their efficiency plans for the year which equated to £2.4bn or 2.9% of their allocation. This is in line with the level of savings delivered by CCGs in 2017/18. Overall, NHS England has delivered almost £3.0bn of efficiencies (90.0% of plan and 2.7% of allocation), 40% of which were transformational.

The NHS England figures in this report are derived from the consolidated financial reports of clinical commissioning groups (CCGs) and direct commissioning units, which have been reviewed and assured by local offices and the regional teams, and from the monthly financial reports on central budgets. The information is presented on a non-ringfenced RDEL basis.

Detailed financial performance information is published on the NHS England website on a quarterly basis (https://www.england.nhs.uk/publication/financial-performance-reports/).

APPENDIX B

NHS IMPROVEMENT FINANCIAL PERFORMANCE
Financial performance overview by sector

Financial performance overview 12 months ended 31 March 2019 by sector	Number of providers	Month 12 Outturn				
		Plan	Actual	Variance to plan		Deficit Providers
		£m	£m	£m	%	No.
Acute	133	(1,392)	(1,548)	(156)	(11.2%)	89
Ambulance	10	10	22	12	119.6%	3
Community	17	30	55	25	83.5%	3
Mental Health	53	177	414	237	133.9%	7
Specialist	17	127	190	63	49.7%	5
Control total basis surplus / (deficit) including PSF	**230**	**(1,048)**	**(867)**	**181**	**(17.3%)**	**107**
Technical adjustments incl. uncommitted PSF		673	59	(614)	(91.2%)	
Less GIRFT funded from PSF		(19)	(19)	0	0.0%	
Reported Deficit before exceptional technical adjs.		**(394)**	**(827)**	**(433)**	(109.9%)	
Exceptional technical adjustment (accounting treatment of Carillion PFI part-donated assets)		0	256	256	-	
Reported adjusted financial position surplus / (deficit) including all PSF		**(394)**	**(571)**	**(177)**	**(45.0%)**	

Based on the final accounts for the year to 31 March 2019, the provider sector reported a deficit of £571 million, £395 million better than last year. This is a £90 million improvement on the forecast at Quarter 3.

The overall position continues to be skewed by a small number of under-performing providers. Excluding the Provider Sustainability Fund (PSF), 29 providers (12.6%) reported a variance from plan of more than £10 million (22 at Quarter 3). In aggregate, these 29 providers account for £569 million (120%) of the sector variance to plan excluding PSF.

The overspend is entirely due to pressures in the acute sector and is offset by small underspends in the ambulance, community, mental health and specialist sectors.

Note: Interim files have been received from 6 providers with final audit opinions still awaited at time of writing on 6 June 2019

NHS IMPROVEMENT FINANCIAL PERFORMANCE
Financial performance overview by region

Financial performance overview 12 months ended 31 March 2019 by region	Number of providers	Month 12 Outturn				Deficit Providers
		Plan	Actual	Variance to plan		
		£m	£m	£m	%	
London	36	(134)	(82)	52	38.8%	13
Midlands	69	(640)	(888)	(248)	(38.7%)	40
North	70	(282)	76	358	127.0%	28
South	55	8	27	19	232.9%	26
Control total basis surplus / (deficit) including PSF	**230**	**(1,048)**	**(867)**	**181**	**(17.3%)**	**107**
Technical adjustments incl. uncommitted PSF		673	59	(614)	(91.2%)	
Less GIRFT funded from PSF		(19)	(19)	0	0.0%	
Reported Deficit before exceptional technical adjs.		**(394)**	**(827)**	**(433)**	(109.9%)	
Exceptional technical adjustment (accounting treatment of Carillion PFI part-donated assets)		0	256	256	-	
Reported adjusted financial position surplus / (deficit) including all PSF		**(394)**	**(571)**	**(177)**	**(42.4%)**	

In absolute terms the Midlands region reported the highest level of overspend at the year end. At an aggregate level the North region reported the biggest positive variance to plan and succeeded in delivering an overall surplus compared with a planned deficit.

NHS IMPROVEMENT FINANCIAL PERFORMANCE
Financial performance overview by income and expenditure

12 months ended 31 March 2019	Year End Month 12 2018/19			
	Plan	Actual	Variance to plan	
	£m	£m	£m	%
Income from patient care activities	73,977	75,738	1,761	2.4 %
Other income	9,505	10,803	1,298	13.7 %
Employee expenses	(53,014)	(54,968)	(1,954)	(3.7%)
Non pay costs	(31,516)	(32,440)	(924)	(2.9%)
Control total basis surplus / (deficit) including PSF	**(1,048)**	**(867)**	**181**	**17.3 %**
Technical adjustments incl. uncommitted PSF	673	59	(614)	
Less GIRFT funded from PSF	(19)	(19)	0	
Reported Deficit before exceptional technical adjs.	**(394)**	**(827)**	**(433)**	**(109.9%)**
Exceptional technical adjustment (accounting treatment of Carillion part-donated assets)	0	256	256	
Reported adjusted financial surplus / (deficit) including all PSF	**(394)**	**(571)**	**(177)**	**(44.9%)**

The year-end figures are driven by higher than expected income (particularly non-elective income) of £3,059m which is offset by an increase in both pay expenditure (up by £1,954m) and non-pay costs (up by £924m). Pay includes the impact of Agenda for Change (AfC) pay awards which were not included in the plan or the earlier months' figures. By the year-end this amounted to £832m, leaving a variance not related to AfC of £1,122m. During the year, the government committed £783 million of additional funding to the provider sector to meet these costs, the bulk of this funding being included in other income. The favourable income variance also includes uncommitted PSF of £655 million which has been allocated to trusts at year end. When PSF is excluded there is an overall adverse variance to plan which is focused in a small number of providers as previously identified.

The common themes underlying these variances include, difficulties in achieving planned efficiency savings; operational cost pressures relating to temporary staffing; substantive workforce pressures including the extent to which the Agenda for Change pay awards are fully funded; unplanned investments required to maintain or improve service quality; and unplanned emergency activity displacing elective income.

NHS IMPROVEMENT FINANCIAL PERFORMANCE
Summary of CIP Performance

Efficiency Summary - Year to date 12 months ended 31 March 2019	Month 12 Outturn			
	Plan	Actual	Variance	
	£m	£m	£m	%
Recurrent	3,126	2,222	(904)	(28.9%)
Non Recurrent	451	1,010	559	123.9%
Total efficiency savings	**3,577**	**3,232**	**(345)**	**(9.6%)**
Efficiencies as a % of Spend	4.1%	3.6%		

During 2018/19, providers achieved savings through cost improvement programmes (CIPs) of £3.2 billion or 3.6%, almost identical to the level achieved in 2017/18 (£3.2 billion or 3.7%). This was set against planned efficiency savings for 2018/19 of £3.577 billion (4.1%), so the efficiencies achieved were £345 million less than plan.

This is consistent with the pattern of CIP delivery seen in previous years with an under achievement of recurrent CIPs (29%) being partially compensated by an over-recovery of non-recurrent CIPs (124%).

Detailed financial performance information is published on the NHS Improvement website on a quarterly basis (https://improvement.nhs.uk/resources/?theme=operational-performance).

Board Meetings held in Common

Meeting Date: 27 June 2019

Agenda item: 4

Report by: Julian Kelly, Chief Financial Officer
Matthew Swindells, Deputy Chief Executive
Pauline Philip, National Director of Urgent and Emergency Care

Report on: Operational Performance Report

Decision Making Responsibility:

NHS England	☐
NHS Improvement	☐
NHS England and NHS Improvement	☐
N/A - joint discussion	☒

Introduction

1. This paper provides a summary of the most up to date operational performance including recent activity trends. The CFO will give a verbal update on the month 2 financial position as the final figures are not available at the time this report is being submitted.

2. We also publish comprehensive statistics regarding NHS performance on our website: https://www.england.nhs.uk/statistics/statistical-work-areas/combined- performance- summary/

Managing Demand and Transforming Care Models

Urgent and Emergency Care

Performance

1. Performance against the A&E 4-hour standard for 2018/19 as a whole finished at 88.0%, 0.3 percentage points below 2017/18, with a 3.8% increase in attendances and 800,000 more patients treated within 4 hours. Within that, performance over winter 2018/19 (December–March) was 85.4%, representing the first year-on-year improvement in the last five years. 380,000 more patients were treated within 4 hours compared to winter 2017/18, with significant improvements in patient flow metrics such as 12-hour waits from decision to admit and ambulance handover delays.

2. 4-hour A&E performance for May was 86.6%, compared to 85.3% in April and 90.5% in May 2018.[1]

Demand

3. The rolling 3-month average growth for February-April 2019 showed significant increases in demand compared to the same period in 2018; total A&E attendances were up 7.8% and total emergency admissions increased by 5.5%.

4. The majority of the reported rise in attendances was among patients presenting with minor conditions. Periods of cold weather in the previous winter had the effect of supressing demand last year, and the broader range of co-located GP-led urgent care services now available means increasing numbers of patients are accessing more services via emergency departments. There are now 110 designated Urgent Treatment Centres meeting the standards, with a further 55 scheduled to be designated by December 2019.

5. Similarly, the reported rise in emergency admissions has coincided with the increase in Same Day Emergency Care (SDEC) provision, which is helping to reduce unnecessary overnight admissions and bed occupancy. The majority of the 5.5% growth in non-elective admissions for February–April was for patients with a zero-day length of stay, which grew by 12.9% compared to the same period last year, while those with a length of stay of one day or more grew by 2.2%.

6. Analysis of the observed demand growth in the early part of the year shows that, while there were some higher than expected increases among certain demographics – for example in paediatric respiratory conditions and for the 45-74-year-old age cohort – there has not been a significant and dramatic decline in population health leading to significantly more people requiring emergency

[1] Note that providers undertaking field testing of new A&E standards were not required to submit 4-hour breaches from May 2019, therefore all performance reporting for 2019/20 and the associated comparisons to previous years will exclude these 14 providers. The usual historic time series of monthly national performance data published on 13th June also included historic data for each month with the 14 sites removed, to enable like-for-like comparisons on previous years.

care. Instead, the reported increase can be attributed to the relatively lower numbers of patients attending A&E last year and increased coding of urgent care activity following the successful implementation of urgent care reforms, with an improved offer of timely and appropriate care for patients via the front door of emergency departments. This is further supported by the 2.6% reduction in non-elective bed days between February–April when compared to the same period last year.

7. In May 2019, demand growth slowed; 2,172,920 people attended A&E, an increase of 0.4% on the same month last year, while total emergency admissions grew by 2.6% over the same period.

Patient Flow

8. The focus on reducing long length of stay for those patients who have been in hospital for 21 days or more continues. In 2018/19 we achieved a reduction on the 2017/18 baseline of 9% and released 1,786 beds by April 2019. In the 2019/20 planning guidance, we increased our ambition in this area and are aiming for a 40% reduction nationally by March 2020. Continued Delayed Transfers of Care (DTOC) reductions show that there were 4,361 occupied beds (equivalent to 130,842 delayed days) in April 2019, down by 484 (-10%) compared to April 2018.

9. A care home capacity tracker funded by NHSE is now being used by 90 CCGs and their associated councils across England to support patient flow and help reduce delayed transfers of care. A further 12 areas are currently being mobilised. As of 12 June, 23,600 vacant care home places, posted by 7,000 care homes, are searchable on the system by 11,000 users with at least one care home sharing vacancies in 191 out of 195 CCG boundaries.

Out of Hospital Care

10. We have seen improved performance delivery in the ambulance sector during 2019 (January–May) with category C1 and C4 response times shorter than in the same months of 2018, and all trusts (excluding Isle of Wight) regularly achieving the 90th centile standard for Category 1 response times for the most life-threatening cases . National performance against the Category 1 mean was 6 minutes and 54 seconds (against a 7 minute standard), the shortest time since current categories were adopted throughout England in 2017

11. In May 2019, the NHS managed 1.36 million 111 calls. The year-to-date figure for 2019/20 (up to May 2019) has seen over 84,500 more calls than the same period last year. Of calls answered by NHS 111 in May 2019, 86.4% were answered within 60 seconds compared to 84.8% in the same month last year, whilst clinical advice was provided in 54.2% of triaged calls, up from 51.6% in May 2018.

12. 100% of the country's population is covered by NHS 111 Online (with at least phase 1 functionality). The full 111 online service (known as phase 3[2] - full integration) covers 81.8% of the population, and a further 18.2% can receive a call back when appropriate (known as phase 2 - CAS integration). The remaining work to bring all areas to phase 3 integration is planned to take place over the coming months. In May, NHS 111 online accounted for 10% of all NHS Pathways triages (across online and telephone).

Referral to Treatment

13. Performance on the Referral to Treatment (RTT) waiting time standard in April 2019 saw 86.5% of patients waiting less than 18 weeks, a slight decrease on 86.7% in the previous month. This compares to 87.6% in April 2018. The overall reported waiting list size increased by 65,000 over March 2019 to 4.3 million in April 2019. 2018/19 saw a record number of over 14.3m patients treated within the 18-week RTT national standard, surpassing the previous record set in 2016/17 by 84,952 (allowing for inclusion of estimated data for non-reporting trusts).

14. The concerted focus to reduce the number of patients waiting 52 or more weeks for treatment continues to show month-on-month progress. There has been a reduction of 70.2% over 52 week waits from the peak in June 2018 (3,517), to the published April 2019 position of 1,047.

15. The year-to-date has seen significant progress with mobilisation of MSK First Contact Practitioner (FCP) services, which follows the successful mobilisation of pilot sites in 41 of 42 STPs in 2018/19. Nationally the ambition is to achieve 15% of adult population coverage by the end of March 2020. A trajectory to support mobilisation has been co-produced with regional teams, which is in line with the NHS Long-Term Plan for FCP services to be rolled out across all health economies and population by 2023/24, covering an adult patient population of approximately 42,000,000. FCP services support patients with MSK conditions to be seen directly by a physiotherapist in GP practices without the need to see a GP.

16. The EyesWise programme is underway – this initiative, in collaboration with the Royal College of Ophthalmologists, is supporting the development and local implementation of new ways of delivering ophthalmology outpatient services to best meet the growing demands on Hospital Eye Service Departments. The aim is to ensure that patients most at risk of sight loss get access to care as quickly as possible, improving patient experience, quality of care and efficiency. This

[2] Phase 1: users can visit 111.nhs.uk, answer questions about their symptoms, and receive appropriate information about what to do and where to go. *This level of functionality is available nationwide.*
Phase 2: 111.nhs.uk is integrated with one local urgent care service, usually the NHS 111 provider. When appropriate, the user can pass their case and phone number to the provider, who will ring them. *This level of functionality is available nationwide.*
Phase 3: 111.nhs.uk is integrated with all local urgent care services able to receive cases. As above, services will phone patients and make appropriate arrangements for their care. *As of 17 June, this level of functionality is available to 83.9% of the population*

work includes a focus on how best to meet the needs of glaucoma patients or those at risk of glaucoma.

17. Tools and resources to support the whole-system transformation of outpatients are available on the Elective Care Community of Practice. This includes eleven published specialty handbooks, with three further handbooks in development ready for publication soon.

Cancer

18. As of now, all new screening invitations will use the Faecal Immunochemical Test (FIT) test. The main benefits of FIT versus the previous gFOBt (guaiac faecal occult blood test) are that it is more accurate, it is easier to use, and pilots have shown that it can increase uptake by circa 7% and potentially double uptake in groups that have previously not taken part in the programme.

19. All provider trusts in England were mandated to record data items for the new Faster Diagnosis Standard from 1 April 2019. This is a key milestone for the Faster Diagnosis Standard implementation, as the data will inform further development of the standard before it is published from 1 April 2020.

20. Personalised care for people living with and beyond a cancer diagnosis is being rolled out across England in line with the NHS England Comprehensive Model of Personalised Care. Since 2017, the proportion of trusts with at least one cancer multi-disciplinary team offering care planning increased from 58% to 97%. Offering a holistic needs assessment increased from 77% to 99.3%. Good progress is being made to redesign follow up and releasing significant outpatient clinic capacity.

21. The new Cancer Quality of Life (QoL) metric will bring parity to QoL as an outcome alongside survival and provide important new information to support planning of service/pathway developments that address QoL.1,758 cancer patients have completed QoL questionnaires in pilot testing to date which is a response rate of 51%. Further testing is needed prior to the decision on roll out in 2020.

22. 2018/19 was a record-breaking year for referrals and treatments on the 62-day pathway from GP referral pathway. In 2018/19 a total of 2,239,453 referrals were made on the two week-wait from GP referral pathway. This is 304,399 (15.7%) more than 2017/18 and 885,323 (65.4%) more than 5 years ago. The increased level of demand has continued into the current financial year, with 196,775 referrals received on the 2ww pathway in April 2019 compared to 173,618 in April 2018, an increase of 13.3%. Of these, 89.9% were seen within two weeks in April 2019, compared to 90.8% in April 2019.

23. In 2018/19, on the 62-day cancer pathway, 162,996 patients received treatment, 15,910 (10.8%) more than the previous year and 39,423 (32%) more than five years ago. Of these patients, 79.4% began first definitive treatment

within 62 days of urgent referral, compared to 82.3% in April 2019. We are seeing more patients within the 62-day target, with 128,892 being treated by day 62 in 2018/19 – 8,053 (6.7%) more than 2017/18 and 22,788 (21.5%) more than five years ago. Treatments are also continuing to rise, In April 2019, 13,147 treatments were delivered, 644 more than April 2018, an increase of 5.4%.

Primary Care and System Transformation (PCST)

Primary Care Networks establishment

24. In the NHS Long Term Plan, Primary Care Networks (PCNs) were identified as an essential building block of every Integrated Care System. Since Sept 2019, we have undertaken extensive engagement to promote networks and held over 40 events involving over 2,700 people across the country. We have also conducted a series of PCN themed webinars reaching over 3,000 people, and run PCN WhatsApp groups with several hundred members.

25. There has been significant positive engagement between practices, CCGs, Local Medical Councils (LMCs) and NHS England and NHS Improvement regional teams, working together to support PCN establishment and resolve local issues where they arise. This is reflected in strong progress towards the goal of 100% coverage by 1 July 2019.

26. Figures remain fluid and are subject to change. In the latest estimation, and subject to approval, over 99% of practices across the country are part of PCNs. Teams from the seven NHS England and NHS Improvement regions are working together to ensure consistency of approach in their discussions with practices, CCGs and LMCs.

Integrating Care Locally

27. NHS England and NHS Improvement continue to support systems to meet the NHS Long Term Plan ambition that integrated Care Systems (ICSs) will cover the whole of England by 2021. ICSs bring together local organisations to redesign care and improve population health, creating shared leadership and collective responsibility for improvement. They are a pragmatic and practical way of delivering the triple integration of primary and specialist care, physical and mental health services, and health with care.

28. Work with current ICSs and Sustainability and Transformation Partnerships (STPs) has helped to identify common characteristics of systems at different levels of maturity. These are shown in the system maturity matrix, which will be published with the Long Term Plan implementation framework. Systems considered to meet the attributes of a ‘maturing ICS’ were nominated by regions for the third ICS wave; an announcement on the new ICSs was made at NHS Confederation on 19 and 20 June 2019.

29. Over the summer, we are working with system leaders and their teams to identify where they are on the maturity matrix – this will be done in a way that

best fits with the size and complexity of systems with activities ranging from comprehensive stakeholder surveys, to system development sessions and workshops. This will identify areas they need to focus on to become an ICS and aspects of support they will need from across NHS England and NHS Improvement.

30. We will also offer a 12-week intensive support programme to eight systems over two waves (one starting at the end of June and the other in December). A programme we ran last year shows that this is helpful in giving systems focussed time in which to boost their readiness for becoming an ICS; by providing tailored support, including priority access to relevant national project teams and other subject matter experts.

International General Practice Recruitment & Workforce

31. We have now recruited over 120 doctors from overseas through the extended national programme and the pilots. Of these, over 70 are in the country either seeing patients or in observer placements in practices. These are part of the pipeline of over 300 doctors who are currently working through our Induction and Refresher (I&R) scheme. The I&R scheme includes all new international doctors, those returning from overseas who trained or worked here previously, and domestic returners.

32. We continue to promote the programme and general practice in England as a place to work, as well as trialling different models to maximise the potential pipeline. We are working with colleagues in the Royal College of GPs and the General Medical Council to explore potential routes into general practice for non-EEA doctors, although regulatory restrictions prevent recruitment from most non-EEA countries.

33. Latest quarterly statistics indicate that there were 34,736 full-time equivalent (FTE) doctors (44,847 headcount) working in general practice in England as at March 2019. This represents an increase of 226 FTE over the last quarter and an increase of 312 FTE (0.9%) since March 2018. There has been a growth of 474 FTE (1.4%) against the GP Forward View baseline of September 2015 (data not directly comparable). This reflects an increase in the number of GP registrars (+752 FTE) and salaried doctors (+394 FTE), alongside a continued decrease in the number GP partners (-819 FTE) since March 2018.

Access to General Practice

34. Work with regions is underway to ensure the full delivery of all the “access” national core requirements. These were largely met by March 2019 and outstanding work is being taken forward as part of the “Access Review” that was identified in the recently published “Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan”. It set out the review will commence in 2019 for full implementation by 2021/22.

35. The initial aim of the review was to look at developing a single coherent access offer out of the extended hours Direct Enhanced Service and the CCG

commissioned extended access service. NHS England has since decided to expand the scope to have a whole system review which would consider access to in-hours general practice as well as out of hours and extended hours services.

36. The review will enable the development and implementation of a coherent access offer to patients accessing general practice and appointments when their practice is closed or unavailable. It will make recommendations to improve access to patient requested pre-bookable and same day general practice appointments with a view to reducing variations in waiting times. It will also make recommendations for developing a single coherent access offer for out of hospital care (including with urgent care services in the community) outside normal practice opening hours.

37. Both will need to consider the patient offer for both physical and digital services, patient satisfaction, and current inequalities in access to ensure the review's main objective can be met.

38. Work is currently underway on data gathering and hypotheses testing to be completed by July when we will take stock of the scope and review timetable. Current expectation is delivery of a report in November.

Mental Health

39. The Long Term Plan highlighted Mental Health as a priority, making at least an extra £2.3bn a year real terms available by 2023/24 to continue our commitment to increasing the share of NHS spending that goes on mental health services. There has been extensive stakeholder engagement on the mental health components of the Implementation Framework over the last several months.

40. Delivery of the Five Year Forward View for Mental Health continues to progress. Latest data from the mental health dashboard shows that for the first time all 195 CCGs (covering every part of England) are on track to meet the Mental Health Investment Standard in 2018/19, an increase from 186 (90%) out of 207 CCGs that achieved it in 2017/18. CCGs are required to undertake an audit to validate their year-end positions against the Mental Health Investment Standard.

41. The latest Improving Access to Psychological Therapy (IAPT) data in March 2019 shows the rolling quarter access rate to be 4.76%, with ongoing work to ensure sufficient workforce expansion to meet the 25% access rate by 2020/21. The 50% recovery rate has continuously been exceeded, reaching 53.1% in March 2019. 88.9% of people entered treatment having waited less than six weeks (against a standard of 75%) and 99.0% of people entered treatment having waited less than 18 weeks (against a standard of 95%) the same month. The national team are currently reviewing and strengthening the IAPT Long Term Condition 2019/20 national support offer. The aim is to replicate best practice models and make it consistent across all regions.

42. Every STP in England has an operational community **perinatal mental health** service. An additional 13,000 women were seen in 2018/19, exceeding the target of 9,000 additional women.

43. NHS Digital published a bespoke data collection for access to **children and young people's mental health services** in July 2018. Results indicate that nationally 324,724 children and young people accessed mental health services in 2017/18, which approximately equates to 30.5% of children and young people and exceeds our annual trajectory of 30% for 2017/18. An additional bespoke data collection for access to children and young people's mental health services will take place for 2018/19.

44. Data for the fourth quarter of 2018/19 shows the proportion of children and young people accessing treatment for **eating disorders** within four weeks for routine cases was 82.4%. The proportion of children and young people accessing treatment within one week for urgent cases was 80.6%. The programme is on track to achieve 95% for both routine and urgent cases by 2020/21.

45. The national standard for 56% of people to start treatment for **Early Intervention in Psychosis (EIP)** within two weeks was exceeded in April 2019, with a performance of 73.4%. Ongoing improvement work is underway to enhance patients' access to the full range of NICE recommended treatment and support once they have been allocated a care coordinator within an EIP team.

46. The Long Term Plan sets out a vision for greater local system integration and autonomy. Specialised mental health, learning disability and autism services will move towards more integrated commissioning with local systems to support greater local system integration and autonomy. NHS Led Provider Collaboratives (piloted as New Care Models) will take responsibility for specialised mental health, learning disability and autism services for their population. This approach has been piloted across 14 sites since 2017, achieving a reduction in out of area placements, length of stay and inappropriate admissions as well as the development of innovative new community models. This roll out is now being established nationally in two phases; the first phase will see some specialised services for children and young people, some secure adult services and specialised adult eating disorder services being delivered through NHS-Led Provider Collaboratives, achieving 75% coverage by April 2020. The mainstreaming process was initiated in May 2019 with a letter to all providers of specialised services inviting submissions from NHS-Led provider collaboratives. A regional selection process will run between July 2019 – October 2019, with involvement from Experts by Experience, Clinicians and local stakeholders. There is an ambition for 100% of specialised mental health services to be delivered by NHS-Led provider collaboratives by 2023/2024.

47. At the end of May 2019, the diagnosis rate for **dementia**, which is calculated for people aged 65 and over, was 68.4%, exceeding the ambition that at least two-

thirds (66.7%) of people living with dementia receive a formal diagnosis. The standard has been consistently achieved since July 2016.

Learning Disability and or Autism

Inpatient

48. Latest data shows a 22% reduction in the inpatient count since March 2015 from 2,890 to 2,245 (the standard is 37 per million population - a 35% reduction). The new target is to achieve a 50% reduction by March 2024.

49. Of the current inpatients 25% are on a MoJ Mental Health Act restriction. Only 9% of current inpatients are recorded as informal patients, 90% are detained under the Mental Health Act or other Acts.

50. Latest data shows there are 240 children and young people aged under 18 in inpatient beds, 11% of total inpatients. Of those children and young people 77% have a diagnosis of autism and no learning disability.

Care (Education) Treatment Reviews (C(E)TR)

51. Over 10,500 inpatient C(E)TRs have been carried out since April 2016 (of which around 1,640 were for under 18s). The proportion of inpatients reported as never having had a CTR in April 2019 was 5% (110 patients) which shows significantly better than the 47% recorded in January 2016.

52. 56% more pre-admission CTRs, and CETRs were undertaken in 17/18 compared to 16/17 and a further 44% more were done in 18/19 compared to 17/18. Over 3,380 pre-admission CETRs and CTRs have been undertaken to date, 80% led to decision not to admit. For children 82% of the 1,020 undertaken led to decision not to admit. Although pre-admission CTRs are resulting in over 80% Decision to Not to admit nationally, compliance with policy standards is well below March 2019 expectations (75%). However, compliance has been rising since Q4 17/18.

LeDeR – Learning from Deaths Review

53. The LeDeR reviews as notified to 31 May 2019 shows that since the programme inception 5,622 have been notified of which 34% have been completed. This is a significant improvement on the data reported as at 31 Dec 2018, used in the third LeDeR Annual Report, at which 25% had been completed.

54. An additional £5 million has been allocated to the LeDeR programme with commitments to tackle the major killer conditions among people with a learning disability based on lessons learned from reviews. These include: Pneumonia, Respiratory, Constipation, Sepsis and deterioration and Cancer.

Quality

55. In response to findings of the CQC's thematic review and the care provided at Whortlon Hall, NHS England and Improvement will be introducing stronger

oversight arrangements. Where someone with a learning disability or an autistic person is in specialist inpatient care out of area they will visited every 6 weeks if they are a child and every 8 weeks if they are an adult. The host CCG will also be given new responsibilities to oversee and monitor the quality of care of sites in their area.

56. Independent reviews commissioned by NHS England for children and young people in seclusion and/or long-term segregation, led jointly by the Learning Disability Programme and Specialised Commissioning have now been completed. those identified in the late 2018 data census, together with any additional reviews identified since the data census, were completed at the end of April 2019.

Annual Health Checks

57. At Q3 2018/19, there were 148,240 patients on a 12-month rolling total compared to 286,620 who on the GP register during 2017/18. Latest data shows a 52% of these patients have received an AHC. This is less than the current target which is 75% and work is ongoing to improve this.