



How is the NHS performing?

Quarterly monitoring report

October 2011

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The NHS in England is now halfway through the first year of one of the tightest four-year funding settlements it has received in its history. The small real increase in funding this year has been made possible in part due to underspending last year. Meeting increased demands will require an unprecedented increase in productivity of around 4 per cent each year at a national level to 2014/15. At the front line, trusts are grappling with a bigger productivity challenge as they cope with real reductions in their prices (the tariff) and likely reductions in the volume of work they carry out.

As part of its work on the pressures faced by the NHS, The King's Fund published its first *Quarterly Monitoring Report* in April this year. This is the third report and it aims to provide a regular update on how the NHS is coping as it tackles the evolving reform agenda as well as the significant challenge of making improvements in productivity.

The quarterly monitoring reports combine publicly available data on selected NHS performance measures with views from a panel of finance directors on the key issues their organisations are facing. The combination of these data sources enables us to keep a finger on the pulse

PANEL OF FINANCE DIRECTORS OCTOBER 2011

The panel is small and not intended to be a statistically representative sample.

Fifty-three finance directors were invited to join the panel; 23 were available to give their views, which were collected via an internet survey between 14 September and 3 October 2011.

For this quarter, the majority of panel members (12) were from acute trusts. Of the remainder, five were from mental health trusts, two from community trusts, four from PCTs. There was a reasonable spread across regions.

The internet survey was supplemented with interviews with three finance directors from an acute trust, a mental health trust and a PCT cluster.

of finance directors, who have been asked to make £20 billion in productivity improvements by 2015 at a time of increasing demand and huge organisational flux.

The performance measures tracked in this report are important to both the general public and patients. They provide an indication of the impact of the current climate on productivity and provide a broad insight into how the reforms are affecting the NHS.

Information from the survey of a panel of finance directors has been supplemented by interviews with a small number of finance directors.

Overview

The reality of tougher financial times is highlighted in the Department of Health's latest analysis of trusts' and PCTs' forecast end-of-year financial position: the number of trusts predicting a full-year deficit by April 2012 trebled compared to the same period last year (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130324.pdf). It is also clear that providers are and will be bearing a significant and disproportionate burden of the £20 billion productivity challenge as they grapple with, among other things, real reductions in tariff and possible reductions in activity. Despite this, the Department also notes that 'At a national level, the NHS has maintained and improved performance on key quality measures.'

A 'cautious optimism' seems to be the general feel that emerged from our panel of finance directors as well. It is apparent that some trusts are struggling, with worries about meeting their productivity targets, but others remain optimistic. A key challenge they face is achieving cost improvement targets while maintaining service quality and staff engagement.

In this report, we have also asked about the next financial year. Perhaps not surprisingly, given the requirement to meet the four-year £20 billion productivity challenge, cost improvement targets for 2012/13 are more or less the same as for this year.

The performance measures (delayed transfers of care, hospital-acquired infections and waiting times) tracked in this report show that broadly, at a national level, performance is either stable (delayed transfers of care), more or less in line with seasonal trends (waiting times) or, in the case of *Clostridium difficile* (*C difficile*) and methicillin-resistant *Staphylococcus aureus* (MRSA), improving slightly.

The data in this quarterly report shows that performance generally in the NHS is holding up under pressure. But this masks a significant variation in performance across all trusts. Looking at 18-week waits, a large number of trusts are managing to admit over 90 per cent of patients within 18 weeks of waiting. However, as the chart on page 19 shows, 26 per cent of trusts admitted less than 90 per cent of patients within 18 weeks of referral by their GP.

Finance Directors' Panel

COST IMPROVEMENT PROGRAMMES AND END-OF-YEAR FINANCIAL SITUATION

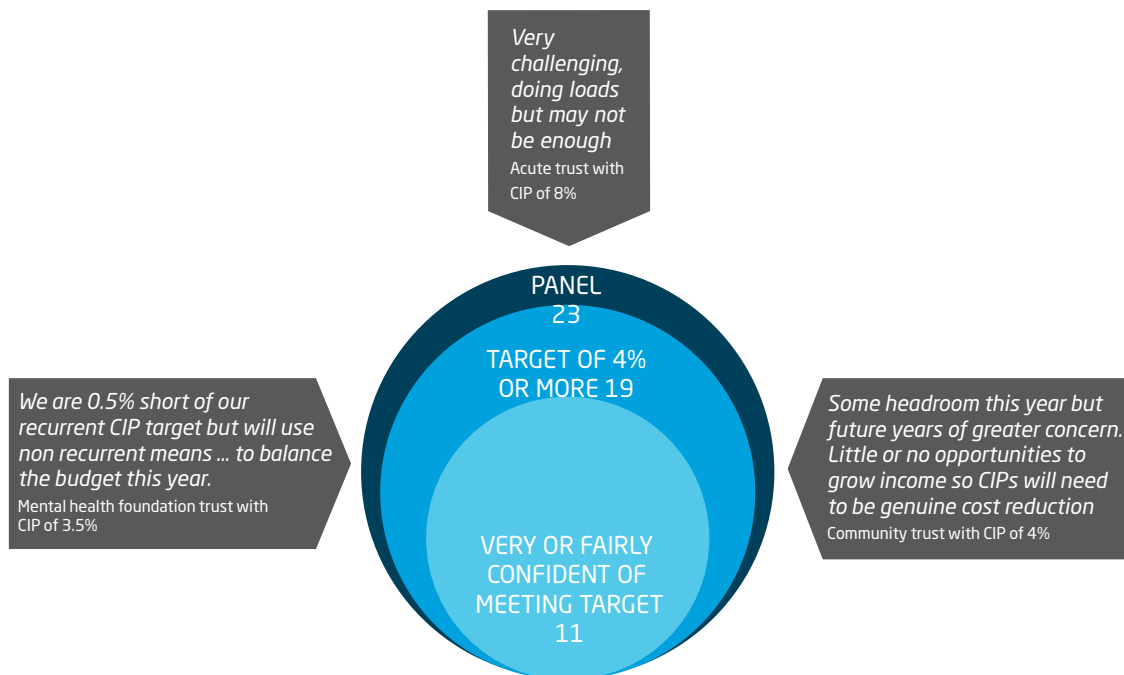
The key challenge for the NHS in England over the next few years is to improve productivity. With only a very small real increase in funding this year – but with growing demands – NHS organisations are now under enormous pressure to increase the value of their services to patients for every pound spent. As we have noted in previous *Quarterly Monitoring Reports*, the hospital sector in particular is facing productivity targets this year in excess of the 4 to 5 per cent for the NHS as a whole, due to the combined impact of real cuts in prices, the need to deal with extant deficits and likely reductions in volumes of work.

The situation six months into the financial year suggests that, as in previous panel surveys, cost improvement targets (CIPs) this year are, for the majority of trusts, higher than 4 per cent, with

PCTs/clusters reporting slightly lower targets than trusts. Across the whole panel the average CIP target this year is between 5 and 6 per cent. This reflects the uneven share of the productivity challenge being borne by acute hospital services. This is a result of the policy tactics adopted to incentivise provider trusts to improve productivity (for example, reducing tariff prices in real terms).

Targets are one thing, achievements, however, are another. We therefore asked our panel how confident they were in achieving their plans. The panel was roughly evenly split: eleven finance directors stated they were either very or fairly confident that they would achieve their CIP targets this year; eight, however, were either very or fairly concerned that they would not, and four were uncertain.

Confidence in meeting productivity targets in 2011/12



Predicting how an organisation's finances will look at the end of the financial year is not necessarily an accurate science, but over half (15) of the finance directors on our panel said that their organisation was likely to end the year in surplus, and the rest that they are likely to break even. Just one forecast a technical deficit.

Optimism concerning the end-of-year financial situation seems in contrast to the number of those uncertain of meeting their CIPs, but cost improvement plans may stretch beyond what is necessary to break even, and several finance directors said that it was still too early in the year to be precise about their financial situation next April.

While many may feel under pressure financially this year, as one finance director noted, while there is 'some headroom this year, future years are of great concern'. The challenge for all NHS organisations is not just in meeting a one-off improvement in productivity, but to maintain this for the next three years – and possibly beyond. It is clear from CIP targets for next year (2012/13) that trusts and PCTs are at least planning to set themselves equally challenging targets, again of the order of 5 to 6 per cent. Four directors reported a CIP target of between 2 and 4 per cent next year; seven a target of between 4 and 6 per cent and eight targets of 6 per cent or more.

What is your organisation's likely end-of-year financial situation?



A MENTAL HEALTH TRUST

Productivity target: 6.2 per cent

The main challenge for this organisation is to transform their clinical services. The trust's focus is on disinvestment - reductions in service/ capacity to curb costs - as well as genuine productivity improvements. But this has generated challenging discussions with commissioners who argue that any savings in efficiency gains should be reflected in reductions in block contract costs.

The trust's main concern in the short term is how it will achieve better quality through transforming services while at the same time absorbing reductions in income. Their focus is on patient pathways and trying to redesign services at key parts of the pathway to maximise value for patients. This is not easy, and it has been difficult to make accurate assessments of savings and benefits involved.

As for the future, a tough few years may not be the end: *I would say it's going to get worse....I'm concerned that the protection afforded to the NHS may not be sustainable and we may see even bigger targets going forward and even bigger challenges.*

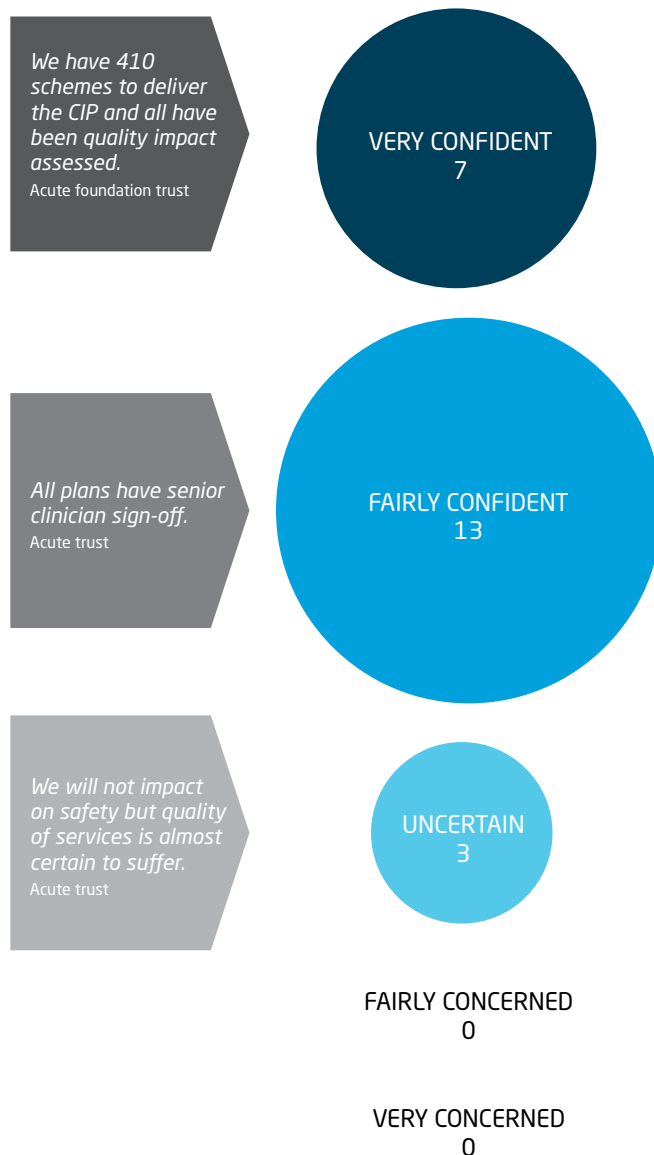
My concern is about the management of the transition - how we get from where we are now to something that is a very different service and what that might mean in terms of short-term management and how we work within the current finance regime and the regulatory framework to make that scale of transition and keep everybody's confidence about what we're trying to get to and that the new services will be as high a quality. It's the management of the transition that worries me the most and how to keep the organisation successful within the current framework during the process.

IMPACT OF COST IMPROVEMENT PROGRAMME MEASURES ON CLINICAL QUALITY

While bearing down on costs and seeking new ways of delivering care in more cost-effective ways are key tasks in improving value for money, there can be a danger that the pressure will harm the quality of patient care or even patient safety. Clearly this will be a top concern for patients and the public, so it is reassuring that our panel of finance directors were confident that clinical quality would not be harmed in pursuit of cost improvements.

Most noted that their measures are submitted to impact assessments to ensure that quality and outcomes are not compromised. Of note, however, is the view of one finance director who thought that while patient safety would not be affected, quality of services was almost certain to suffer.

How confident are you that measures to achieve your CIP target will not harm clinical quality?



CLUSTER PCT

Productivity target: 5 per cent

The director of finance for a PCT cluster noted that a key problem this year was making changes to meet very challenging targets without impacting adversely on quality and performance - managing this delivery was tricky.

The plan to deal with the CIP targets included a wide range of initiatives and service areas from planned and urgent care, to pathway redesign. They are making sure that they have consistent models of urgent care among the three centres and that the appropriate budgetary controls are in place.

Forming a cluster of three PCTs has presented a challenge in terms of management and control, but also in ensuring that planned savings are met; a lot of people have left the PCTs, which has raised concerns about the ability of the cluster to see through its CIP.

The CIP for next year is expected to be the same and there is some optimism about achieving this as most of the infrastructure changes have now taken place and many initiatives have now started.

For the coming years, the main challenge is getting clinical commissioning groups ready to take on their new roles. This further transition will be challenging at a time when the PCTs are having to manage the largest savings programme ever. The size of this challenge is affecting morale and performance.

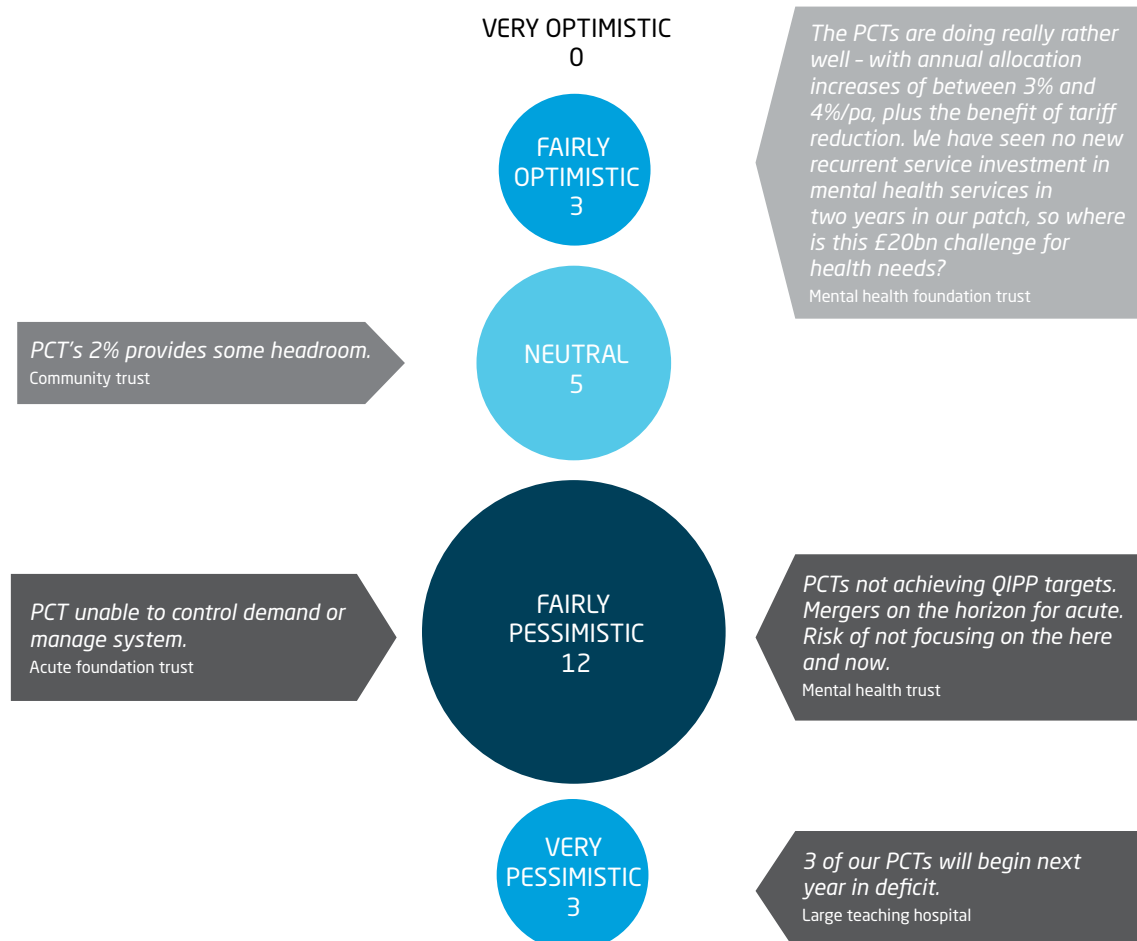
Trying to make changes inevitably has impact on quality of services and performance targets - it is how you ensure you manage that delivery aspect. And unfortunately many of the targets are pretty stretching and it is difficult to ensure that we get the balance right. Going forward it will be trickier to stay in that level of performance with the resources available. Something has to give!

OPTIMISM ABOUT FINANCES OF LOCAL HEALTH ECONOMY

The finances of NHS organisations – trusts and PCTs – locally are highly interdependent, often resembling bilateral monopolies with effectively one purchaser and one provider. In these situations any difficulties in one organisation have the potential to impact on others. So, potential optimism about the finances of a single organisation may be tempered by pessimism over the situation facing others.

A majority of the finance directors who responded to this quarter's survey stated that they were either very or fairly pessimistic about the financial state of their local health economy. While there appears to be some slide towards a more pessimistic view compared with last quarter's report, total numbers are small.

Overall, what do you feel about the financial state of the wider health economy in your area over the next year?

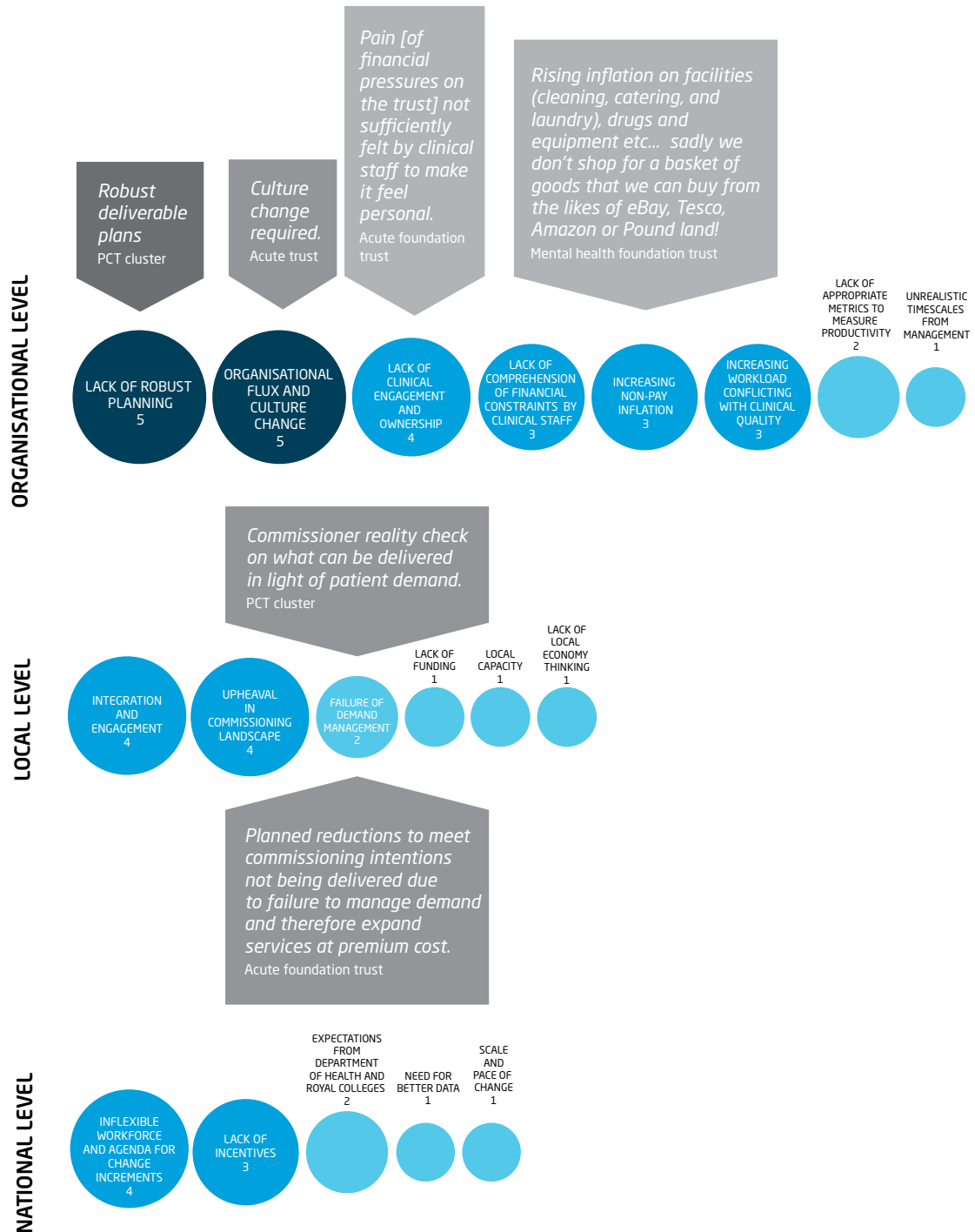


KEY BARRIERS TO PRODUCTIVITY IMPROVEMENTS

To gain a better understanding of the main factors that are hindering NHS organisations from making productivity improvements, we asked finance

directors what they see as the top three barriers. Responses are grouped into three categories, those at the organisational, local and national levels.

What are the top three barriers to achieving improvements in productivity in your organisation?



LARGE ACUTE TRUST

Productivity target: 6 per cent

The finance director at a large teaching hospital confirmed that they are on track to meet their cost-improvement target of 6 per cent. Their original plans to achieve this were focused mostly on permanently reducing activity. In addition, however, significant cost reductions were achieved in part through better management of temporary staff - for example, using electronic rosters and hand scanners to clock staff in and out.

Management effort is focused on reducing capacity through referral reduction schemes. Improved clinical triage to route patients through the hospital is designed to reduce demand on resources and to identify more appropriate care for patients outside the hospital. However, there are problems with the capacity of community-based services that need to be addressed.

The hardest relationships are with PCTs. They are under pressure financially and have uncertain futures and a high turnover of staff, which disrupts continuity of management engagement with the trust.

The pressure on finances is unabating with at least another three years of difficult work to create value for money and cost savings. Losing core administrative staff and asking a lot of permanent staff is creating a strain that will make the situation harder next year.

...Because of the hiatus caused by the Health Bill no strategic planning is being done - that has been left for the hospitals to do. So we are doing it...but we have no idea whether we will be supported. [In terms of] planning - we are at least a year behind where we are supposed to be now; it is a problem.

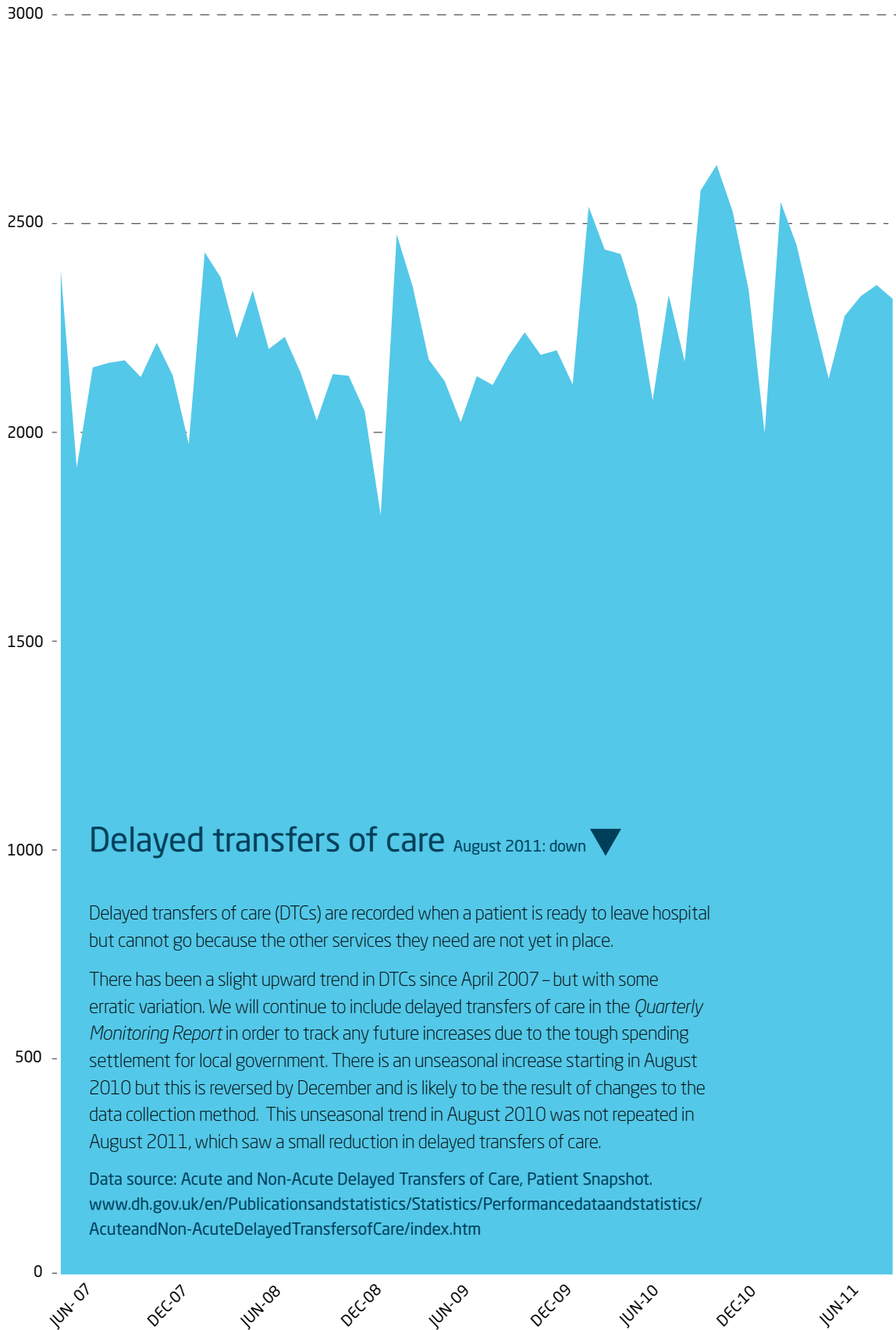
Selected NHS performance measures

The second part of our report gives data on selected NHS performance measures. There are, of course, thousands of possible statistics available to measure the performance of the NHS. Here, we have selected a small group that reflect key issues of concern to the public and patients as well as providing some indicative measures of the impact of tackling the productivity and reform challenges confronting the NHS. The measures selected are:

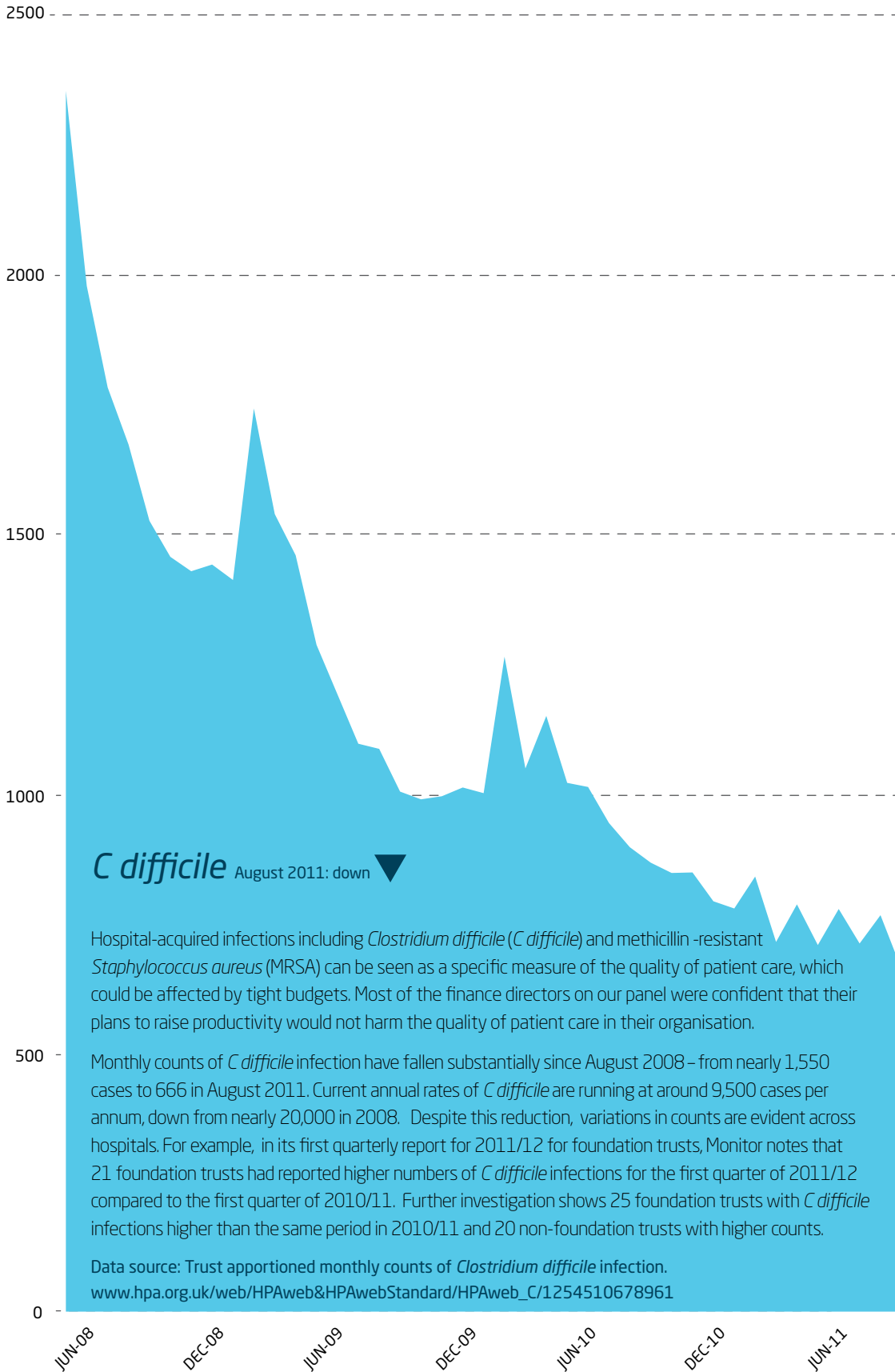
- delayed transfers of care
- hospital-acquired infections
- waiting times.

Note: It has not been possible to update information on compulsory redundancies (tracked in previous *Quarterly Monitoring Reports*) as the data is no longer published by the Department of Health. The NHS Information Centre has undertaken a review of redundancy data previously published by the Department and will be publishing details of this towards the end of October.

MONTHLY COUNTS, ACUTE



MONTHLY COUNTS

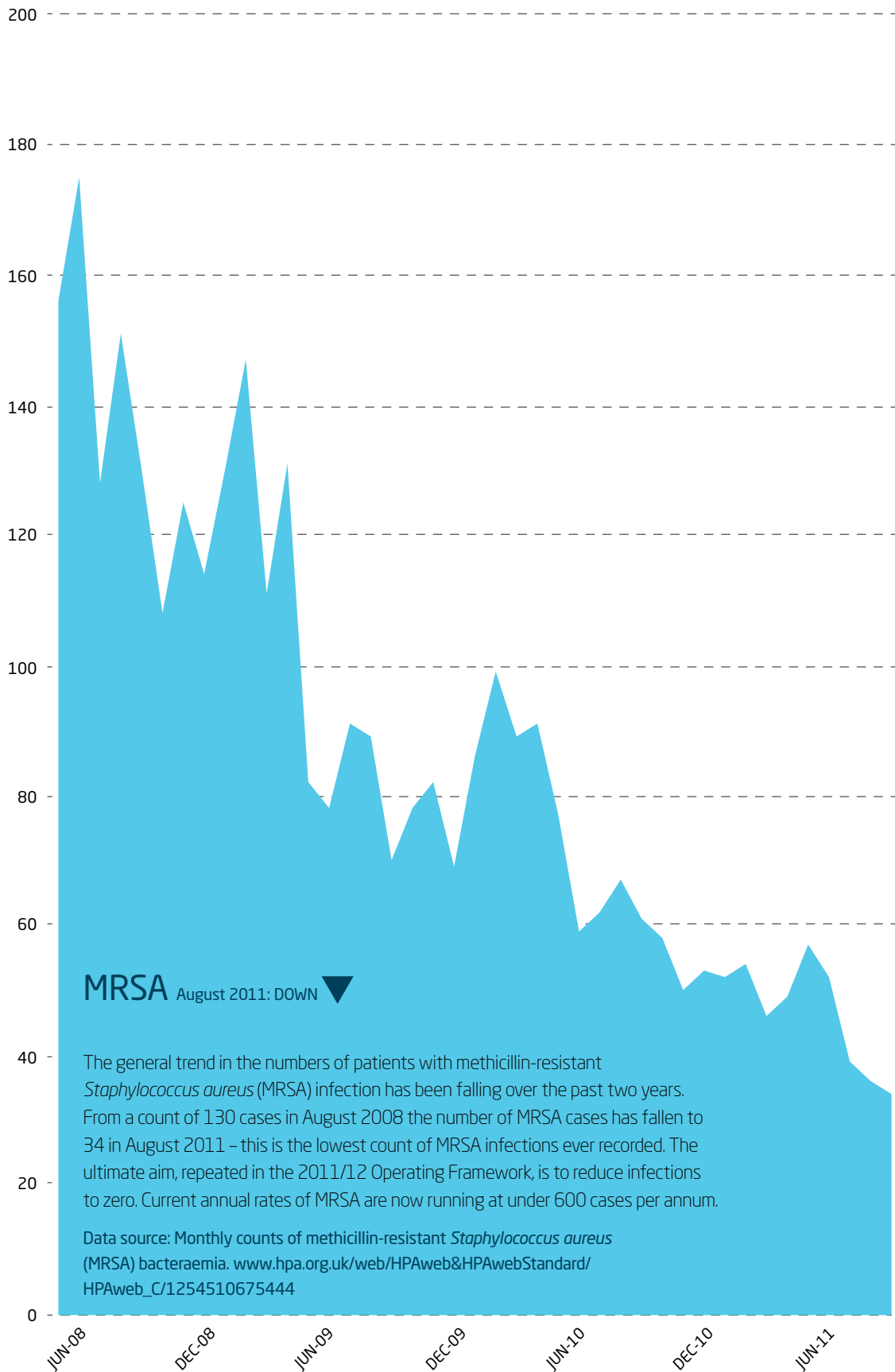


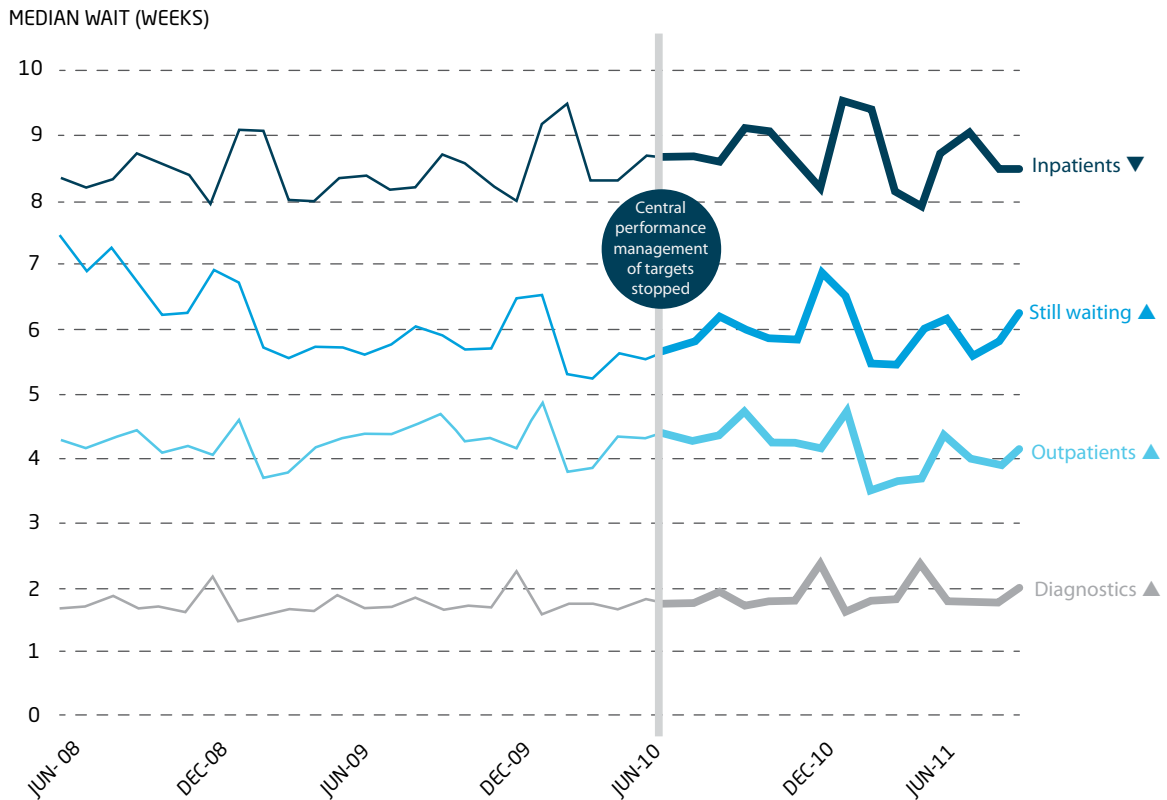
Hospital-acquired infections including *Clostridium difficile* (*C difficile*) and methicillin-resistant *Staphylococcus aureus* (MRSA) can be seen as a specific measure of the quality of patient care, which could be affected by tight budgets. Most of the finance directors on our panel were confident that their plans to raise productivity would not harm the quality of patient care in their organisation.

Monthly counts of *C difficile* infection have fallen substantially since August 2008 – from nearly 1,550 cases to 666 in August 2011. Current annual rates of *C difficile* are running at around 9,500 cases per annum, down from nearly 20,000 in 2008. Despite this reduction, variations in counts are evident across hospitals. For example, in its first quarterly report for 2011/12 for foundation trusts, Monitor notes that 21 foundation trusts had reported higher numbers of *C difficile* infections for the first quarter of 2011/12 compared to the first quarter of 2010/11. Further investigation shows 25 foundation trusts with *C difficile* infections higher than the same period in 2010/11 and 20 non-foundation trusts with higher counts.

Data source: Trust apportioned monthly counts of *Clostridium difficile* infection.
www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510678961

MONTHLY COUNTS





Waiting times: Median*

In August 2011, median waiting times have decreased slightly for those admitted (inpatients), but rose for those not admitted (outpatients) and patients still waiting. These broadly reflect seasonal trends for this month.

Diagnostic median waiting times remained at a consistent level in June and July 2011 but rose in August. This reflects seasonal trends for these months. The overall trend in diagnostic waiting times remains above that from June 2010 although at just under 2 weeks, in absolute terms it remains very short.

* The median is the mid-point of the waiting times distribution (ie, the 50th percentile) and can be interpreted by saying that 50 per cent of all patients, whose RTT clock stopped during the month, were treated within this time.

Data sources:

Referral to Treatment Waiting Times Statistics.
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

Diagnostic Waiting Times Statistics.

www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm

Data sources:

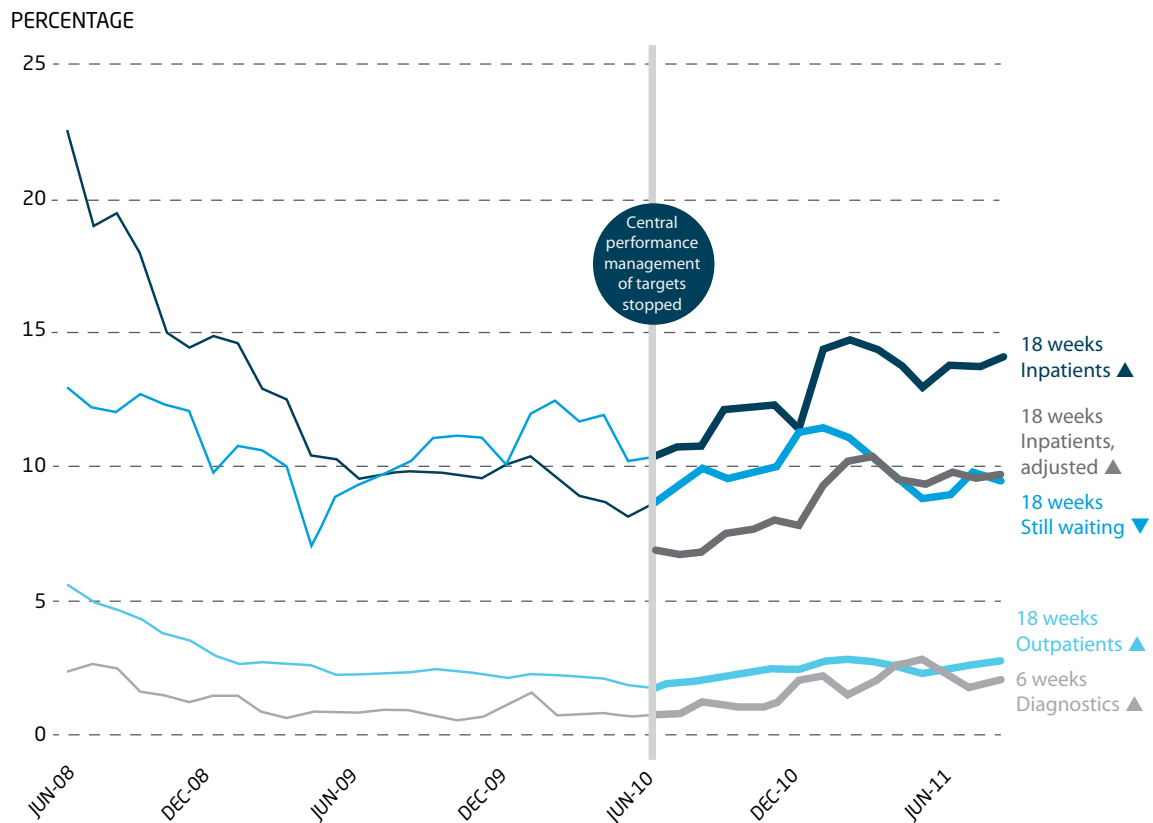
Total time spent in A&E.
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/AccidentandEmergency/DH_079085

Waiting times: 18 weeks and A&E

The latest 18-week referral-to-treatment waiting times data for August 2011 show increases in the percentage of patients waiting longer than 18 weeks for inpatients (adjusted and unadjusted)*. Figures for outpatients and those still waiting remained more or less static. Compared with August 2010, however, performance remains poorer for inpatient and outpatient waiting. Despite these increases, overall the 18-week operational standard was met in August with just over 90 per cent (90.4 per cent) of inpatients having waited less than 18 weeks.

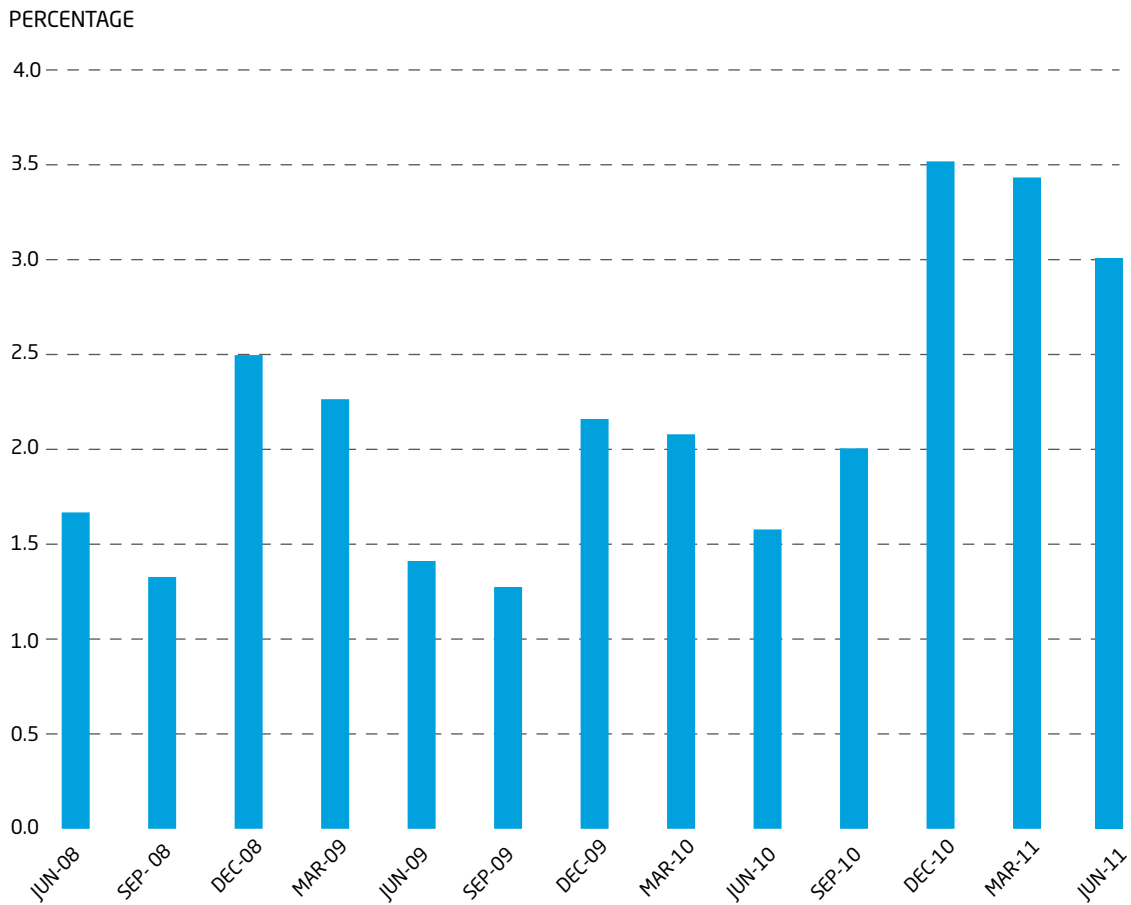
The trend since June 2010 for the proportion waiting more than 6 weeks for diagnostics has been upward and the percentage waiting more than 6 weeks has risen from 1.13 per cent in August 2010 to 2.0 per cent in August 2011 – equivalent to a rise in the number of patients from 5,800 in August 2010 to more than 11,400 in August 2011. However, this is still relatively low in terms of recent history; in August 2007 over one-third of patients waited over 6 weeks in April 2007.

Percentage still waiting/having waited more than 18 weeks (more than 6 weeks for diagnostics)



* Adjusted figures exclude periods of delay introduced as a result of patients turning down offers of admission made with reasonable notice.

Percentage of patients waiting more than four hours in A&E



The Department of Health has changed the threshold for performance management against the previous government's target that no-one should wait more than four hours in A&E from 98 to 95 per cent with effect from quarter two of 2010/11. In future a range of indicators will be used to assess performance. The latest data for four-hour A&E waits (2011/12, quarter one) showed a continued decrease but remains high and masks considerable variation. 128 providers report less than 1 per cent waiting more than four hours whereas 29 report over 5 per cent. These 29 providers have in effect breached the new target threshold.

Data source:
 Total time spent in A&E.
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/AccidentandEmergency/DH_079085

Waiting times: Variations across trusts

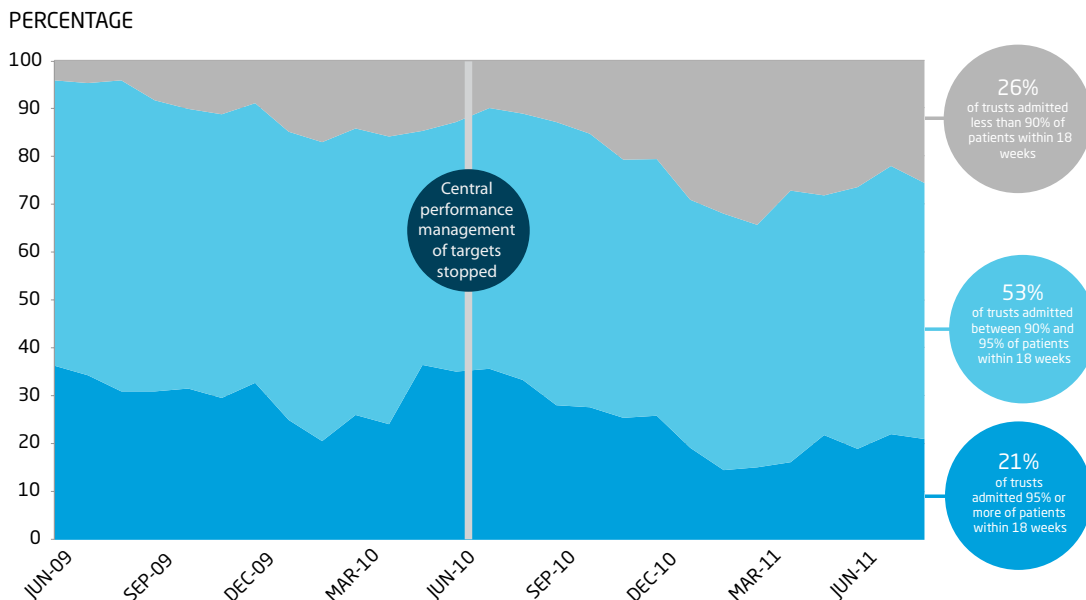
While the proportion of patients waiting more than 18 weeks for treatment has increased nationally since the scrapping of the 18-week maximum target, it has (apart from two months) remained below 10 per cent. However, the national average conceals considerable variation at local level.

The majority of trusts (53 per cent) admitted between 90 and 95 per cent of their inpatients

within 18 weeks, and around a fifth admitted between 95 and 100 per cent within 18 weeks of referral in August.

However, 45 trusts – over a quarter – admitted less than 90 per cent of their patients within 18 weeks. This is more than double the number of trusts failing the 18-week target in August 2010 (19).

Percentage of trusts admitting more than 95%, 90-95% and less than 90% of patients within 18 weeks



Data source:

Referral to Treatment Waiting Time Statistics, Provider Data - Adjusted Admitted Pathways.

www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

