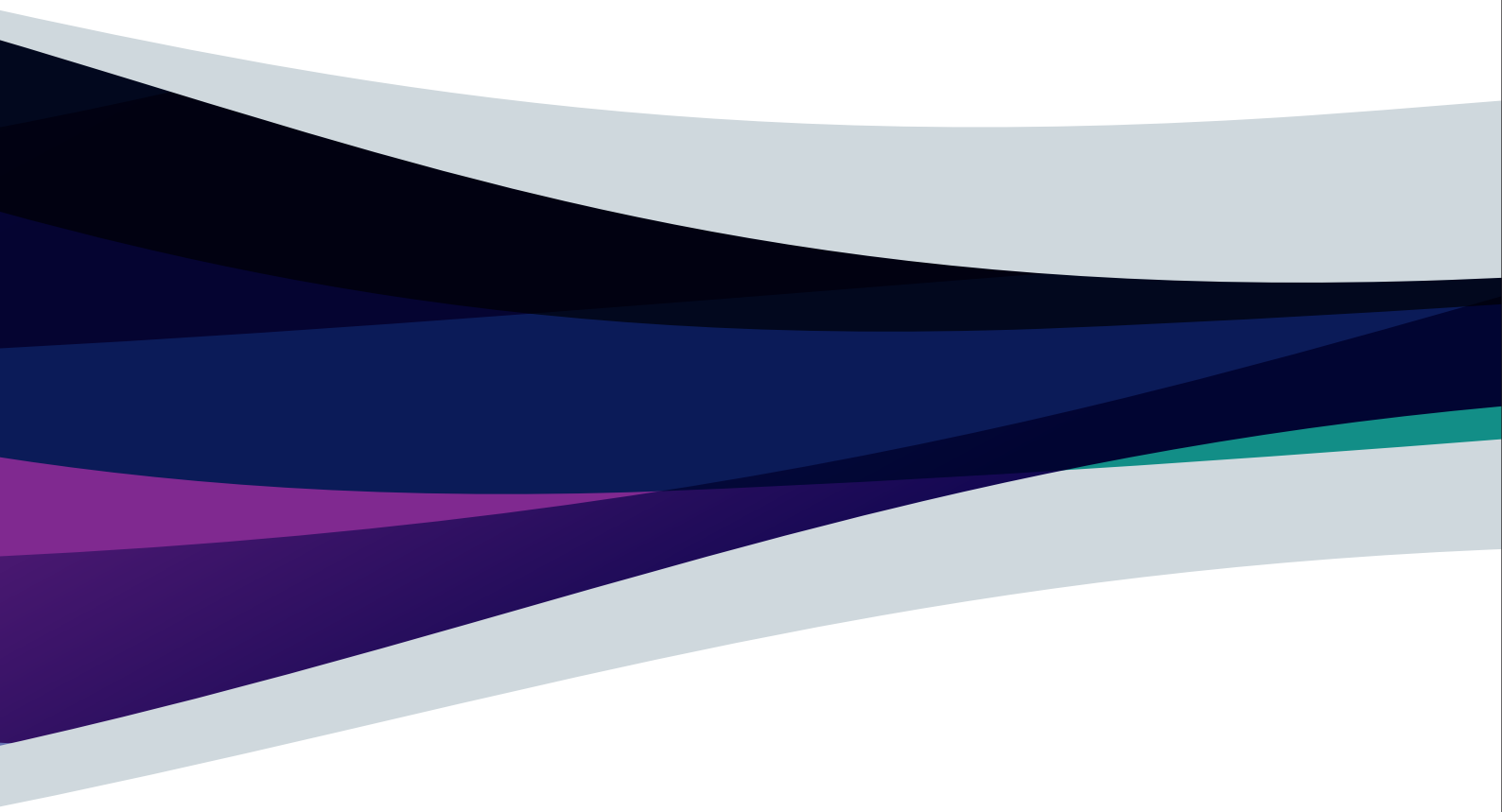
NHS Providers

MISSION IMPOSSIBLE?

The task for NHS providers in 2017/18



SUMMARY

The 2017 Budget on 8 March confirmed that, while there was extra money for social care and a small amount of extra capital funding for the NHS, there would be no extra revenue funding for the NHS in 2017/18, with the new financial year starting on 1 April 2017.

Analysis by NHS Providers predicts that, without realism, flexibility and support, it will be impossible for the NHS hospital, ambulance, community and mental health trusts who account for more than 63%[1] of NHS spend to deliver all that they are being asked for in 2017/18.

What NHS trusts need to deliver in 2017/18

2017/18 NHS trust delivery requirements are set out in the NHS 2017/19 planning guidance. They can be summarised as:

- absorb a forecast 5.2% demand and cost increase
- deliver the required NHS constitutional performance targets, for example the 95% A&E four hour standard, the 18 week elective surgery standard and the cancer targets
- eliminate the provider sector financial deficit and deliver a minimum zero aggregate provider sector financial balance
- all within the NHS funding allocation, which will increase in 2017/18 by a much lower amount than in 2016/17.

Why the 2017/18 delivery requirement is currently impossible to deliver

While individual NHS trusts may be able to meet all their delivery requirements, and individual requirements can be met at a sector level, the aggregate 2017/18 provider sector task is currently undeliverable for the following six reasons:

1. NHS trusts will receive a smaller funding increase in 2017/18: provider NHS funding increases are dropping from 4% in 2016/17 to 2.6% in 2017/18 (see section 2).[2]
2. However, demand and cost is predicted to rise by 5.2% in 2017/18, double the 2017/18 NHS provider funding increase of 2.6%.
3. Evidence from the last decade indicates it is impossible for NHS provider efficiency savings, which average between 1 and 2% per year, to close this gap, which would be required to just maintain existing performance.
4. Key performance targets are already being missed and achievement of the performance targets in 2017/18 will require a significant improvement and extra investment. For example:
    - Performance against the key 95% A&E standard in the 12 months to January 2017 was running, on average, at 88.9%. NHS Providers estimate it would cost an extra £400-600 million to recover performance to the required level across the year.

- Performance against the key 92% 18-week elective surgery target is running at 89.9%. NHS Providers estimate it would cost a minimum estimated £2.0-2.5bn to recover performance to the required level.

5 The NHS provider sector will enter 2017/18 with a likely deficit of between £800-900m and therefore needs to improve its financial performance by this amount to eliminate the deficit and achieve the required balance.

6 NHS trusts are required to deliver a new set of extra commitments from the recent cancer and mental health taskforces which NHS Providers estimates will cost between £150 and 200 million.

In short, the 2017/18 funding increase, together with best case scenario provider efficiencies, does not even cover the predicted cost and demand increases in 2017/18, which is required to just maintain existing performance levels. NHS Providers estimates it would cost a minimum further £2.4-3.1 billion, which the NHS cannot afford, to recover the performance standards to required levels. There are two further £800-900 million and £150-200 million pressures to eliminate the provider sector deficit and meet extra new commitments. If NHS trusts could not deliver NHS performance standards on a 4% funding increase for trusts in 2016/17, there is no evidence to suggest they can deliver them on a 2.6% funding increase in 2017/18.

The 2017 budget[3] announcements of £2 billion for extra social care, £100 million capital for extra GP front door triage in A&E Departments and £325 million capital for the most advanced sustainability and transformation plan (STP) footprints were welcome. However, they are unlikely to make a significant difference to this underlying position. The impact of extra social care support on NHS performance in 2017/18 is uncertain given that there are no "must benefit the NHS conditions" attached to the new funding. Extra capital of £425 million is marginal in the context of an estimated £2.4 billion a year required for STPs[4] and a forecast maintenance backlog of £5.8 billion.[5]

Impact on patients and staff

Patients will be impacted if NHS trusts are unable to meet all their delivery requirements. Depending on what is prioritised, this impact could, on current performance trajectory, mean an estimated 1.8 million patients having to wait more than 4 hours for A&E treatment and an estimated 100,000 patients waiting longer for elective surgery than they should do – 40% and 150% increases on the respective levels this year.[6] Trying to meet performance targets on inadequate funding levels also places an unfair and unsustainable burden on NHS staff.

NHS Providers is particularly concerned by the impact on patient safety of current bed occupancy levels in both acute and mental health settings. Events in January 2017 showed that, in a number of local systems, we are now putting patient safety at unacceptable levels of risk. We argue that in the re-prioritisation the NHS must now undertake, addressing this risk should be a key priority.

NHS Providers shares the recent judgement of the chief inspector of hospitals that *"the scale of the challenge that hospitals are now facing is unprecedented – rising demand coupled with economic pressures are creating difficult-to-manage situations that are putting patient care at risk".*[7] This applies to the entire provider sector.

What next – the options

NHS trust leaders are strongly committed to providing the best possible care for patients, meeting their NHS constitutional performance standards and achieving financial balance, including an appropriate degree of performance, productivity and financial stretch. Their strong and clear preference is for the NHS to be funded at a level that enables the average trust to deliver that aggregate task. However, in the absence of adequate funding to achieve this and with less than a fortnight till the start of the new financial year, NHS Providers believes that the NHS now has to make some rapid, difficult, choices.

There are two broad approaches. One is to act as though delivery of the requirements is still achievable. This risks setting an impossible task for trusts, misleading the public, preventing the NHS from planning to maximise patient benefit from the resource spent and placing an unsustainable burden on frontline staff.

The second is to fully develop the emerging approach being adopted by the NHS arm's length bodies, who have recently indicated that the 95% A&E standard will not be deliverable across the year.[8] The NHS leadership needs to recognise that delivery of all the current requirements in aggregate is no longer possible and they need to set more realistic targets, with appropriate flexibility:

- The NHS England mandate and the new NHS delivery plan, due at the end of March, need to set out what can be realistically delivered for 2017/18 in relation to each priority.
- Building on work already undertaken, the NHS should carry out an urgent exercise to examine whether, by the end of quarter 1, money could be reallocated from non-frontline care (commissioning costs, and further reductions to administration budgets from the Department of Health and its arm's length bodies),[9] to frontline care.
- Frontline and central NHS leaders need to work together to identify what support and investment is required to enable trusts to make significant progress in reducing the unwarranted variation in performance between trusts that has been identified in several recent reviews.

NHS trusts will do everything they can to deliver what they are asked but they will need realism, support and flexibility from NHS political and system leaders.

MISSION IMPOSSIBLE?
THE TASK FOR NHS PROVIDERS IN 2017/18

In 2017/18 trusts are required to...

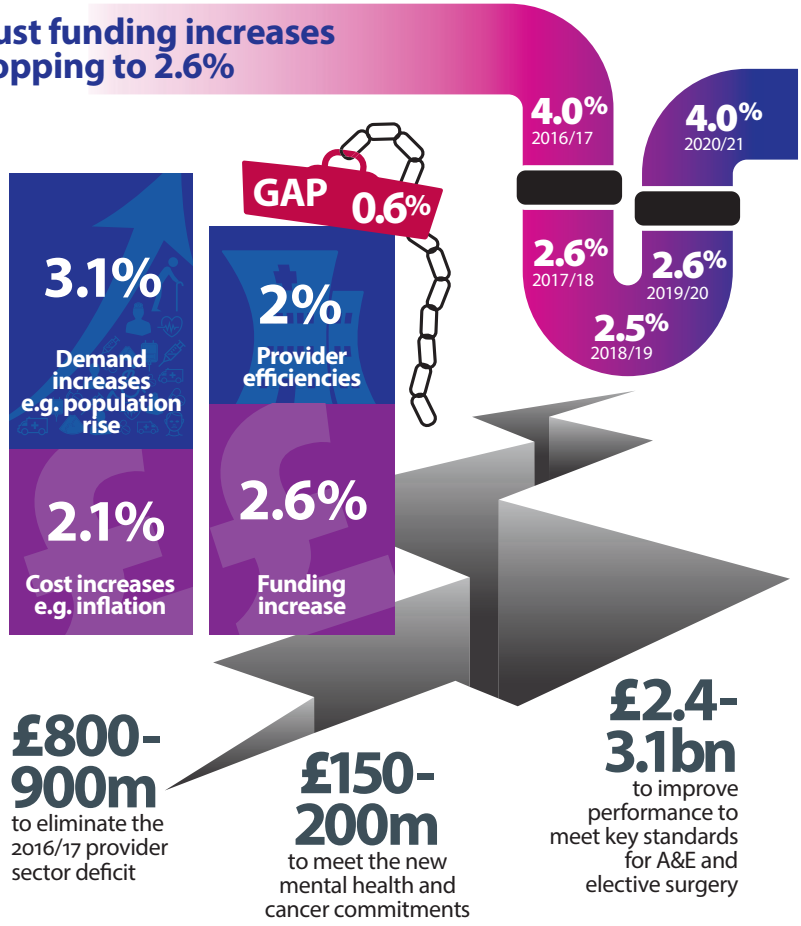
5.2% Absorb predicted 5.2% cost and demand increases

Hit key targets, such as the 4-hour A&E standard

Cut the provider sector deficit to zero

Meet the new cancer and mental health commitments

However NHS trust funding increases in 2017/18 are dropping to 2.6%



This isn't enough to cover the demand and cost increases and maintain current performance

...even with trusts achieving 2% efficiency savings (the best case scenario)

And that is before an estimated...

£800-900m to eliminate the 2016/17 provider sector deficit

£150-200m to meet the new mental health and cancer commitments

£2.4-3.1bn to improve performance to meet key standards for A&E and elective surgery

What can we do?

NHS trusts want to meet performance standards and hit financial balance but need the right funding to do so. In the absence of that funding, we need to:

1 Recognise trusts can no longer deliver everything asked for

2 Re-prioritise and re-set realistic targets for each key priority

3 Move money from commissioning and arm's length bodies administrative budgets to frontline care

4 Better support to trusts to reduce unwarranted variation

NHS trusts will do everything they can to deliver what they are asked but they will need realism, support and flexibility from political and system leaders.

1 INTRODUCTION

The 2017 Budget on 8 March confirmed that, while there was extra money for social care and a small amount of extra capital funding for the NHS, there would be no extra revenue funding for the NHS in 2017/18,[10] the new financial year which starts on 1 April 2017.

Analysis by NHS Providers predicts that without realism, flexibility and support, it is impossible for the NHS hospital, ambulance, community and mental health trusts who account for more than 63%[11] of NHS spend, to deliver all that they are being asked for in 2017/18.

The analysis sets out the following:

Section 2
The NHS 2017/18 financial envelope

Section 3
What NHS trusts need to deliver in 2017/18

Section 4
An analysis of each element of this task

Section 5
An estimate of the patient impact of failing to deliver in 2017/18

Section 6
NHS Providers' proposals on what next

NHS 2017/18 FUNDING LEVELS

2

The 2015 Spending Review set out the NHS funding settlement for the rest of the parliament including the funding allocated to the NHS in 2017/18.[12]

The government has argued that, in looking at future NHS funding, the focus should be on 'NHS frontline funding' – the amount allocated to NHS England. The health select committee and other commentators, such as The King's Fund, Nuffield Trust and Health Foundation,[13] have argued that the focus should be on the total Department of Health (DH) spending allocation as there have been substantial cuts to the non-NHS England element of DH spending, making the increase in the overall DH departmental allocation significantly lower. In the analysis below, we have deliberately used the government's preferred measure of NHS England allocation, even though we know that providers are adversely affected by the reductions in the wider DH budget.[14] Overall we have sought to take a conservative approach.

The table below (table 1) sets out the NHS England funding increases between 2016/17 and 2020/21 announced in the Spending Review:[15]

Table 1:
NHS England funding increases 2016/17 to 2020/21

	15/16	16/17	17/18	18/19	19/20	20/21
Billions (£)	101.3	106.8	110.2	112.7	115.8	119
Real term increase billions (£)	-	5.5	3.4	2.5	3.1	3.2
% increase	-	3.6	1.3	0.4	0.7	1.4

Within NHS England's 1.3% real terms 2017/18 funding increase, actual CCG allocations (the primary source of NHS provider sector funding) will increase by 2.1% and specialised commissioning spend (a second source of NHS provider sector funding) will increase by 4.8%. Taken together total commissioning spend therefore increases by 2.6% overall. For the provider sector this represents the following estimated growth in income streams:[16]

Table 2:
Estimated growth in provider income streams

	15/16	16/17	17/18	18/19	19/20	20/21
Billions (£)	84.1	87.5	89.1	92	94.3	98.2
Actual increase billions (£)	n/a	3.4	2.2	2.2	2.4	3.8
% increase	n/a	4	2.6	2.5	2.6	4

2

This settlement has a number of well known features:

- The average overall real terms annual increase in NHS England funding across the life of this parliament is 1% per year, significantly below the NHS historical average[17] and the assumptions around annual NHS cost and demand growth of between 4% and 5.5% (see assumptions for 2017/18 in section 4.1 below).
- The settlement was described by Simon Stevens, chief executive of NHS England, as a U-bend[18] given that it was deliberately front loaded, with the largest increase in the current financial year and significantly lower funding increases in the middle years of 2017/18 to 2019/20.
- From the day the settlement was announced, commentators have pointed to the difficulty the NHS would have in the middle years of the settlement.[19] Simon Stevens told the public accounts committee that "...we got less than we asked for in that process. So I think it would be stretching it to say that the NHS has got more than it has asked for."[20]

Now that the NHS has reached the middle years of the U bend, it is no great surprise that it faces challenges in trying to deliver what is required of it, given the sharply lower funding increases.

WHAT NHS TRUSTS NEED TO DELIVER IN 2017/18?

3

What NHS trusts need to deliver in 2017/18 is set out in the 2017/19 NHS planning guidance.[21] The requirement is best summarised in the form of the key provider sector elements of the "nine must-dos for 2017-19"[22] from the planning guidance. These must all be delivered while absorbing cost and demand pressures of 2.1% and 3.1% respectively – totalling 5.2%. These must-dos include:

Targets

- Four-hour A&E standard – 95% of patients should be seen, treated or discharged within four hours
- 18-week elective surgery standard – 92% of patients should wait no longer than 18 weeks for non-urgent consultant led treatment

New taskforce report implementation

- Implement the independent cancer taskforce, which resulted in the cancer strategy implementation plan[23]
- Implement the *Five year forward view* for mental health including increasing baseline spend on mental health to meet the mental health investment standard

Money

- Provider sector in financial balance

Transformation

- Implement agreed sustainability and transformation plan (STP) milestones, though we have excluded this element in our analysis as these milestones have not been agreed and do not, at this stage, represent 2017/18 operational delivery tasks.

While individual trusts may be able to meet all their delivery requirements, and individual requirements can be met at a sector level, the 2017/18 provider sector task is currently undeliverable in aggregate. To demonstrate this, section 4 analyses each individual element, the extra cost required to deliver it in 2017/18 and then compares this to increased funding levels for the year ahead. We set out in section 6 how the NHS could ensure the task is more deliverable.

ANALYSIS OF WHAT NHS TRUSTS ARE REQUIRED TO DELIVER IN 2017/18

4

This section looks at each key element of what NHS trusts need to deliver in 2017/18 and assesses what it would to take to achieve this. These elements are:

- absorbing 2017/18 NHS cost and demand increases
- delivering the 95% 4-hour A&E and 92% 18-week referral to treatment time elective surgery standards
- delivering new commitments from cancer and mental health taskforce recommendations
- eliminating the provider sector deficit.

We also consider the impact of the recent Budget announcements and triangulate the conclusions against NHS trust performance in 2016/17.

4.1 NHS 2017/18 cost and demand increase

The 2017/19 NHS tariff sets out a forecast of how NHS costs will rise by 2.1% in 2017/18. Table 3[24] below sets out the relevant items, with a short commentary.[25]

Table 3:
NHS Improvement / NHS England forecast 2017/18 cost increases

Item	Cost uplift	Commentary
Pay costs	1.3%	Combined impact of pay settlements, pay drift, staff group mix and extra overhead costs from the apprenticeship levy and the immigration skills charge. Based on Department of Health (DH) central estimates.
Drugs costs	0.2%	Based on DH estimates.
Other operating costs	0.4%	Uplifts in general costs such as medical, surgical and laboratory equipment and fuel. Based on the GDP deflator used by the Office of Budget Responsibility.
Capital costs	0.2%	Depreciation charges and PFI payments, using DH projections.
Total costs	**2.1%**	

NHS demand in 2017/18 is scheduled to rise by 3.1% according to the Nuffield Trust's analysis[26] of NHS England's assumptions to 2020.[27] Demand increases in Q3 2016/17 compared to Q3 2015/16, are in line with the 3.1% assumption, as set out in table 4 below.

Table 4:
Actual demand increases at Q3 2016/17 compared to Q3 2015/16[28]

Service	Demand increase (Q3 2016/17)
Ambulance service calls	up 7%
A&E attendances	up 3%
Emergency admissions	up 3%
Calls to NHS 111	up 8%
Numbers of diagnostic tests	up 4%

In summary, NHS cost and demand is forecast to rise by 5.2% in 2017/18. CCG and specialist commissioning funding allocations are due to rise by 2.6%. This leaves a 2.6% gap.

Over the last few years, the NHS has planned on the basis that the gap between cost / demand increases and NHS funding increases would be filled by provider efficiency and productivity savings and gains.[29] Between 2011/12 and 2015/16 providers were therefore set an efficiency target of 4%.[30] In the view of the National Audit Office,[31] the public accounts committee,[32] the chief executive of NHS Improvement[33] and the Nuffield Trust,[34] this has placed an undeliverable expectation on NHS trusts and has directly led to record provider deficits.

In the 2016/17 tariff providers were set a 2% efficiency target.[35] This is regarded as the most stretching reasonable target to set,[36] particularly when considering the improvements that have been delivered in practice. Although these are difficult to calculate, table 5 below[37] sets out the results of five multi-year studies measuring NHS efficiency and productivity improvements across several years. It is striking that the highest (and mode) result is 1.4%, some way below the 2% target.

Table 5:

Results from five multi-year studies estimating NHS efficiency and productivity gain

Study	Scope	Annual average gain
University of York, 2016	England, NHS wide Total Factor Productivity (TFP) with quality adjusted output, 2004/05 -2013/14	1.4%
Office of National Statistics, 2015	UK NHS-wide TFP with quality adjusted output, 1995 -2013	0.8%
Deloitte, 2014	English NHS acute Hospital efficiency frontier shift, 2008/09 -2012/13	1.2%
The Health Foundation, 2015	Acute care in English NHS hospitals, 2009/10 -2013/14	0.4%
Monitor, 2016	English NHS acute hospital trend efficiency, 2008/09 -2013/14	1.4%

So, even on the best case scenario of hitting the required 2% efficiency target (an ambitious assessment as set out in table 5), NHS providers face a significant gap arising from the difference between 2017/18 cost / demand increases and funding / efficiency increases. This is set out in table 6.

Table 6:

Gap between funding and efficiency versus demand and cost assumptions

Area	2017/18 change
Cost and demand increases	
Forecast cost increases (table 3)	+2.1%
Forecast demand increases	+3.1%
Sub total	**+5.2%**
Matched against **Funding and productivity increases**	
Provider funding increase (table 2)	+2.6%
Stretch target productivity / efficiency increase	+2.0%
Sub total	**+4.6%**
Gap between cost and demand increases and funding and productivity increases	**0.6%**

There is a gap of 0.6% for providers to close in 2017/18 just to maintain the existing levels of performance, without taking account of the need to:

- Improve performance to regain required performance against targets (see section 4.2)
- Deliver extra mental health and cancer commitments (see section 4.3)
- Improve financial performance to eliminate the provider deficit (see section 4.4)

4.2 Target/performance standard delivery

The 2017/19 planning guidance requires providers to meet a range of performance standards covering A&E, elective surgery, diagnostic waits, cancer care, ambulance response times, infection control and mental health standards. To illustrate the financial challenge associated with meeting this task our analysis focuses on two key hospital performance standards on A&E and elective surgery. These are the most well-known and most scrutinised targets, and they have the best quality data. However the scale of the performance challenge across all sectors – mental health, community and ambulance – is just as great.

4.2.1 Four-hour A&E standard

Current performance

The NHS mandate requires NHS trusts to treat, admit or discharge 95% of accident and emergency patients within 4 hours.[38] As we set out in our November 2016 *The state of the NHS provider sector* report, performance against the four-hour A&E standard has declined significantly over the last few years.[39] As charts 1 and 2 below show, the last time the standard was consistently met for all types of A&E was in 2013/14, and for type 1 (major A&E departments) the standard has not been consistently met for over 5 years. Performance in January 2017 was the worst on record, at 85.1% for all types and 77.6% for type 1.

Chart 1:

Average percentage above or below the 95% A&E target (all types).

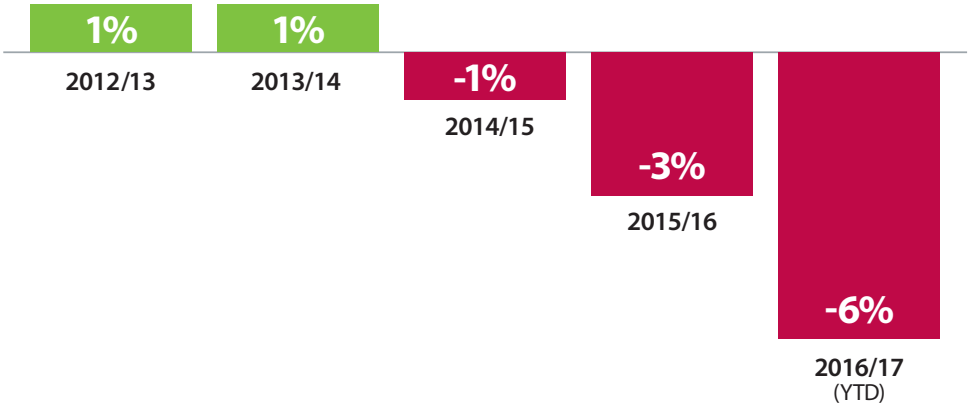
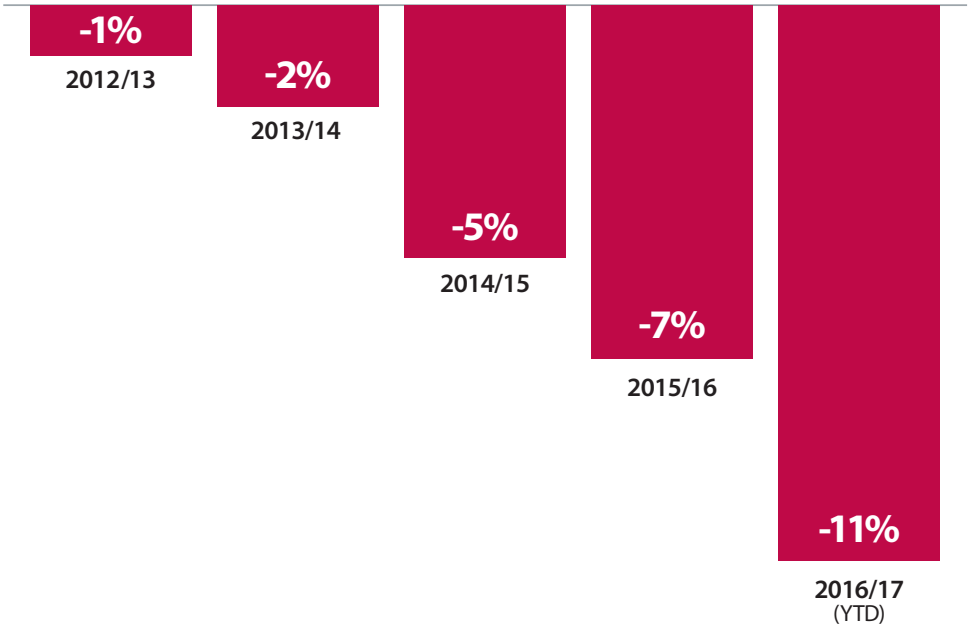


Chart 2:

Average percentage above or below the 95% A&E target (type 1).

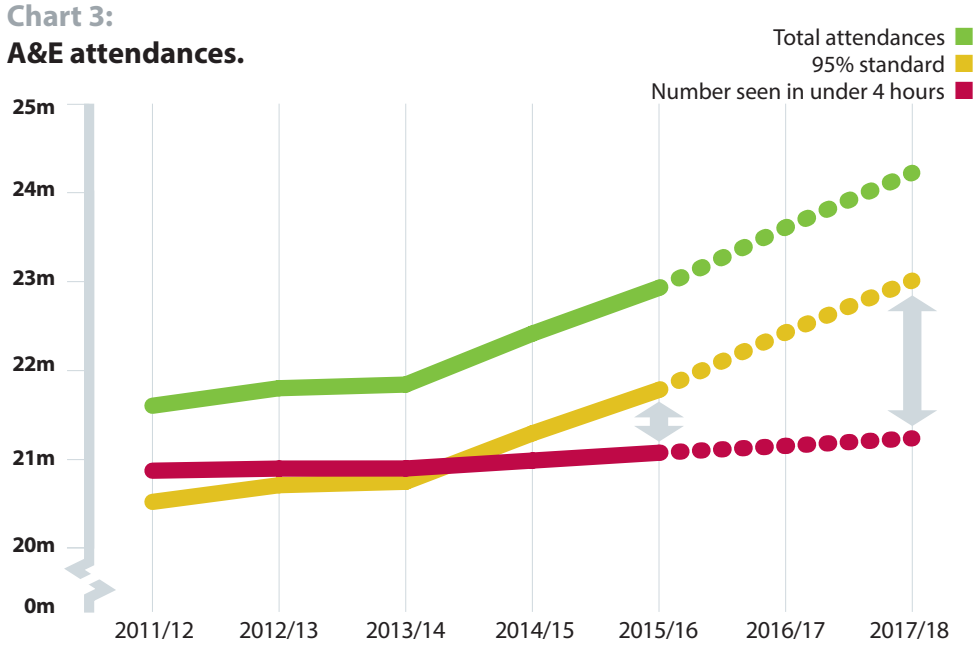


Delivering the 95% standard in 2017/18

Performance against this standard is determined by demand and capacity levels and whether improvement activity is enabling providers to perform better. There is no evidence to suggest that any of these factors will change sufficiently to enable the 95% performance standard to be regained across the year as a whole. On current trajectory, we believe performance is more likely to deteriorate than improve.

Demand for A&E services has risen continuously over the last five years, as measured by both A&E attendances and admissions, with strong evidence that growth in demand is speeding up. The NHS is treating more patients than ever before and performance remains high by international standards. However historical performance shows that the number of patients seen within four hours remains relatively stable. This means an increasing performance gap against the 95% 4-hour standard as demand grows. This is illustrated in chart 3 below.

Chart 3:
A&E attendances.



Demographic and disease burden pressures – particularly the growth in the number of frail elderly with multiple long term conditions – will increase demand in 2017/18.[40] The emerging evidence from the new care models programme suggests that it may be possible to reduce A&E demand over the longer term by integrating care more effectively, increasing out of hospital capacity and improving primary care. However there is no evidence to suggest that these will be delivered at sufficient scale and pace to significantly reduce demand in 2017/18. It is likely that demand for A&E services will, at best, remain at the current rate of growth and, at worst, increase.

There are no current plans to significantly increase A&E capacity on a system-wide basis (much needed though this is) and, on current plans, no extra money available to fund such a capacity increase.

There are a number of different A&E performance improvement initiatives under way, however given expected continuing demand increases, we do not believe they will deliver sufficient performance improvement to hit the 95% A&E standard across the year as a whole. In reaching this judgement, we are drawing on the experience of 2016/17 when trusts were given strong financial incentives to hit the 95% standard, supported by a range of performance improvement initiatives, but performance still declined as demand climbed. Our analysis of the impact of the 2017 Budget is contained in section 4.4.

Without substantial extra investment, our judgement is that it is impossible for the sector to achieve the 95% A&E standard across the year as a whole.

What would it take to meet the 95% standard?

It is impossible to model exactly how much extra resource would be required to consistently deliver the 95% standard across the whole of 2017/18. However, looking at the forecast cost of providing A&E services in 2017/18,[41] and modelled A&E income for 2017/18[42] we can estimate that A&E services will be underfunded by around £400-600 million. In reality, of course, even if this funding were available, the NHS would have to create the extra capacity – doctors, nurses and mental health, acute or community beds or visits – to provide the extra treatment required. Given workforce shortages, it is difficult to see where the extra staff would come from and extra beds take time to create. Using current demand trajectories, we have estimated the extra number of patients that would need to be seen to meet the 4-hour standard as around 1.8 million.

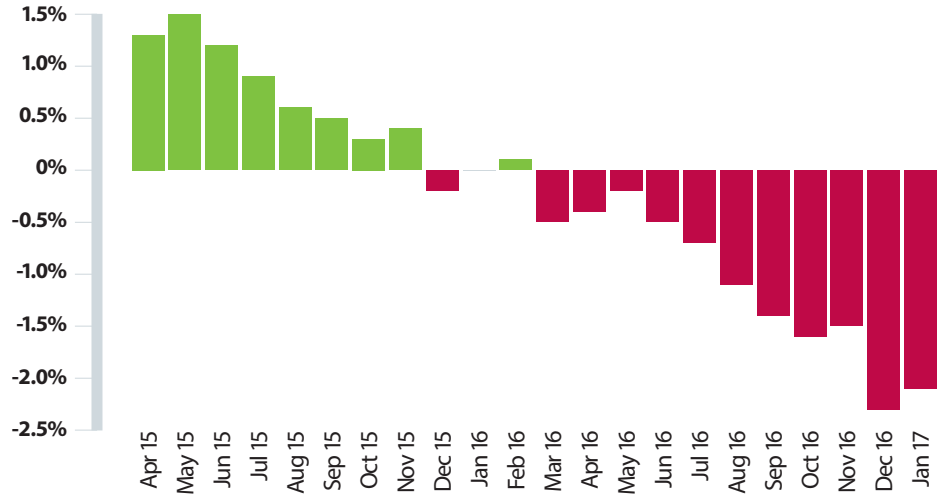
4.2.2 92% referral to treatment time elective surgery standard

Current performance

The NHS Mandate requires NHS trusts to treat 92% of non-emergency patients within 18 weeks.[43] Performance against this standard has declined significantly over the last 22 months.[44] As chart 4 below shows, the last time the standard was met was in February 2016; in January 2017 performance against the standard was 89.9%. Waiting times topped 20 weeks in December 2016, the worst performance since March 2011, before the target was even introduced.

Chart 4:

Percentage above or below 92% RTT target.



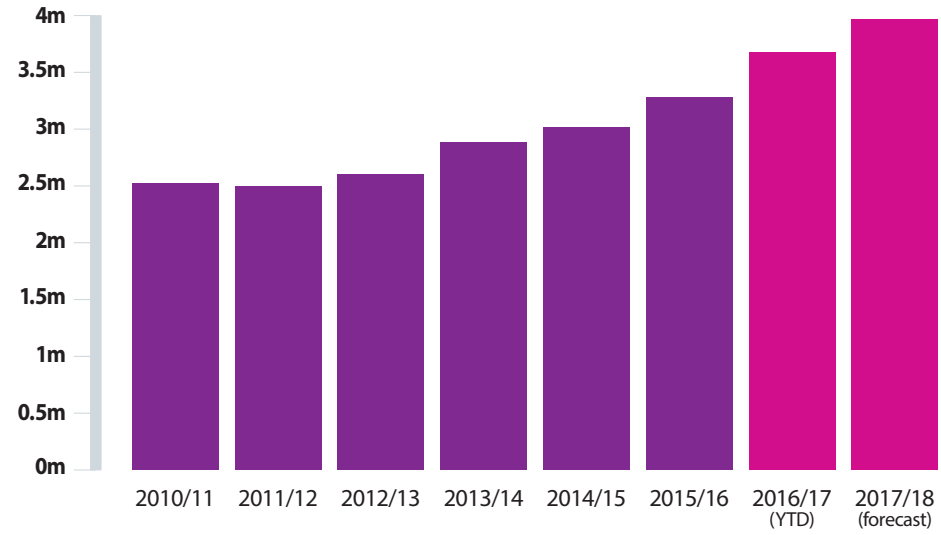
Delivering the 92% referral to treatment time standard in 2017/18

Performance against this standard is also determined by demand and capacity levels and whether improvement activity is enabling providers to perform better. Again, there is no evidence to suggest that any of these factors will translate into sufficient performance improvement in 2017/18 to regain the 92% performance standard. On current trajectory, we believe performance is more likely to deteriorate than improve.

Demand for elective surgery has risen continuously over the last five years, as shown in chart 5 below:

Chart 5:

Total waiting list for elective care (monthly average).



Again we know that demographic pressures will increase demand in 2017/18. There are no current plans to significantly increase elective surgery capacity on a system-wide basis and, on current plans, no extra money available to fund such a capacity increase. Compared to A&E there are fewer performance improvement initiatives under way and there is no evidence that they will be able to deliver significant, system-level, performance improvements in 2017/18.

On that basis, without substantial extra investment, our judgement is that it is impossible for the sector to achieve the 92% RTT standard in 2017/18. This is confirmed by Rob Findlay, an industry analyst specialising in RTT waiting times, who said in December 2016: "Every trust in England has agreed a trajectory to recover and sustain '18 weeks', but things are clearly heading in the wrong direction. Unless something big happens, and the NHS starts keeping up with demand again, I cannot see the 18-week target ever being achieved again."[45]

What would it take to meet the 92% standard?

It is impossible to model exactly how much extra resource would be required to deliver the 92% standard in 2017/18. However, methodologies to calculate this figure involve estimating the cost of eliminating the backlog as well as the extra level of activity required to keep up with increasing demand. NHS Providers estimates that the range of extra cost to regain and consistently meet the 92% 18-week standard across all of 2017/18 would be between £2-2.5bn.[46] We recognise that this range can only be indicative. Capacity and workforce constraints would again apply in terms of delivering the standard across the whole of 2017/18.

4.3 New cancer and mental health taskforce commitments

The Independent Cancer Taskforce published its results in July 2015[47] which was followed by the publication of NHS England's detailed delivery plan.[48] These add a new set of extra requirements on trusts, in addition to what was delivered in 2016/17. These requirements include significant improvements to one-year survival rates, as well as giving patients definitive cancer diagnosis, or the all clear, within 28 days of being referred by a GP.[49] The extra cost of this 2017/18 cancer taskforce related activity is estimated as £90-120 million[50] constituting a further financial pressure for trusts that was not present in 2016/17.

NHS England published the results of its mental health taskforce in February 2016[51] which was followed by the publication of a detailed delivery plan.[52] These add a set of extra requirements on trusts including increasing the number of people with a severe mental illness receiving a full annual physical healthcheck, increasing the number of people access psychological therapies and increasing the number of hospitals with an all-age mental health liaison service achieving the Core 24 service standard. The extra cost of this 2017/18 mental health taskforce related activity is estimated as £60-80 million,[53] constituting a further financial pressure for trusts that was not present in 2016/17.

4.4 Eliminating the provider financial deficit and achieving financial balance in 2017/18

The final key requirement for trusts in 2017/18 is to achieve financial balance by eliminating the provider deficit which, in Q4 2015/16, stood at £2.45 billion.

The NHS provider sector delivery task increases when the sector ends a year in deficit. Trusts then have to improve their financial performance by a similar amount to end the following financial year in financial balance.

The original 2016/17 NHS England provider sector financial target was -£250m[54] partly because this was regarded as the "worst" 16/17 financial performance commensurate with hitting financial balance in 2017/18. NHS Improvement then set the target at -£580m.[55] The latest official data at quarter 3[56] shows the sector headed for a -£873m deficit in 2016/17. We have estimated the end year provider sector as being between -£800m and £900m. This means that NHS trusts will have to improve their financial position by at least that amount to achieve financial balance next year.

Our recent survey of trust finance directors[57] shows that the picture is, in reality, worse than this as trusts are relying on significant levels of one-off, non-recurrent items, balance sheet adjustments and capital to revenue transfers to deliver their year end targets. Of trusts responding, 66% report they are either very or fairly reliant on these elements to meet their 2016/17 financial control totals. NHS Providers estimates that they constitute up to £1 billion of one-off gains for the sector as a whole. Trusts consistently tell us that they do not believe they will be able to realise similar levels of non-recurrent gains next year. However, following the conservative approach, we use the £800-900 million figure in the rest of our analysis.

The scale of pressure on provider sector finances in 2017/18 is revealed by the following new data from our recent finance directors' survey which shows:

- 30% of trusts have not yet signed up to a 2017/18 control total
- trusts who have not signed up to a control total would have had an undeliverable median efficiency requirement of 6.4% which explains why those trusts have been unwilling to sign up to a control total for 2017/18
- of those who have signed up to a 2017/18 control total no trusts are very confident and less than one in five (19%) are fairly confident of hitting their control total.

In summary the scale of the 2017/18 provider delivery challenge is significantly increased by the fact that providers are likely to start the year with a minimum financial pressure of £800-900 million.

4.5 Budget 2017

The 2017 budget announcements of £2 billion for extra social care, £100 million capital for extra GP front door triage in A&E departments and £325 million capital for the most advanced sustainability and transformation (STP) footprints were welcome. However they are unlikely to make a significant difference to this underlying position. The impact of extra social care support on NHS performance in 2017/18 is uncertain given that there are no "must benefit the NHS conditions" attached to the new funding. £425 million of extra capital is marginal in the context of an estimated £2.4 billion a year required for STPs[58] and a forecast maintenance backlog of £5.8 billion.[59]

4.6 Triangulation of 2016/17 and 2017/18 information

One way of triangulating the size of the delivery task in 2017/18 is to make an explicit comparison with 2016/17, the current financial year.

This year, despite best efforts and a 4% NHS provider funding increase (see table 2), the NHS provider sector will:

- record a likely official £800-900m deficit
- significantly miss the 95% A&E standard with year to January 2017 average monthly performance at 83.3% for type 1 A&E departments and 88.9% for all types
- significantly miss the 92% RTT 18 weeks standard with performance currently at 89.9%.

In 2017/18, the NHS provider sector is being asked to:

- eliminate the official £800-900m deficit
- substantially improve performance to hit the 95% A&E standard at an extra cost that we estimate to be in the range of £400-600 million
- substantially improve performance to hit the 92% RTT 18 weeks standard at an extra cost that we estimate to be in the range of £2-2.5 billion
- deliver £150-200m of new commitments resulting from the cancer and mental health task forces
- absorb 5.2% demand and cost increases.

All on a 2.6% NHS provider funding increase which is smaller than the current financial year's 4% increase. All the indications are that this is impossible.

5 IMPACT ON PATIENTS AND STAFF

Patient impact

It is likely that patient experience and patient safety will be at risk if NHS trusts are unable to deliver the 2017/18 requirements. There is also likely to be an adverse impact on NHS staff. It is impossible to predict the exact nature and extent of these impacts but they include patients waiting longer for surgery and urgent care as set out below:

Patients waiting longer for elective surgery

Not meeting the 18-week elective surgery standard means that more patients will have to wait for elective surgery. In section 4.2.2 we identified that performance against the 18 week elective surgery standard in 2017/18 is unlikely to improve and is more likely to deteriorate.

NHS Providers estimates that, on the current trajectory, the average monthly waiting list in 2017/18 will be 4 million. To hit the 92% standard 3.7 million patients would need to be waiting less than 18 weeks. Forecasting from current performance suggests this figure will only be 3.6 million, meaning almost 100,000 patients will be waiting longer than they should.

The patient experience and safety impacts of these delays is well known and is set out in recent commentary from the Royal College of Surgeons[60] and the Patients Association.[61] These include:

- patients have to live with the consequences of debilitating conditions longer
- the risk of the condition worsening, requiring more complex, difficult and expensive treatment
- in the most extreme examples, conditions becoming permanent and untreatable.

Urgent and emergency care

Not meeting the 95% four-hour A&E target means that patient experience and safety in the provision of urgent and emergency care will also be adversely affected. In section 4.2.1 we identified that performance against the 95% four-hour A&E standard is unlikely to improve, will at best be maintained at current levels, but is more likely to deteriorate.

NHS Providers estimates that, on the current trajectory, 1.8 million patients will not be seen within the standard. The patient experience and safety impacts of these delays is, again, well known, and is set out in recent commentary from the Royal College of Emergency Medicine,[62] the Royal College of Physicians[63] and the Patients Association.[64] These include:

- Patients having to wait for long periods of time in overcrowded and uncomfortable A&E Department waiting rooms
- Patients' conditions worsening significantly before treatment can be given, increasing patient safety risk.

The 95% target is widely regarded as a good proxy for the provision of high-quality urgent and emergency care. If performance drops below the 95% standard, patient experience starts to drop and risk increases. However, performance against the 95% target is not a particularly sensitive indicator of the most serious patient safety risk. For example, the Royal College of Emergency Medicine argues that performance below 75% is the point at which patient safety risk becomes seriously elevated on a systematic basis.[65] Other measures of patient safety risk include persistent periods of 12-hour trolley waits, significant ambulance handover delays and bed occupancy rates over 85%.[66] Throughout the three peak winter months general and acute bed occupancy did not drop below 89%, peaking at 96% in early February. This is in spite of additional capacity created by opening temporary (escalation) beds.[67]

Experience over the current winter shows that performance against all these measures is deteriorating significantly at both an aggregate, system, level and, in particular, in a number of increasingly fragile local systems. As we pointed out in our November 2016 *The state of the NHS provider sect*or report,[68] there are now a number of local systems where the system is overwhelmed as demand rises well above the capacity level for sustained periods. NHS Providers has undertaken two initial analyses[69] of performance over the 2017 winter period that highlight the significantly increased patient safety risk that some systems are now running. We have also highlighted the risks of consistently high bed occupancy levels, in a joint letter with the Royal College of Surgeons.[70] Our December 2016 survey also pointed to the fact that, in many systems, intermediate out of hospital bed capacity is declining.[71] One estimate shows that, overall, as much as 8% of capacity has been lost over the last six years.[72]

There is widespread agreement from, among others, the Royal College of Emergency Medicine, the Society of Acute Medicine and the Royal College of Physicians that levels of NHS performance over the winter period were unacceptably low, risked patient safety, and need to be improved. This has been echoed by the secretary of state for health.[73]

As set out in section 4.2.1, while improvement initiatives can ameliorate some of the impact of rapidly increasing demand for emergency care, they will not address the fundamental mismatch between current demand and capacity. The only way to deal with this is to increase capacity within the NHS, either through more inpatient mental health beds in the right locations, more community beds, more home care capacity or more acute hospital beds. It is impossible to calculate the exact investment required to deliver the right capacity increase however our estimate is £400-£600 million of A&E underfunding in 2017/18 as set out in section 4.2.1. Any investment should be targeted at the systems that need it most and where performance is in most danger of dropping to unsafe levels over a prolonged period.

Other targets

This analysis has focussed on performance against the 18-week elective surgery target and the 4-hour A&E standard. Failure to deliver against other standards also means significant patient safety risk. Most obviously, the continuing inability of the provider sector, despite best efforts, to meet the cancer standard of 85% of patients having a first treatment within 62 days of an urgent GP referral, carries high patient safety risk. The latest data shows performance in January 2017 was 79.7%; the last time the target was met was December 2015.

Taking all this together, NHS Providers shares the recent judgement of the chief inspector of hospitals that "the scale of the challenge that hospitals are now facing is unprecedented - rising demand coupled with economic pressures are creating difficult-to-manage situations that are putting patient care at risk".[74] This applies to the entire provider sector, not just hospitals.

Staff impact

Trying to meet performance targets on inadequate funding levels is also placing an increasingly unsustainable burden on NHS staff. Although the 2016 NHS staff survey[75] showed an overall increase in staff engagement it also showed that only 30% of staff agreed that "there are enough staff at this organisation for me to do my job properly", with 47% disagreeing.[76] 59% of staff reported working unpaid overtime each week.[77]

Recent frontline testimony from this winter - "nowhere to go, not enough beds, corridor wards, patients in danger, stuck at hospital or sent home with support, pressure across the system, staff at risk of burnout"[78] – also shows the increasing burden we are placing on NHS staff.

6 WHAT NEXT – THE OPTIONS

6.1 Adequate funding to deliver NHS constitutional standards

NHS trust leaders are strongly committed to providing the best possible care for patients, meeting their NHS constitutional performance standards, reducing unwarranted variation and achieving financial balance, including an appropriate degree of performance, efficiency and financial stretch.

While delivery of the constitutional performance standards imposes a significant delivery challenge, there is widespread recognition among trust leaders that, taken as a set of standards, they provide a clear, easily understood, proxy for the access to treatment and quality of care the NHS should provide. There may be some need to update some standards to reflect the development of new clinical pathways.[79] However NHS trust leaders have a strong and clear preference for their trusts to be funded at a level that enables them to both deliver the standards and achieve financial balance.

As this analysis clearly shows, the NHS has now reached a point where this is impossible without realism, flexibility and support. The vast majority of trusts did not achieve that task in 2016/17, despite a 4% NHS funding increase, and we have shown that the required performance improvement will be impossible on a 2017/18 2.6% NHS funding increase.

As the 2017/18 financial year begins, NHS Providers believes that the NHS now has to make some rapid, difficult, choices.

6.2 Two approaches in the absence of the funding needed

There are two broad approaches.

The first is to act as though delivery of all the requirements set out in the 2017/19 planning guidance is still possible. The principal argument in favour of this is that it provides an appropriate degree of stretch for NHS trusts to aim for.

However, NHS Providers believes there are several risks to this approach:

- It sets an impossible delivery task for NHS trusts: there is clear difference between appropriate stretch and "impossible to deliver". This risks eroding the relationship between trust leaders and NHS system leaders and risks disincentivising trusts as they try to chase delivery requirements they can never deliver.
- It risks misleading the public, who pay for the NHS, as to what is deliverable on the funding levels available. It also prevents mature debate that is now needed about how, as a nation, we will meet rapidly growing healthcare needs on an inevitably constrained amount of public expenditure.

- It risks undermining public confidence in the way the NHS is run, as it may look as though NHS providers are incapable of meeting a delivery task that system leaders are publicly arguing they should be able to achieve.
- It prevents the NHS from properly planning and allocating scarce resources where they could provide maximum benefit. If trusts seek to meet a range of different, impossible to deliver, targets they are likely to miss all of them. Delivering a smaller range of priorities is much more likely to maximise overall benefit for the money spent.
- It risks placing an unsustainable burden on frontline staff, adversely affecting their morale and engendering a constant sense of failure as they work harder but fail to deliver requirements that NHS system leaders publicly argue are deliverable.

The second approach is for the NHS's political and system leaders to openly recognise that delivery of the requirements set out in the 2017/19 planning requirements is now impossible and that a more flexible and realistic approach is needed. NHS Providers believes this approach should have three elements.

6.2.1 Realism and flexibility

NHS England and NHS Improvement have already started to recognise that the requirements set out in the 2017/19 planning guidance are undeliverable. In a letter to trusts and CCGs in March 2017 on getting A&E performance back on track they set out a target to "achieve performance before or in September that is above 90% [against the 4 hour A&E standard], sustaining this and returning to 95% by March 2018."[80]

- This approach now needs to be developed across the full range of 2017/18 delivery requirements. The NHS England mandate and the *Five year forward view* delivery plan, both due to be published in March 2017, should explicitly focus on a smaller number of priorities with a realistic delivery trajectory for each priority.
- Assure trajectories against both funding and workforce levels that are demonstrably achievable by the average trust operating at an appropriate degree of stretch.
- Involve trusts in this assurance so that there is appropriate ownership of the delivery task.
- There should be an explicit statement of what will be deprioritised. We recognise the risk to performance that is likely to follow from deprioritising a particular requirement. This can, to some extent, be mitigated by continuing to robustly manage performance, albeit to realistic performance levels set below the current standards.

NHS Providers is reluctant to anticipate the results of this reprioritisation as the best result will emerge through the right quality of rigorous dialogue between national and local NHS leaders. However we observe that:

- the greatest patient safety risk appears to be in those local systems unable to cope with winter pressures and this winter's performance suggests failure to address these now constitutes an unacceptable risk
- realistic performance trajectories for the 4-hour A&E and 18-week elective surgery

standards, are likely, at best, to involve a gradual return to the required performance levels over an extended period

- while it is tempting to treat performance against the 92% 18-week elective strategy as a "balancing item", many district general hospitals, including those under significant A&E pressure, have relatively small amounts of elective surgery, so deprioritising the 18-week standard may have less effect than presumed
- mental health has long suffered a structural disadvantage in the NHS and investment in mental health pays for itself, and more, through less physical ill health and enabling people to return to work
- given that funding increases and an ambitious efficiency target do not cover the forecast cost and demand increases, a stretching financial performance target for the provider sector would be to reproduce the £800-900 million deficit likely to be recorded in the current financial year
- any targets set must be realistic and achievable, particularly if they are linked to access to funding. Trusts were set A&E performance targets they had to hit in each quarter of 2016/17 to access a £1.8bn sustainability and transformation fund, designed to assist in the elimination of the provider sector deficit. In January 2017 only three trusts hit their target.[81] Yet, in 2017/18, acute hospital trust access to 30% of the sustainability and transformation fund will be dependent on hitting A&E targets.[82] If those targets are unrealistic, then it will be even more difficult for trusts to achieve financial balance.

6.2.2 Reallocation of resource

The NHS needs to treat 2017/18 as a year when patient safety will be put at unacceptable risk unless the service mobilises all the resources available to it. The NHS spends an estimated minimum of £5.65 billion on non-frontline care in the form of:

- spend on the Department of Health
- spend on the arms length bodies like NHS England, NHS Improvement, the Care Quality Commission, Public Health England, and Health Education England
- spend on the administration of CCGs.

NHS Providers believes the NHS should conduct an immediate review of this spend to see how much can be reallocated to frontline care, building on earlier reviews that have reduced spending in this area. The review should be completed by the end of quarter 1 2017/18 and it should target a specific amount of money to reallocate to front line care.

6.2.3 A concerted approach to supporting trusts to improve performance

If the NHS is to close the gap between funding and desired performance levels, NHS trusts need to be supported to deliver as much performance improvement as possible as quickly as possible.

Several major pieces of work – for example the Carter Review, the *Get it right first time* (GIRFT) programme and the CQC trust inspection regime[83] – have shown that there is significant unwarranted variation in performance between trusts across a range of different areas including clinical outcomes, use of staff and procurement of supplies. Reduction of these variations represents a significant opportunity for the provider sector. However, securing this opportunity requires a different approach to delivery.

Trusts report that they consistently lack the capacity and capability to deliver improvement given the complexity and difficulty of delivering the required changes, reliant as they often are on changing long held clinical practice. Trusts report that they lack capacity as leadership and management focus is almost entirely used up keeping an increasingly unstable system upright. They report that they lack capability as previous rounds of cost improvement programmes have stripped out the analytical, change and project management resource required to support changes to clinical and other practices.

The approach of NHS system leaders to support change is, too often, to provide data showing variation and then create central teams to monitor and measure elimination of that variation. This does nothing to invest in the capacity and capability to drive the required change at trust level, or to share best practice between trusts.

We therefore need NHS leaders, particularly NHS Improvement, to quickly review what support and investment is needed to drive the required change at trust level. This review should, again, be completed by quarter 1 2017/18 and involve frontline trusts.

Driving the required change at trust level will require NHS system leaders to significantly shift the balance of time, energy and resource they spend, away from measuring and controlling performance towards supporting improvement. This will provide a significant organisational challenge for those organisations. NHS Improvement has begun this journey, for example through its accident and emergency care support programme, but this needs to be speeded up.

As the beginning of the 2017/18 financial year approaches, it will be impossible for the NHS to gain the full year benefits of these three approaches, making delivery of 2017/18 even more unlikely. The sooner these exercises are completed the better, not least because the prospects for 2018/19 look even more difficult as NHS England's real term funding increases are scheduled to drop even further from 1.3% in 2017/18 to 0.4% in 2018/19 and 0.7% in 2019/20.

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NHS Providers has 95% of all NHS foundation trusts and aspirant trusts in membership, collectively accounting for £70 billion of annual expenditure and employing more than 964,000 staff.

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