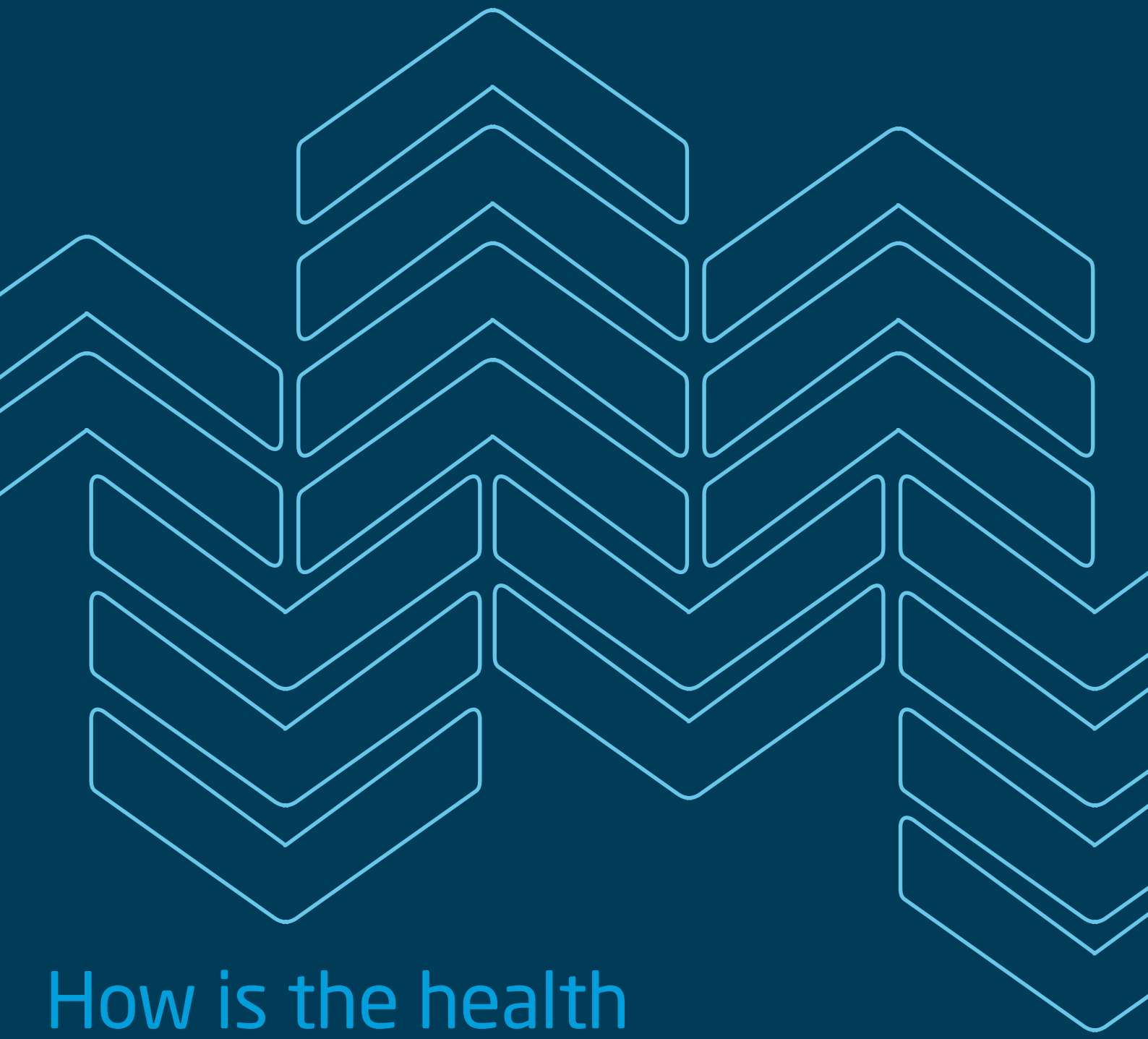
The King's Fund

Ideas that change health care



How is the health and social care system performing?

Quarterly monitoring report

September 2013

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The King's Fund published its first *Quarterly Monitoring Report* in April 2011 as part of its work to track, analyse and comment on the changes and challenges the health and care system is facing. This is the ninth report and aims to take stock of what has happened over the past quarter and assess the state of the health and care system more than halfway through the £20 billion Nicholson Challenge. It provides an update on how the NHS is coping as it continues to grapple with this productivity challenge while implementing the government's NHS reforms.

The *Quarterly Monitoring Report* combines publicly available data on selected NHS performance measures with views from a panel of NHS trust finance directors, clinical commissioning group (CCG) finance leads, and local authority directors of adult social services (see box below).

SURVEYS OF NHS TRUST FINANCE DIRECTORS AND CCG FINANCE LEADS

This quarter we carried out an online survey of NHS Trust finance directors between 11 July 2013 and 25 July 2013. One hundred and thirty six NHS trust finance directors were contacted to take part and 42 were available to give their views. In addition, 100 clinical commissioning group finance leads were contacted and 29 responded.

SURVEY OF LOCAL AUTHORITY DIRECTORS OF ADULT SOCIAL SERVICES

We carried out an online survey of directors of adult social services over the same period. Of the 152 directors contacted, 22 responded.

Overview

- Although nearly 9 out of 10 NHS trust finance directors and CCG finance leads forecast a surplus or break even position by the end of this financial year, only 1 in 10 is very or fairly optimistic about the financial state of their local health economy over the next 12 months.

- Savings targets for trusts remain at an average of around 5 per cent of turnover this year. For clinical commissioning groups (CCGs), the productivity target (quality, innovation, productivity and prevention) averages around 2.5 per cent of allocations.

- However, confidence in achieving savings plans has dropped markedly among NHS trust finance directors compared to this time last year: last year only 5 NHS trust finance directors (11 per cent) were either fairly or very concerned about their cost improvement programme (CIP) plans for 2012/13 and 33 (73 per cent) were confident; now, four months into the new financial year, 18 (43 per cent) expressed concern about achieving their plans for 2013/14 and just 14 (33 per cent) were confident.

- On the task for the NHS to realise productivity improvements totalling £20 billion over the four years to 2014/15, all bar seven NHS trust finance director/CCG finance lead put the odds of achieving this no higher than 50/50, and more than half rated the likelihood of failure as high or very high.

- Although 1 in 7 NHS trust finance directors and CCG finance leads thought patient care in their area had improved in the past 12 months, half thought it had stayed the same and nearly a third that it had got worse – a more pessimistic view compared to this time last year when 16 per cent thought it had got worse.

- Despite the accident and emergency four-hour waiting time target now being met at a national level following breaches last winter/spring, this target remains the top current concern for trusts and CCGs. Delayed transfers of care, the 18-week elective waiting time target, hospital infections and staff morale also rank high as current performance worries.

- NHS trust finance directors have become more pessimistic about the financial state of their local health and care economies over the next year; slightly more than 80 per cent are very or fairly pessimistic compared to around half surveyed this time last year. On the other hand, CCG finance leads appear slightly more optimistic: only six out of ten are very or fairly pessimistic.

- In adult social care the position is bleaker. More than half of directors thought they would overspend their budget this year. Although most felt the quality of care had stayed the same over the past 12 months, rising demand and financial pressures were taking their toll; nearly three-quarters were pessimistic about the financial state of their local health and care system.

- While the NHS has transferred nearly £3 billion to local authorities over the past three years – and with plans to increase this in 2015/16 to a NHS/local authority pooled budget of £3.8 billion – around two-thirds of those in this quarter's survey say there have been impacts on NHS services arising from councils' funding allocations with consequences for increased delayed transfers of care and generally increased demand pressures on health care services as local authorities cope with real cuts in their budgets. However, local authority respondents indicate that NHS money is helping to offset budget cuts, with some signs that financial challenges in the NHS are adding to pressures on social care.

- A major policy introduced in 2010/11 to stabilise or reduce the number of emergency admissions to hospital (which have risen by more than 40 per cent since 2000) by paying hospitals just 30 per cent of the tariff price for admissions over levels in 2008/9 has not, in the opinion of NHS trust finance directors, had much impact on admissions. Reduced payments have involved lost income averaging £4.6 million across half the trusts (13) in this quarter's survey that carry out emergency work.

- Although the reduced payment rate for hospital emergency admissions was also meant to stimulate commissioners to invest some of the saved payments in schemes to reduce admissions, more than 80 per cent in this survey said the

policy had either had no impact or had been ineffective in encouraging such initiatives. In the light of these results, Monitor's current review of this financial incentive will need to examine alternative approaches to controlling emergency admissions.

- The concern expressed by NHS trust finance directors over accident and emergency (A&E) departments' performance is reflected in the latest quarter's waiting times figures; although between April and the end of June this year the national target that no more than 5 per cent of patients should wait more than four hours was met, at 4.3 per cent (equivalent to 241,000 patients) this remains the highest proportion of patients waiting longer than four hours since quarter 1, 2004/5.

- Pressure in the hospital system was also evident in the proportion of so-called 'trolley waits' – patients waiting more than four hours to be admitted into hospital from A&E – which reached almost 4.5 per cent in the last quarter and, again, was the highest first quarter figure since 2003/4.

- Median waiting times for inpatients, patients still on waiting lists and diagnostics all remain steady within the usual fluctuations from month to month. The increase in median waits for outpatients, however, may indicate emerging pressures to treat patients from the waiting list and may presage an upturn in the median wait for inpatients.

- Overall, referral-to-treatment time waits remain within current targets nationally, although the proportion of inpatients waiting longer than 18 weeks for treatment appears to be increasing since January this year and is at its highest proportion for more than a year.

- On the basis of official statistics, the number of delayed transfers of care across England remains steady at around 4,000 patients per day – more or less unchanging since December 2010. The proportion of delays attributable to the NHS – rather than social care – has increased. The dissonance between these official figures and the anecdotal evidence from trusts about the problems of delayed transfers requires further investigation.

NHS trust and clinical commissioning group survey

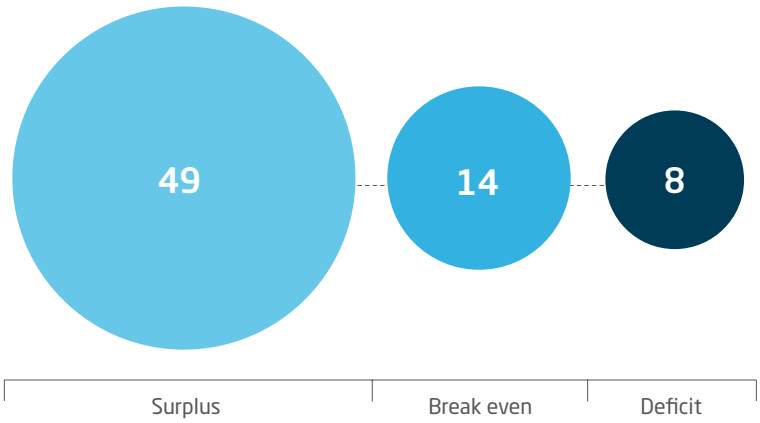
This quarter's report is based on an online survey of 42 finance directors of NHS trusts and 29 finance leads of clinical commissioning groups.

END-OF-YEAR FINANCIAL SITUATION AND COST IMPROVEMENT/ QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PROGRAMMES

Projected end-of-year financial balance (2013/14)

Trusts' and CCGs' forecasts for their financial situation by the end of the current year are generally positive. More than two-thirds (49) forecast a surplus and a fifth (14) a break even position (see figure below). However, seven trusts and one CCG forecast a deficit at the end of 2013/14. Compared to forecasts made at this time last year (for the end-of-year position for 2012/13 and for trusts only), projections for 2013/14 are more pessimistic than at this time last year when 35 NHS trust finance directors (more than three-quarters) were projecting a surplus for 2012/13 and just three a deficit (Appleby *et al* 2012).

What is your organisation's likely end-of-year (2013/14) financial situation?



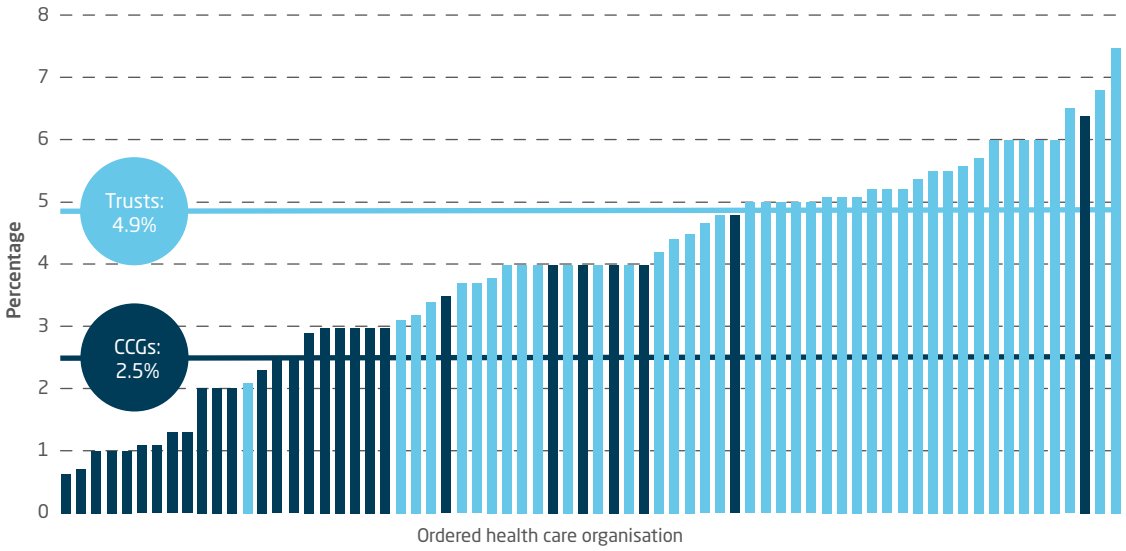
Cost improvement programmes (CIPs) and the £20 billion productivity challenge

2012/13 was the second full year of the four-year £20 billion productivity challenge, and our previous survey (carried out in April this year) indicated that NHS trusts achieved CIPs amounting to 4.6 per cent of their turnover – slightly less than the planned amount of 4.9 per cent. Now, part way into the third year of the productivity challenge, how are NHS organisations faring?

The average target CIP for trusts this financial year is again 4.9 per cent, ranging from 2.1 per cent to 7.5 per cent of turnover (see figure below).

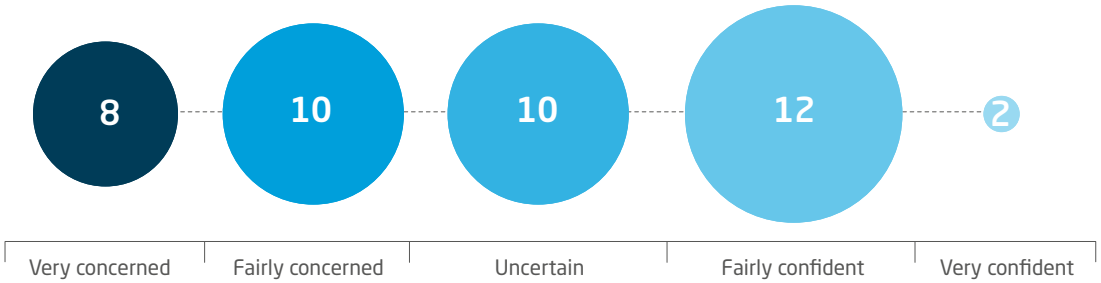
On the commissioning side, quality, innovation, productivity and prevention (QIPP) targets are generally lower (and exclude the 4 per cent efficiency target built into the tariff prices this year). CCGs' average QIPP target is 2.5 per cent ranging from 0.7 per cent to 6.4 percent (see figure below).

What is your organisation's CIP/QIPP target for this financial year (2013/14) as a percentage of turnover/allocation?



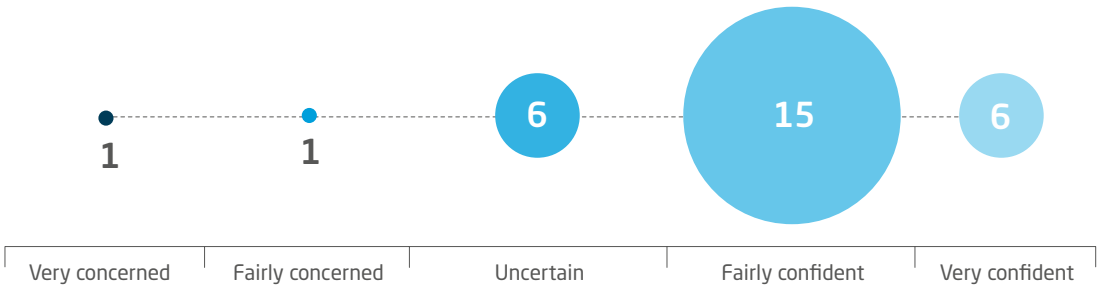
Setting targets is one thing but achieving them another. Confidence in achieving their planned CIP or QIPP targets was lower among trusts than CCGs (see figures below). Around a third of NHS trust finance directors (14) felt either very or fairly confident that their CIP plans would be met. However, confidence has dropped compared to a year ago (Appleby *et al* 2012) when just 5 NHS trust finance directors (11 per cent) were either fairly or very concerned about their CIP plans for 2012/13 and 33 (73 per cent) were confident; now, four months into the new financial year, 18 (43 per cent) expressed concern about achieving their plans for 2013/14 and just 14 (33 per cent) were confident.

How confident are you of achieving your CIP target in 2013/14?
Trusts



Among CCG finance leads on the other hand, around seven out of ten were very or fairly confident about achieving their CIP/QIPP targets this year.

How confident are you of achieving your QIPP target in 2013/14?
Clinical commissioning groups



SELECTED COMMENTS: CONFIDENCE IN ACHIEVING CIP/QIPP TARGET IN 2013/14

The challenge (of a 5.5 per cent CIP) would be enormous in any context – but with the post-Francis concerns there is great reluctance to press for cost reductions without copper-bottomed guarantees on clinical safety and quality.

Conflicting funding vs quality issues, pressures on non-elective system.

Several schemes are still not signed off for implementation due to concerns about impact on quality, therefore we are developing alternative contingency plans.

I am concerned that while we have cover for in-year slippage, the required run rate by the year-end will mean savings will be higher next year than the overall efficiency target set by Monitor.

Very limited options around clinical staff costs (versus quality), you can only knock a building down once!

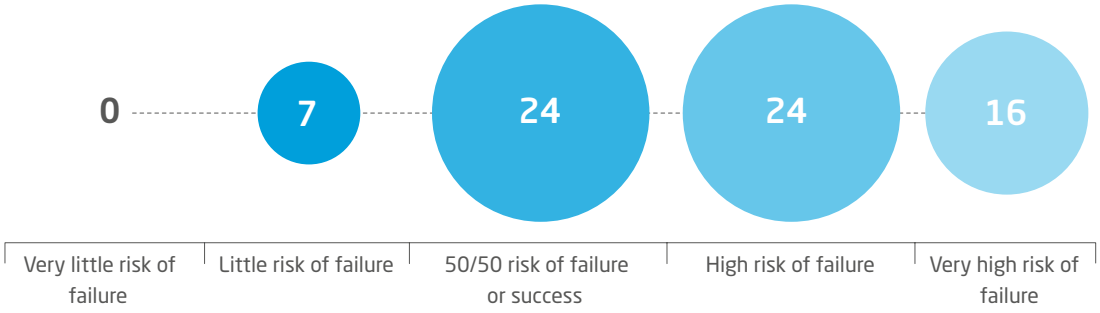
The scale of change required to deliver some CIPs means, at the least, significant delay in implementation. Trust will need to hold back on planned investments to make sure achieve financial plan.

[The QIPP/CIP target] requires significant changes in clinical behaviours and full participation of both local authority and key NHS partners who have conflicting priorities/pressures.

Nearly 50 per cent of QIPP programme is targeted at reducing outpatient follow-ups to a ratio of 1 to 1.5, an ambitious target which our main provider organisation has committed to helping deliver.

Concerns about local savings plans are reflected in views about the ability of the NHS as a whole to meet its four-year £20 billion productivity challenge by 2014/15. Slightly more than half of NHS trust finance directors and CCG finance leads (40) rated the risk of failure to meet the challenge as high or very high and just a third as an evens chance of failure or success (see figure below).

What is your estimate of the risk involved in achieving productivity gains of the value of £20 billion by 2014/15?



As some of the comments on this issue suggest, there are decreasing marginal returns to productivity improvements (see box below). And in particular, as one NHS trust finance director noted, it is clear that the productivity challenge will continue post-2014/15.

SELECTED COMMENTS: THE RISK INVOLVED IN ACHIEVING THE £20 BILLION PRODUCTIVITY CHALLENGE BY 2014/15

The easy stuff has been done and delivered. Not much evidence of commissioners/politicians being prepared to make and support the necessary difficult decisions.

While such a demanding challenge inevitably carries a high risk of failure, the phrase 'It always seems impossible until it's done' comes to mind.

I think a lot of efficiency [gains] go uncounted – such as quality improvements, activity paid under the emergency rate discount, etc.

It is getting more difficult each year and it does not appear to stop in 2014/15.

[There is a high risk of failure] unless significant central support in reducing the pay bill (eg, Agenda for Change increments, consultant contract, etc).

£20 billion has little resonance locally... It's about 5 per cent efficiency each and every year.

Achieving £20 billion of productivity gains by 2014/15 is certainly feasible (although the pressure is really on providers to deliver the savings), however,

there is a much bigger risk to the achievement of the savings that will be required beyond 2014/15, both in terms of the value of savings likely to be required being higher than the so-called Nicholson Challenge, and due to the 'easy' savings having already been made.

The cuts in social care effectively mean having to deliver well over the £20billion as cuts in [social care] services lead to increases in demand on health services.

I think it will be 'nominally delivered' but will have trade off in terms of quality of services. I think it's noticeable in this year that the efficiency targets have cut too deeply into the front line.

The issue will be reduced health care provision and acute providers increasingly at risk of failure.

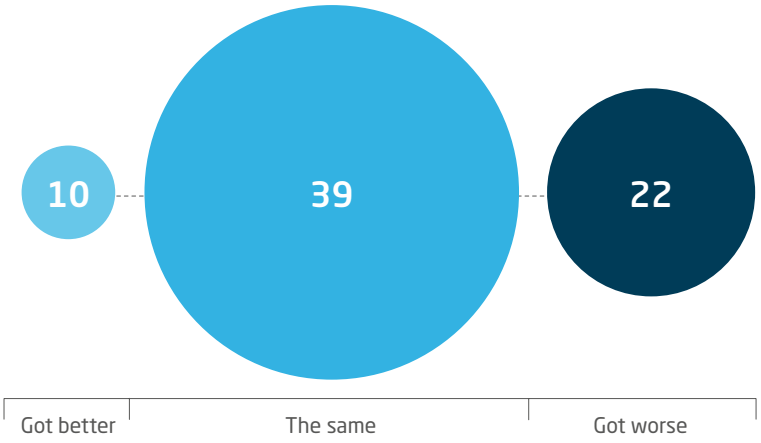
I believe NHS organisations have planned well to deliver the challenge. However, the significance of the reforms has injected a level of risk that now makes me concerned about the next 18 months.

For the years beyond 2014/15, NHS England has recently suggested that by 2020/21 the gap between what the NHS needs by way of funding to cover increased demands and improved quality and what it is likely to receive could vary from £30 billion (based on a worst case scenario of flat real growth in funding) to a more modest £7 billion (based on funding matching growth in GDP) (NHS England 2013d). While the more parsimonious scenario appears unduly pessimistic – assuming a 1.7 per cent cash increase each year versus a 5.2 per cent per annum increase in needed funding – nevertheless, some pressure on funding beyond 2014/15 is certain to remain and will mean continued productivity improvements will be required each year to 2020/21 of between 1 per cent and slightly more than 4 per cent.

Meeting cost improvement and QIPP targets and ensuring financial balance remain key objectives for the NHS in 2013/14. But the driving ambition underlying the challenge to deliver greater productivity and a stable financial position is not only to maintain the quality of services to patients, but to improve it.

When asked about the state of patient care in their area, slightly more than two-thirds of NHS trust finance directors and CCG finance leads (49) expressed the view that it had got better or stayed the same over the past 12 months. The remaining third (22) stated it had got worse (see figure below). This represents a worsening of views compared to this time last year when around 16 per cent said that patient care had got worse in the previous 12 months (Appleby *et al* 2012)

Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



ORGANISATIONAL CHALLENGES

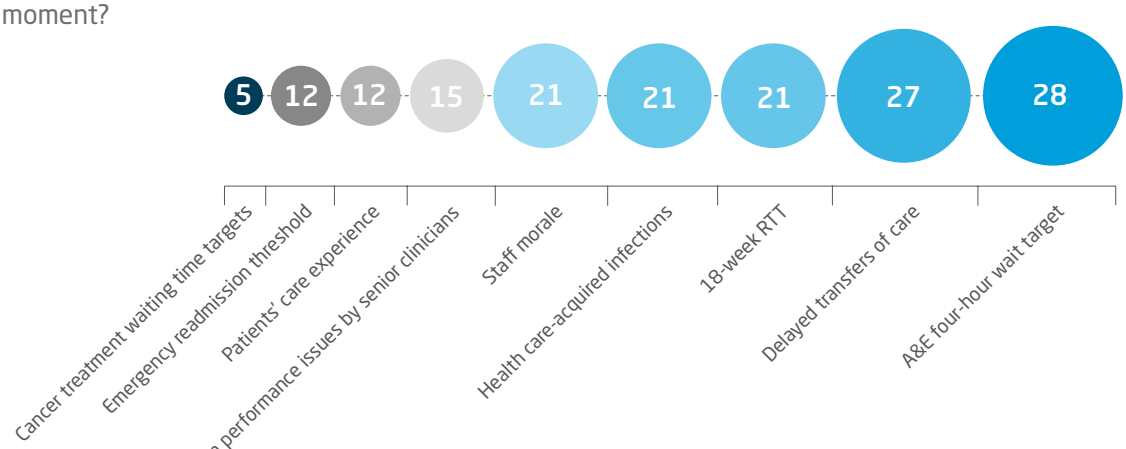
The scale of the current system reform, overlaid on an unprecedentedly tough financial settlement and the associated and equally unprecedented productivity target, continue to present a particularly challenging environment for NHS organisations.

To understand how this was affecting them, NHS trust finance directors and CCG finance leads were asked to state the three aspects of their organisation's performance that were giving them most concern at the moment.

The most commonly cited concerns were the A&E four-hour waiting time target closely followed by delayed transfers of care and then the 18-week referral-to-treatment (RTT) waiting time targets, health care-acquired infections and staff morale (see figure below).

The concerns with A&E and delayed transfers of care are, of course, connected, and provide some insight into part of the diagnosis of the waiting times problems that became increasingly evident earlier this year. The announcement of funds – £500 million over two years from within the NHS budget (Prime Minister's Office 2013) – to be targeted at hospitals experiencing further difficulties in A&E later in the year will hopefully go some way to alleviating concerns expressed by trusts and CCGs on the A&E waiting times target.

Which aspects of your organisation's performance are giving you most cause for concern at the moment?



NB: Finance directors/CCG leads were asked to select their top three concerns; not all selected three and some selected more.

In addition to the concerns noted in the figure above, other worries ranged from issues arising from the recent Keogh review of poorly performing trusts (NHS England 2013e) to problems with the financial penalties associated with emergency admissions (see box below).

OTHER ISSUES OF CONCERN IDENTIFIED BY NHS TRUST FINANCE DIRECTORS/CCG FINANCE LEADS

CIPs and growth in activity.

Managing within contract terms on specific performance, eg, follow up outpatients.

Improving staffing levels on wards and moving to 24/7 consultant-present service in the wake of Keogh reviews may have a significant cost pressure.

Mortality issues associated with being one of the fourteen trusts subject to a Keogh review.

CQC inspection findings.

Ever higher bar for aspirant foundation trusts, which feels much higher than it is for current foundation trusts to remain as such.

Maturity of directory of services within primary care and impact upon 111 service.

Infections are a huge problem, not because they are increasing (in fact they continue to fall) but because of the punitive arrangements that the national contract puts around them.

We are responsible for delegated commissioning – local budgets have had too much money taken out by our Local Area Team [with respect to] prescribed services.

Ambulance handovers and the [emergency admission] financial penalty regime.

Operation of the emergency care system within the area.

The emergency threshold payment of 30 per cent is causing a real financial difficulty. Emergency admissions in 2012/13 went up by circa 1 per cent on 2011/12 while incurring a loss of £5.5m (70 per cent proportion). While there have been some reasonable debates on urgent care economy issues, in reality these initiatives have had marginal impact.

Waiting times for primary care mental health services and adult mental health inpatient bed pressures.

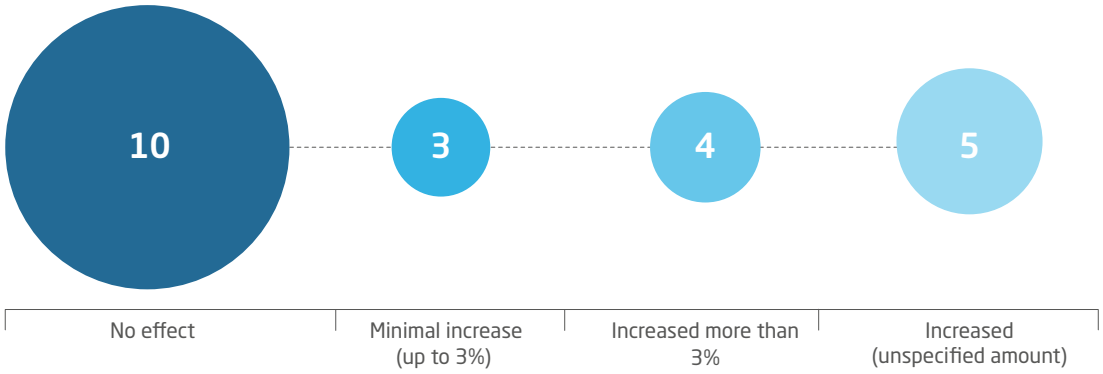
Mental health Payment by Results.

Taking on buildings from now abolished primary care trust provider arms, which are riddled with backlog issues that have not been addressed for a long while and have adverse financial consequences. Pensions auto-enrolment could be a problem, but we have no real information on likely financial magnitude as yet.

While Monitor is currently investigating the effects of the marginal rate tariff (Monitor 2013), our survey sought to explore the general effects on emergency admissions and trust income of the reduced payment (30 per cent of the standard tariff) for admissions above 2008/9 levels – an attempt to reduce/stabilise recent increases in the number of such admissions.

In terms of changes in the numbers of admissions, the figure below suggests that the introduction of the marginal rate tariff has had no impact on the numbers of admissions for 40 per cent of those trusts (10) for whom this question is applicable (ie, the 25 trusts carrying out emergency work – although three gave no indication of changes in activity). For the remainder, there have been increases in admissions ranging from up to 3 per cent per annum to over 3 per cent and 'unspecified' increases.

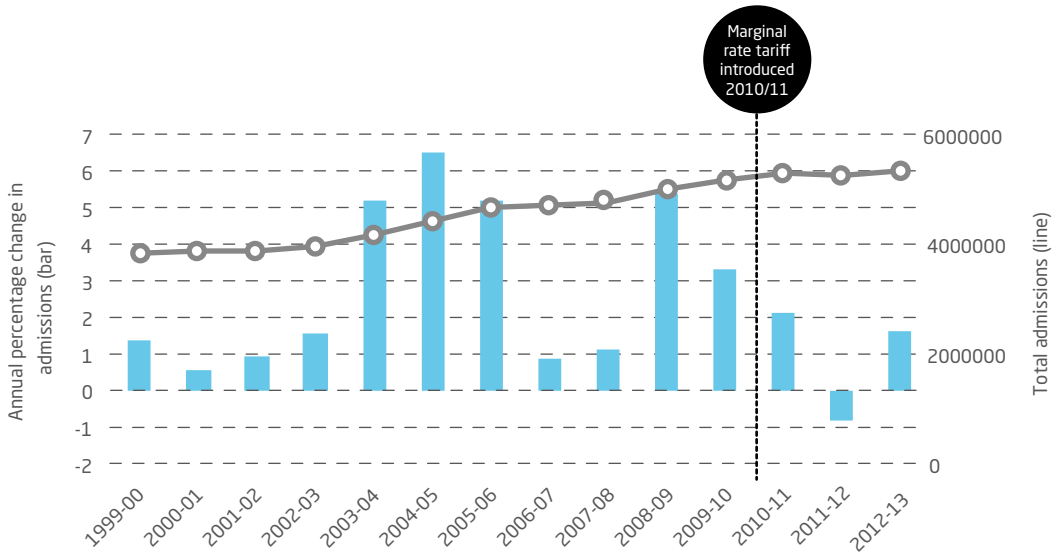
Since its introduction in 2010/11, what impact has the 30 per cent emergency admissions marginal tariff had on your trust in terms of emergency admissions?



(NB: three trusts gave no details of changes in admissions)

Nationally, as the figure below shows, there has been significant growth in admissions between 1998/9 and 2012/13 of around 41 per cent. However, while the rate of growth fell in the two years since the introduction of the marginal rate tariff in 2010/11, it rose in 2012/13 and, historically, annual changes in admissions have been somewhat erratic, making it hard to draw any firm conclusions about the impact of the policy. It is worth noting too that – as our survey shows – the marginal rate tariff has not been implemented to the same degree across the country, adding to the difficulty in interpreting changes in admissions since 2009/10.

Trends in emergency admissions, England, 1999/2000-2012/13

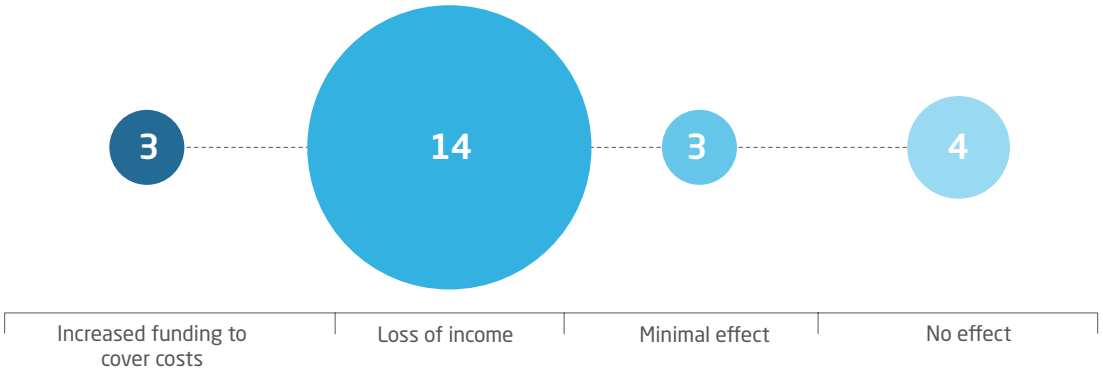


Data source: HSCIC 2013a, 2013b

However, the marginal rate emergency admission tariff has affected many trusts' incomes. As the figure below shows, more than half of trusts (14) in our survey incurred a loss of income. This totalled around £60 million and ranged from £600,000 to £12 million. Three trusts received some additional funds to cover losses either from central budgets or local commissioners.

Two trusts (not included in figure below) have struck fixed price deals with their commissioners, essentially block contracts that bypass the marginal tariff policy. For one trust this still meant treating emergency admissions at a loss.

Since its introduction in 2010/11, what impact has the 30 per cent emergency admissions marginal tariff had on your trust in terms of trust income?



Further comments from NHS trust finance directors on the marginal rate tariff were almost universally negative (see box below).

SELECTED COMMENTS: IMPACT OF THE 30 PER CENT EMERGENCY ADMISSIONS MARGINAL TARIFF

For us, this policy has had almost the exact opposite effect as was apparently intended.

Very unhelpful policy lever that has not had the required impact.

[The marginal rate policy] allowed commissioners to reduce focus on prevention.

Negative impact on 18-weeks [referral-to-treatment waiting time].

Every initiative to reduce demand on A&E pushes it up.

Staff morale – feeling undervalued for the emergency care they provide.

Transfer of significant volume of admissions to ambulatory care

While there have been some reasonable debates on urgent care economy issues, in reality these initiatives have had marginal impact.

Confusion and resentment among clinicians who are treating patients at a major loss.

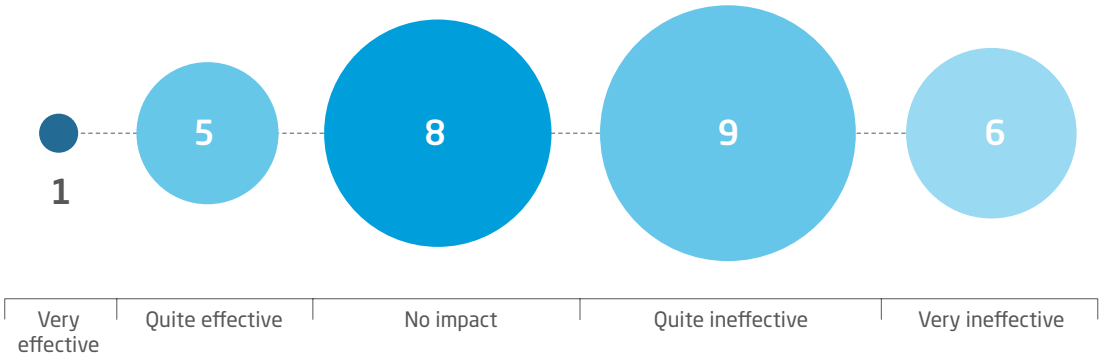
Additional beds have had to be provided at costs significantly above the 30 per cent rate.

Cancellation of previously working demand management schemes as no longer economic for commissioners.

No evident commissioner QIPP delivery in emergency care volumes.

Clinical commissioning group finance leads are also less than enthusiastic about the impact the marginal rate tariff has had on encouraging effective demand management in their area. As the figure below shows, 23 out of the 29 CCG finance leads responding to the survey thought the scheme had had no impact or been very or quite ineffective.

Since its introduction in 2010/11, how effective has the 30 per cent emergency admissions marginal tariff been in encouraging effective demand management in your area?



And again, the consensus from the commissioning side is that the marginal rate tariff has not been effective – in part, in some areas, due to the fact that commissioners have effectively attenuated the financial incentive faced by providers by negotiating higher threshold baselines and/or simply topping up payments presumably to help providers avoid financial problems (see box below). Clearly, there is an urgent need for Monitor's review of this policy to rethink the approach to this issue.

SELECTED COMMENTS FROM CCG FINANCE LEADS: EMERGENCY MARGINAL RATE TARIFF AND DEMAND MANAGEMENT

Effective demand management continues to be a commissioner priority to ensure that patients are treated at the right time and in the right place. The hard tool of 30 per cent marginal admissions rate is a distraction in [part] due to the local negotiations on which emergency admissions this should be applied.

The marginal tariff has had very little impact in terms of successfully reducing emergency admissions and has just led to increased time and resources being diverted to reviewing, reporting and debating the issue with providers.

Think the theory is right and we have used the 70 per cent to pump-prime some initiatives that appear to have been effective – although overall emergency admission rates have continued to increase. But as we have generally had to make a top-up payment to our main acute provider to compensate for the loss of income, we could have financed the initiatives anyway.

We have funded to threshold as it seems unfair to penalise the providers when the CCGs are effectively in control of demand.

It has ensured that there is a shared objective for both foundation trust and CCG. The TCS movements are key to this but acute trusts have been slow to realise that they have the solution to the problem within their grasp if they now have community services also.

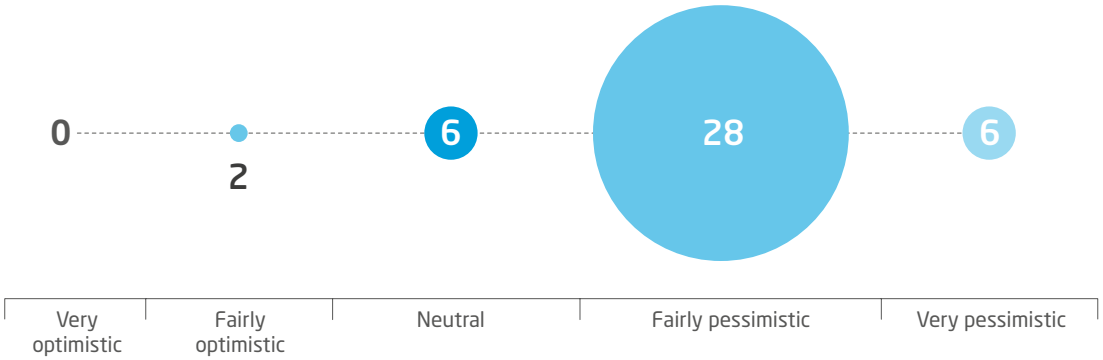
Demand management is not influenced by the marginal tariff. My experience is that clinicians taking ownership of the issue and looking at effective primary/community-based schemes to manage patients effectively have a greater impact. This policy line needs to change.

We have recycled the savings to invest in assessment pathways that are much better for patients.

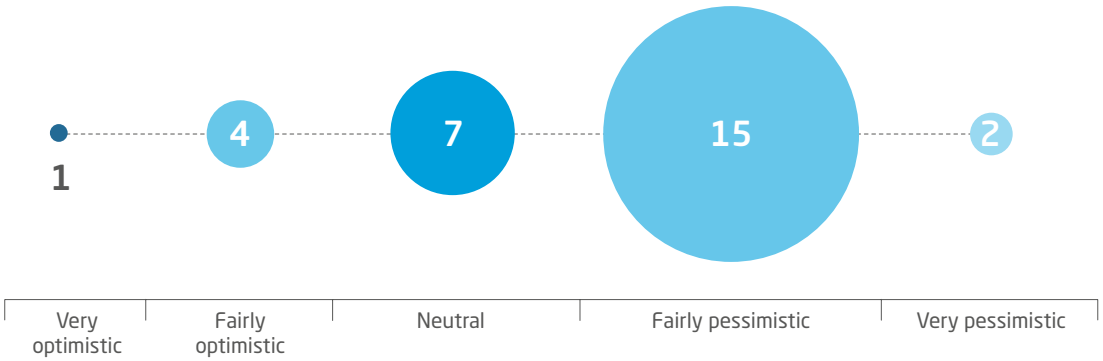
THE FINANCIAL STATE OF LOCAL HEALTH AND CARE ECONOMIES

More broadly, when asked how they felt in general about the financial state of their local health economy – not just their own organisation – over the next 12 months, more than three-quarters of NHS trust finance directors (34) were fairly or very pessimistic (see figure below). This is a more pessimistic view than that expressed at this time last year when around half were either very or fairly pessimistic about the next twelve months (Appleby *et al* 2012) and it is up on the last quarter's survey (in April this year) when around two-thirds expressed pessimism about the next twelve months (Appleby *et al* 2013). On the other hand, CCG finance leads appear slightly less pessimistic about the next twelve months (see figure below).

Overall, what do you feel about the financial state of the whole health and care economy in your local area over the next 12 months? NHS trust finance directors



Overall, what do you feel about the financial state of the whole health and care economy in your local area over the next 12 months? CCG finance leads



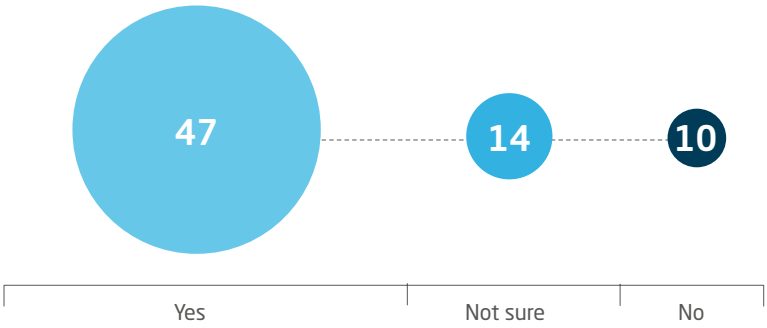
Impacts of local authority funding settlements/spending

As in our last quarter's survey, we asked NHS trust finance directors (and this time, CCG finance leads as well) whether there had been any impact on their organisation as a consequence of the funding settlement for, or spending by, local authorities in this financial year. As the figure below shows, two-thirds (47) said there was likely to be an impact on their organisation this financial year and around a third either were not sure or thought there would be no impact.

As the comments in the box below make clear, in the opinion of NHS trust finance directors the key issue arising from local authority funding settlements concerns the actual (and potential) impact on discharges from hospital. And as noted above, in terms of the important issues challenging their organisations, delayed transfers of care was the second most commonly cited problem by NHS trust finance directors. However, national figures (see p 36) suggest that the total number of delays has remained broadly unchanged for some years. Furthermore, within the overall total, the majority of delays are attributable to the NHS rather than social care, and in recent years the proportion of delays deemed to be the responsibility of the NHS has steadily risen – from 58 per cent in 2010 to 68 per cent in June this year. Over the same period the percentage of delays attributable to social care fell from 35 per cent to 26 per cent (NHS England 2013a).

As noted in a previous *Quarterly Monitoring Report* (Appleby *et al* 2013), there appears to be some dissonance between the picture presented by official delayed transfer of care statistics and the anecdotal evidence from our NHS trust finance director surveys which requires some further investigation.

Will there be any impact on your organisation due to your local authority's funding settlement/ spending in this financial year (2013/14)?



SELECTED COMMENTS FROM NHS TRUST FINANCE DIRECTORS: IMPACTS ON NHS OF LOCAL AUTHORITY FUNDING SETTLEMENT

Lack of adult social care provision is leading to increasing numbers of delayed discharges and increased length of stay.

Probably OK for 2013/14, but definite impact for 2014/15.

Already affecting [us]. Impact on delayed transfers of care, not just withdrawal of social workers but also local authority investment in third sector and other support packages.

There will be an inevitable impact on health and access to health care as a consequence of the requirement to withdraw/step down some social care/support.

Social care appears increasingly to want to slow discharges.

Significant increased risk of problems associated with discharge of patients into social care.

We work very closely with local authority to minimise impact, however, any impact is likely to be incremental and will emerge over the autumn/winter.

Trust provides social care services through Section 75 agreements. These are under pressure from financial settlements in local authorities and will impact on ability to provide integrated services.

Social care demands continue to rise and council spending is being cut.

...delayed transfers due to difficulty in securing care packages.

For CCG finance leads there are similarly pessimistic comments on current (and future) impacts on the NHS of local authorities' funding settlements. While some foresee bigger problems next year, others are concerned about the use of NHS money transferred to councils being used to support existing council services and the impact that reductions in local authority services will have in general on NHS workload.

SELECTED COMMENTS FROM CCG FINANCE LEADS: IMPACTS ON NHS OF LOCAL AUTHORITY FUNDING SETTLEMENT

Limited impact in 2013/14 but serious implications from 2014/15 onwards.

Likely to be services that bleed into the NHS but not sure of the extent for this year. Probably more so in 2014/15.

Significant pressures at the council. Unlikely forums not to be affected, struggling to quantify at present.

I expect the local authority to make allocation decisions that will have a direct impact on health expenditure.

Impacting on their ability to fully participate in our unscheduled care redesign programme.

Local authorities are dis-investing from services which directly impact on the NHS. I am concerned that the integration announcement will simply partially fill the hole left by the cuts of local authorities.

The impact is already being realised. A positive is that it has bought together CCGs and local authorities in common and joint approaches to delivering our commissioning intent.

The process used to determine the local authority's funding settlement was extremely flawed in the first instance, which resulted in additional funding being transferred to the local authority over and above recurring budgets (resulting in a shortfall in remaining budgets). The funding transferred is then being used to support existing local authority services, reducing the amount available to spend on 'public health' services as previously commissioned by the primary care trust.

Will be pressures from reductions in services linked to health care – increased hospital attendance as a consequence of closures of day facilities, etc.

The integration agenda and pooled budget arrangements will all be impacted upon.

NHS performance dashboard

The second part of our report highlights data on selected NHS performance measures. There are 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. In particular, we report on trends in health care-acquired infections (*C difficile* and MRSA); compulsory redundancies and workforce numbers; waiting times for inpatients, outpatients, diagnostics, those still on lists and accident and emergency; and delayed transfers of care.

Health care-acquired infections

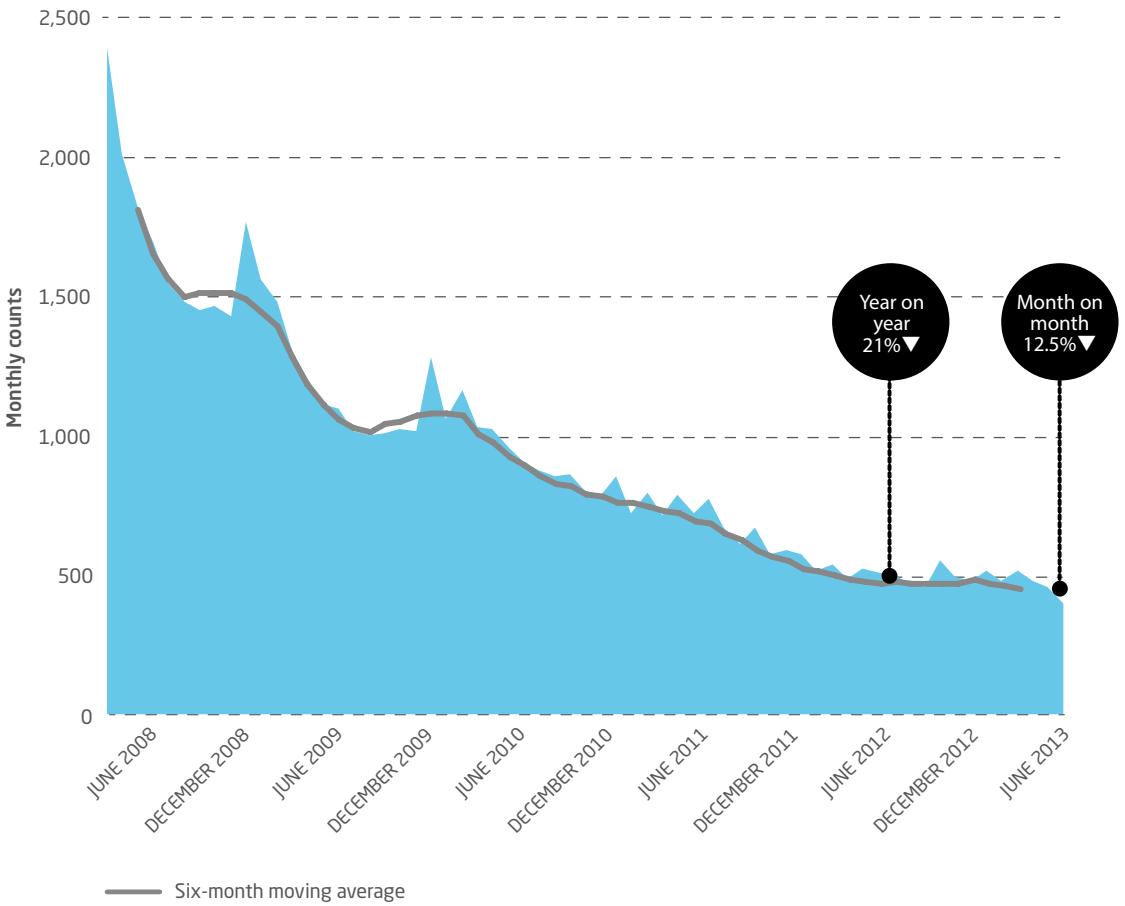
Health care-acquired infections, including *Clostridium difficile* (*C difficile*) and methicillin-resistant *Staphylococcus aureus* (MRSA), can be seen as a specific measure of the quality of patient care, and potentially sensitive to financial pressures.

The figures below are reported at a trust level. From 2013/14 there is also a financial incentive for CCGs as part of the Quality Premiums initiative to improve the quality of care received by their residents (NHS England 2013c). CCGs will have a financial incentive to reduce MRSA infections to nil and achieve CCG-specific reductions in *C difficile*, along with a suite of other measures (NHS England 2013c).

C DIFFICILE

Monthly counts of *C difficile* infection have fallen substantially since April 2008 – from more than 2,350 cases per month to 398 in June 2013. Counts for June 2013 show a decrease on the previous month of 12.5 per cent and a drop year-on-year of 21 per cent.

Everyone Counts: Planning for patients 2013/14 (NHS England 2013b) set a national objective for reduction in *C difficile* cases for acute trusts of 29.6 per cent in 2013/14 (measured as April to March 2013/14 compared with October to September 2011/12). In the first quarter of 2013/14 there was a 27 per cent reduction on the target period from 2011/12, suggesting that the NHS is close to achieving its target.

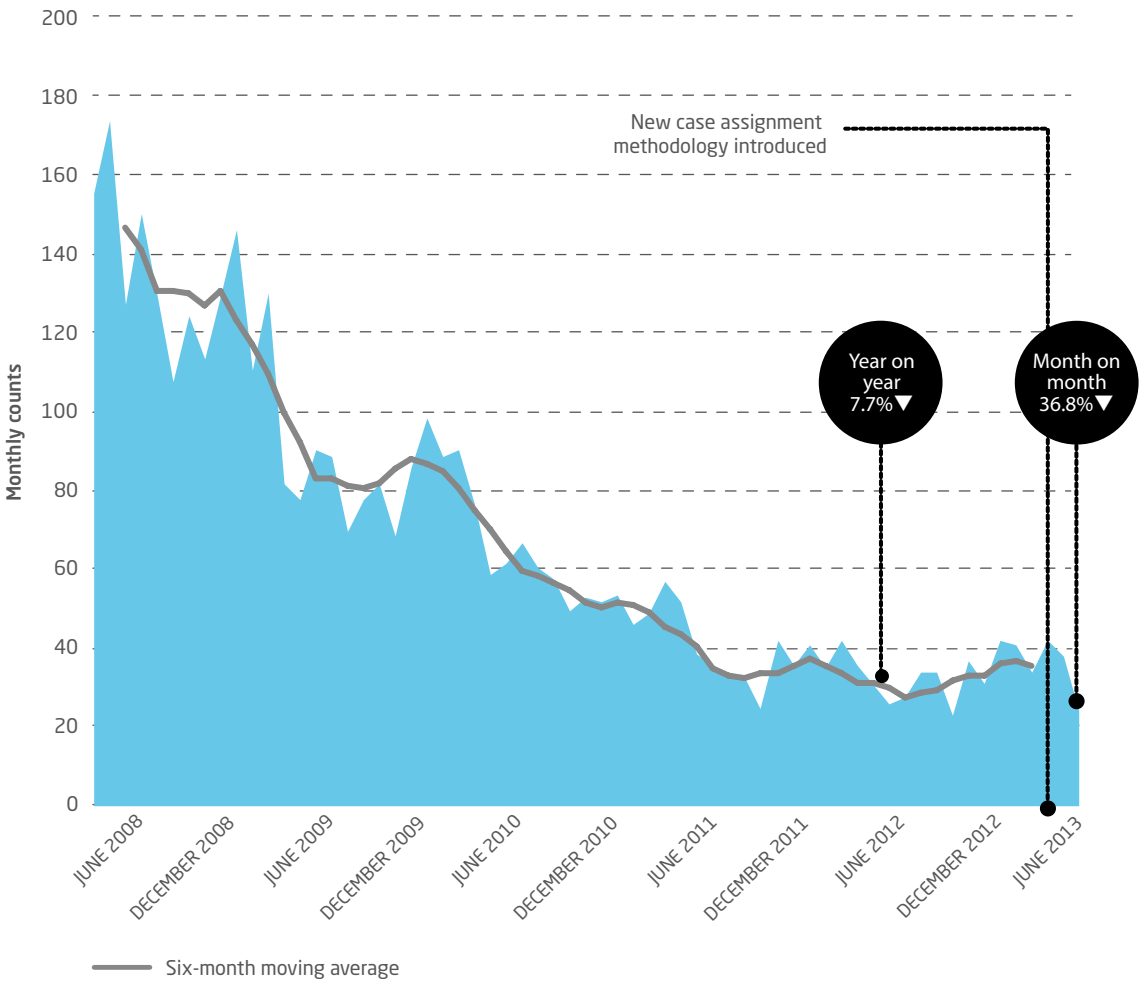


Data source: Trust-apportioned monthly counts of *C difficile* infection
www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510678961

MRSA

The general trend in the numbers of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) infection has been falling over the past five years. The count of 24 in June 2013 was almost 8 per cent less than a year previously and a fall of more than 36 per cent month on month. Current annual rates of MRSA are now running at around 408 cases, around one-quarter of the total cases in 2008/9.

As part of NHS England's 'zero tolerance' campaign (NHS England 2013f) there is now an expectation that all organisations avoid any MRSA infections. In the first quarter of 2013/14 (April–June), more than half of NHS organisations have reported no cases of infection (55 per cent) and a further 31 per cent of hospitals reported just one case.



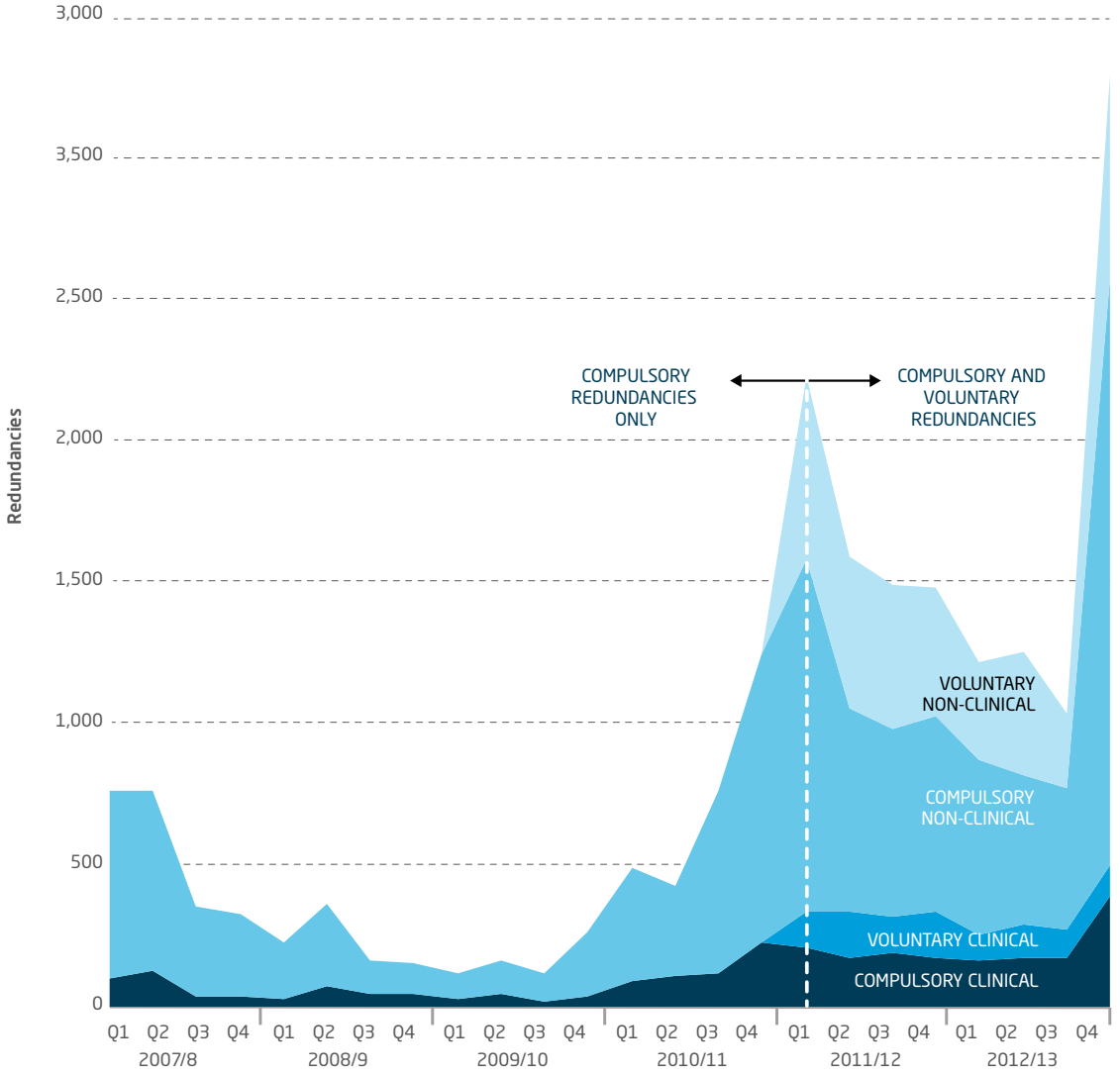
Data source: Post infection review assigned monthly counts of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510675444

Note: It is not known what impact the change in recording MRSA cases has had on the comparability of data pre and post April 2013.

Workforce

REDUNDANCIES

In quarter 4 2012/13 there were a total of 501 clinical redundancies, of which 392 (78 per cent) were compulsory and 109 (22 per cent) voluntary. There were 2,794 total non-clinical redundancies in the same period, of which 2,078 (74 per cent) were compulsory and 716 (26 per cent) voluntary. The figures include data from strategic health authorities (SHAs), primary care trusts (PCTs), trusts and foundation trusts and include the period of the dissolution of PCTs and SHAs.



Data source: Quarterly head counts of compulsory redundancies
www.hscic.gov.uk/article/2021/Website-Search?q=Monthly+NHS+Hospital+and+Community+Health+Service+%28HCHS%29+Workforce+Statistics+in+England&go=Go&area=both

The large increase at the end of 2012/13 is likely to be due to the system changes across the NHS beginning on 1 April 2013, with contracts coming to an end and staff moving to different organisations. Overall, the total number of redundancies in this quarter was 3,295, equivalent to 0.3 per cent of the total NHS workforce of more than one million.

STAFF NUMBERS

The trend in employment for all staff groups in the NHS decreased by 1.5 per cent between September 2009 and May 2013, a reduction of more than 15,000 full-time posts. Since 1 April 2013, the number of full-time equivalent staff decreased by almost 11,500 over the previous month. Forty per cent of this decrease appears to be from staff moving out of the data collection used for this series, when the system changes were introduced on 1 April; significantly, 4,700 full-time posts moved from the Health Protection Agency to Public Health England, which is excluded from this data.

The remaining reductions are harder to identify, although there is an 'April effect' each year when staff numbers tend to fall and there are likely to have been staffing consequences as a result of the system reforms of the NHS.

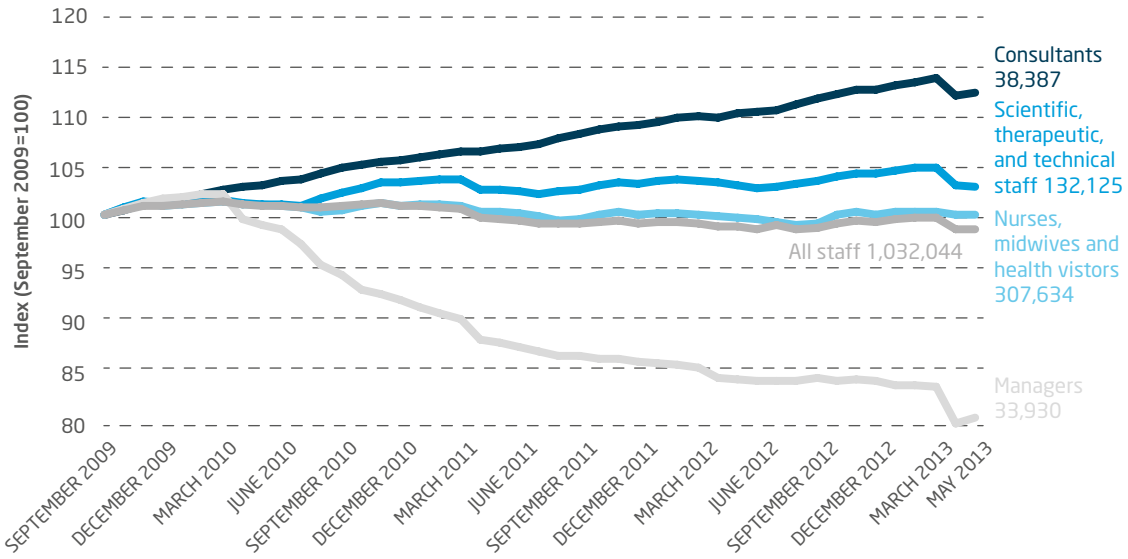
The number of nurses, midwives and health visitors is very fractionally down on September 2009, by 0.04 per cent, equivalent to 115 posts. Over a shorter period, from May 2012 to May 2013, the number of posts has increased by 635, or 0.2 per cent.

For the first time since April 2012 there has been a decrease in the number of consultants. In April 2013 there was a decrease of 1.5 per cent, 570 posts, compared to March 2013. In May 2013 the numbers have increased once again but only slightly, by 178 posts, equivalent to less than 1 per cent.

The number of scientific, therapeutic and technical staff has also decreased. There were successive decreases in April and May 2013 resulting in more than 2,300 fewer full-time posts compared to March 2013, a decrease of more than 1.5 per cent.

The impact of the decision announced in the coalition government's White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010) to reduce management costs by more than 45 per cent over four years are clearly evident from the trends in the number of managers (both senior managers and managers). Over the three and a half years since September 2009 there has been a decrease in managers of around 21 per cent – from 42,722 to 33,930, a reduction of more than 8,750 posts.

Index change in NHS full-time equivalent staff: September 2009–May 2013



Data source: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – May 2013, Provisional statistics
www.hscic.gov.uk/article/2021/Website-Search?q=Monthly+NHS+Hospital+and+Community+Health+Service+%28HCHS%29+Workforce+Statistics+in+England&go=Go&area=both

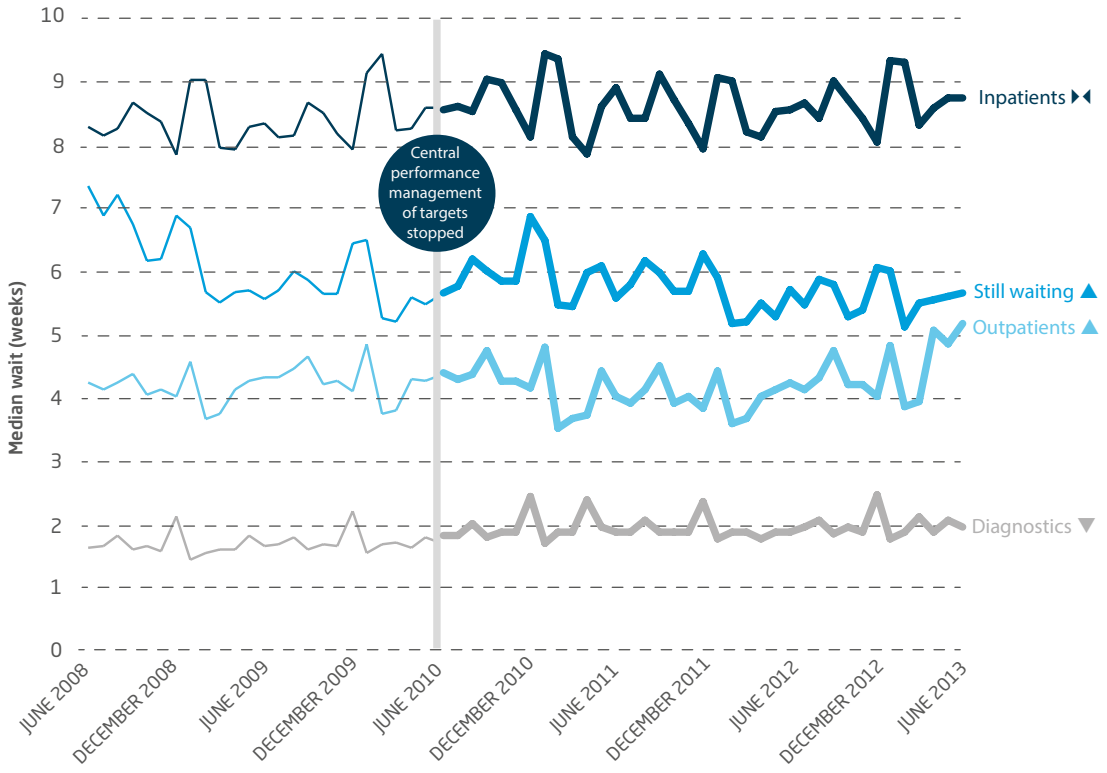
Waiting times

MEDIAN WAITS

Median waits in June 2013 decreased compared to the previous month for diagnostics, remained constant for inpatients and increased for outpatients and those still on waiting lists. These changes are broadly in line with seasonal variations. The median waiting times for inpatients, those still on waiting lists and diagnostics appear generally constant despite fluctuations.

For outpatients however, median waiting times have now crept above five weeks, the longest median waiting time since January 2008. This chimes with this quarter's survey of CCG finance leads and NHS trust finance directors, which reports that 18-week RTT waiting times were their third highest concern, an indication of growing pressure on waiting times. Given the lagged correlation (albeit relatively weak) between outpatient and inpatient waiting times, this increase in outpatient waiting may presage an increase in inpatient waiting in July.

Waiting times: Median wait (weeks)



Data sources: Consultant-led referral-to-treatment waiting times data
www.england.nhs.uk/statistics/rtt-waiting-times/
Diagnostic waiting times statistics
www.england.nhs.uk/statistics/diagnostics-waiting-times-and-activity/

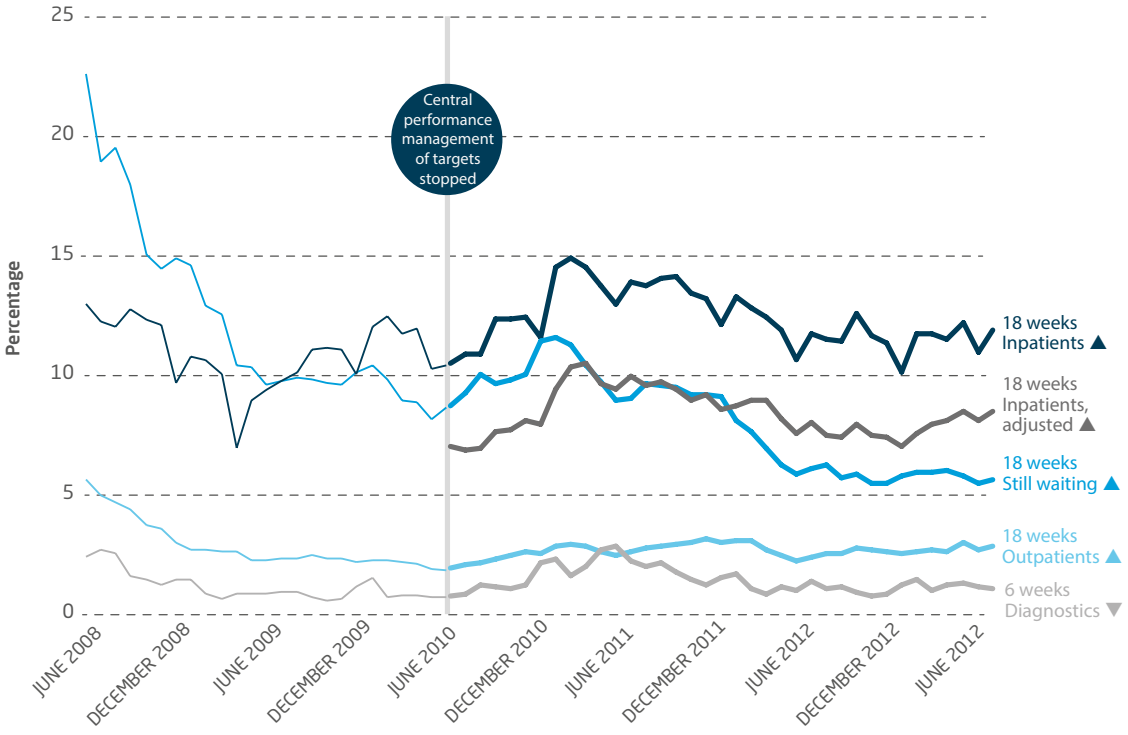
REFERRAL-TO-TREATMENT TARGET WAITS

Since the start of 2013/14 the proportions of patients waiting longer than the operational standards (as defined by the NHS Constitution (Department of Health 2013)) have reduced for all waiting lists, broadly in line with seasonal variations for these months.

Over the longer term – from June 2010, when the government relaxed the central performance management of waiting time targets – general trends for inpatients, those still waiting, outpatients and diagnostics were increasing around January to May 2011, before trending downwards in all cases (notably for those still on waiting lists), except for outpatients, which remained broadly level.

More recently, however, it appears that there is an increase in the number of patients waiting longer than 18 weeks for inpatient treatment, following adjustment for 'clock pauses' (that is, legitimate delays in waiting). Since the proportion of patients waiting longer than 18 weeks reduced to its lowest level in recent history in December 2012 (6.9 per cent), it has crept back up to a similar level for June as seen in 2012 (8.3 per cent).

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



Data sources: Referral-to-treatment waiting times statistics
www.england.nhs.uk/statistics/rtt-waiting-times/
Diagnostic waiting times statistics
www.england.nhs.uk/statistics/diagnostics-waiting-times-and-activity/

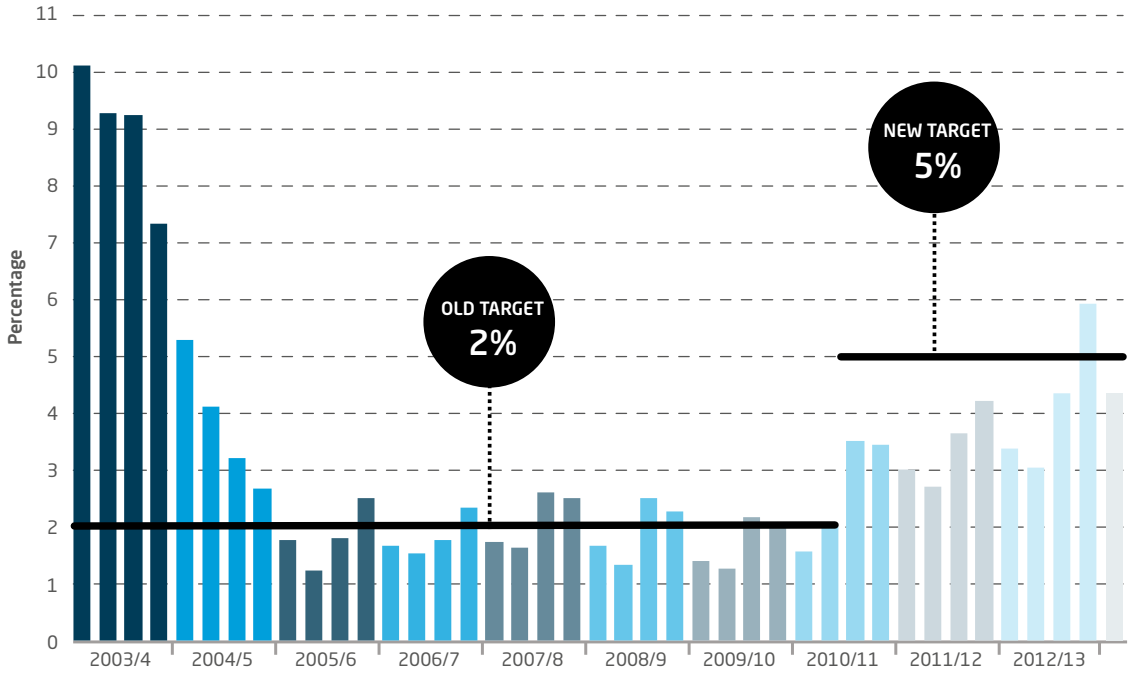
ACCIDENT AND EMERGENCY

The latest data for four-hour A&E waits (quarter 1, 2013/14) shows a decrease in the proportion of patients waiting longer than four hours in A&E compared to quarter 4 2012/13. This is in line with previous seasonal patterns and brings the proportion of patients waiting longer than four hours back within the government's target of 5 per cent. At 4.3 per cent, however, it is the highest first quarter proportion since 2004/5.

In total, more than 241,000 patients waited more than four hours in A&E in quarter 1 of 2013/14 – a decrease of 23 per cent over the previous quarter, but a 28 per cent increase over quarter 1 in 2012/13.

The ongoing pressures on emergency care services recently prompted the Prime Minister to announce a £500 million fund to support struggling A&E units over the next two years (Prime Minister's Office 2013). It remains to be seen whether this and other action being taken to address these pressures is enough to prevent the target being breached again next winter.

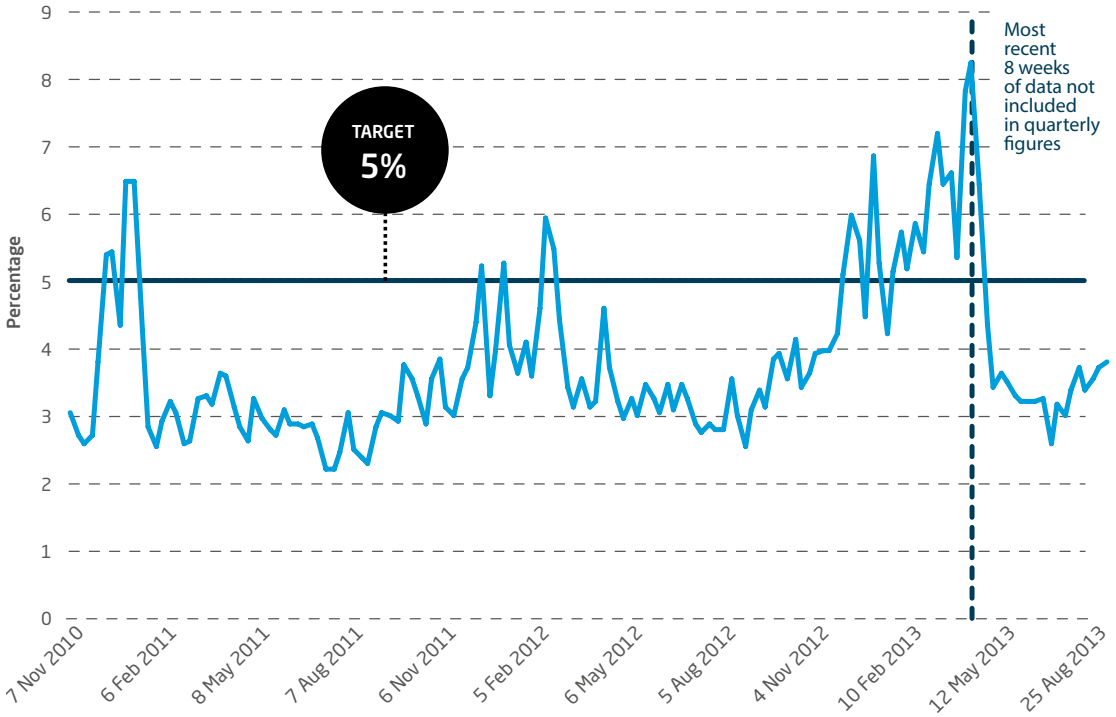
Percentage waiting more than four hours in A&E from arrival to admission, transfer or discharge



Data source: Weekly A&E SitReps 2013-14
www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

While the quarterly data goes up to the end of June this year, the weekly data for the percentage of patients waiting longer than four hours shows that in the eight weeks beyond the end of the first quarter of this year the proportion of patients waiting longer than 4 hours has started to rise (to 3.8 per cent in the week ending August 25th). This reflects similar trends at this time of year.

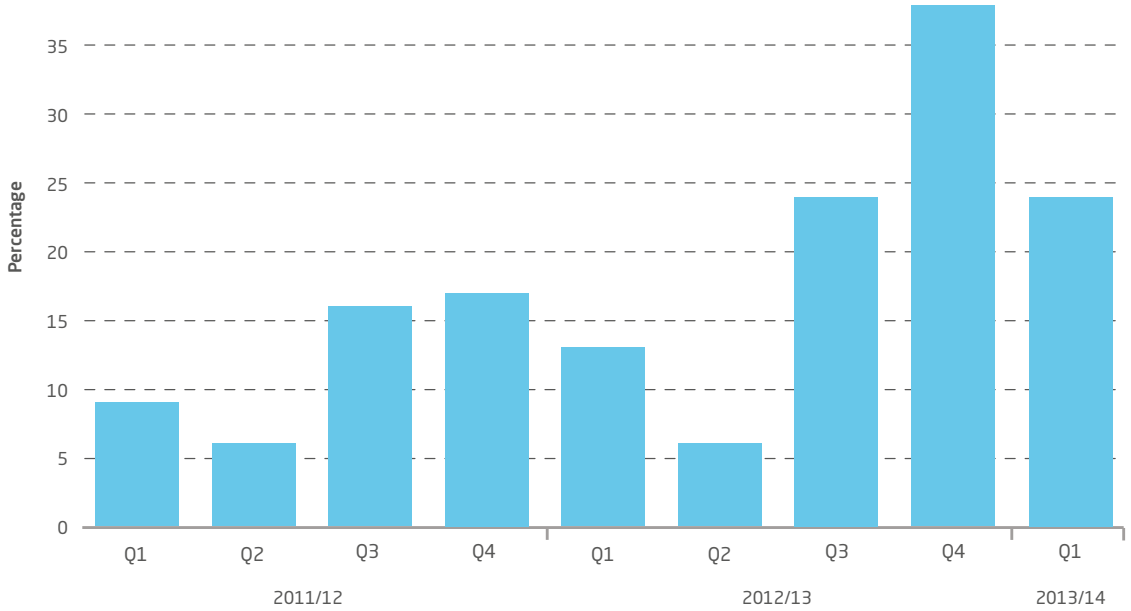
Percentage waiting more than four hours in A&E from arrival to admission, transfer or discharge: Weekly data: November 2010-August 2013



Data source: Weekly A&E SitReps 2012-13
www.england.nhs.uk/statistics/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

National figures tend to mask variations between hospitals. For example, at an organisational level, in quarter 1 this year, 61 organisations (25 per cent) reported breaches in the proportion of patients waiting longer than the four-hour target. The figure below shows the increase in the proportion of providers reporting patients waiting longer than four hours in A&E departments.

Percentage of providers reporting more than 5 per cent of patients waiting longer than four hours in A&E departments from arrival to admission, transfer or discharge

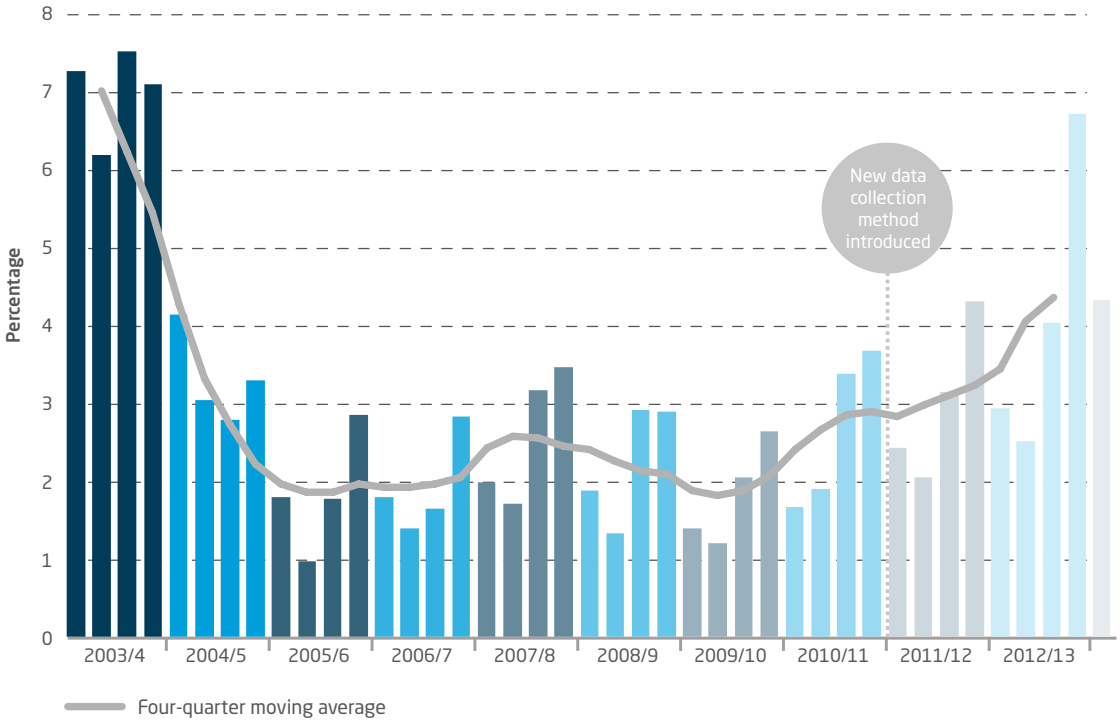


Data source: Weekly A&E SitReps 2013-14
www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

While most patients who attend A&E departments are treated within the department and then sent home, some need to be admitted into hospital. A potential indicator of pressures in hospitals is the time these patients wait to be admitted – so-called 'trolley waits'.

Latest figures covering quarter 1 this year show that the proportion of patients waiting four hours or more for admission to hospital continues to vary from quarter to quarter, with a tendency for quarter 1 figures to show a decrease over the previous quarter. However, quarterly fluctuations aside, from quarter 1 2009/10, an upward trend emerges; the proportion of patients waiting more than four hours for admission has risen from 1.4 per cent in 2009/10 to almost 4.5 per cent in the latest quarter. This is the highest quarter 1 proportion since 2003/4. This increase is in part explained by the easing of the total time in A&E target from no more than 98 per cent to 95 per cent waiting longer than four hours in June 2010. Nevertheless, it is also indicative of pressures on the system.

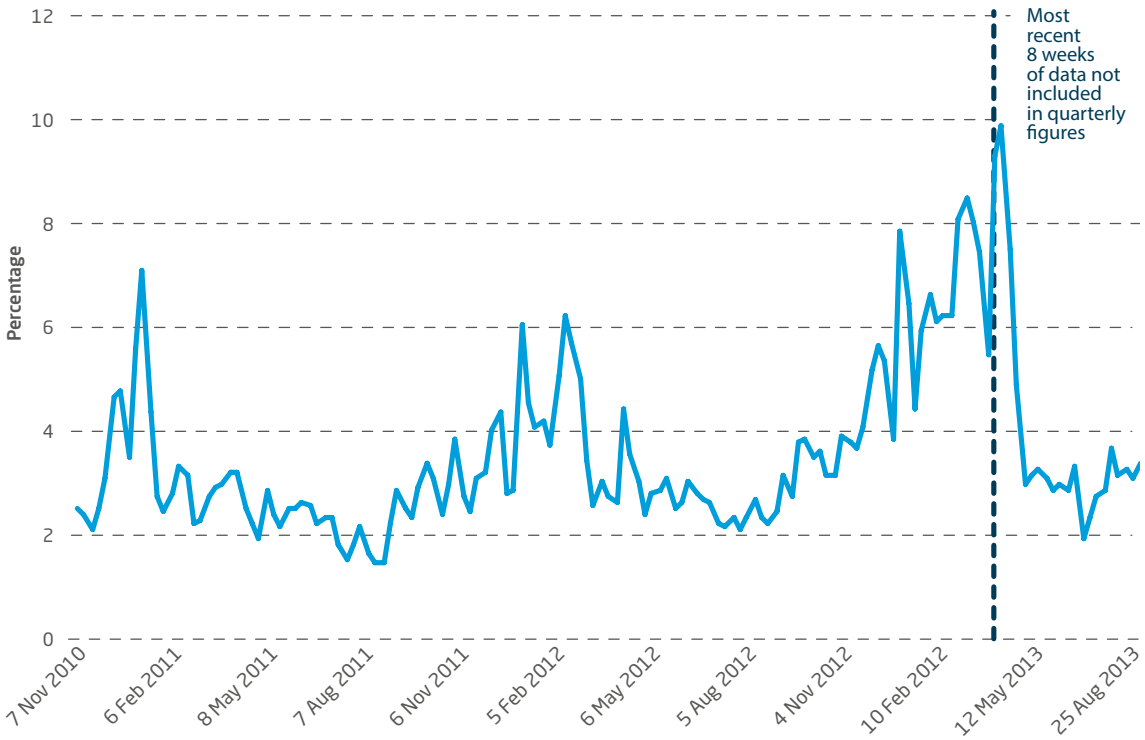
'Trolley waits': The proportion of patients spending more than four hours in major A&E departments from decision to admit to admission into hospital



Data source: Weekly A&E SitReps 2013-14
www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

As with the data on four-hour waits in A&E departments, weekly data in addition to the quarterly data detailed above is available from November 2010 to the week ending 25 August 2013 – an additional eight weeks. The figure below shows that in the two months beyond the first quarter of this year the proportion of patients waiting more than four hours for admission rose to 3.4 per cent in the week ending 25 August from a low of just 1.9 per cent in the week ending 30 June – an upturn expected at this time of year.

'Trolley waits': The proportion of patients spending more than four hours in major A&E departments from decision to admit to admission into hospital: Weekly data, November 2010 to August 2013



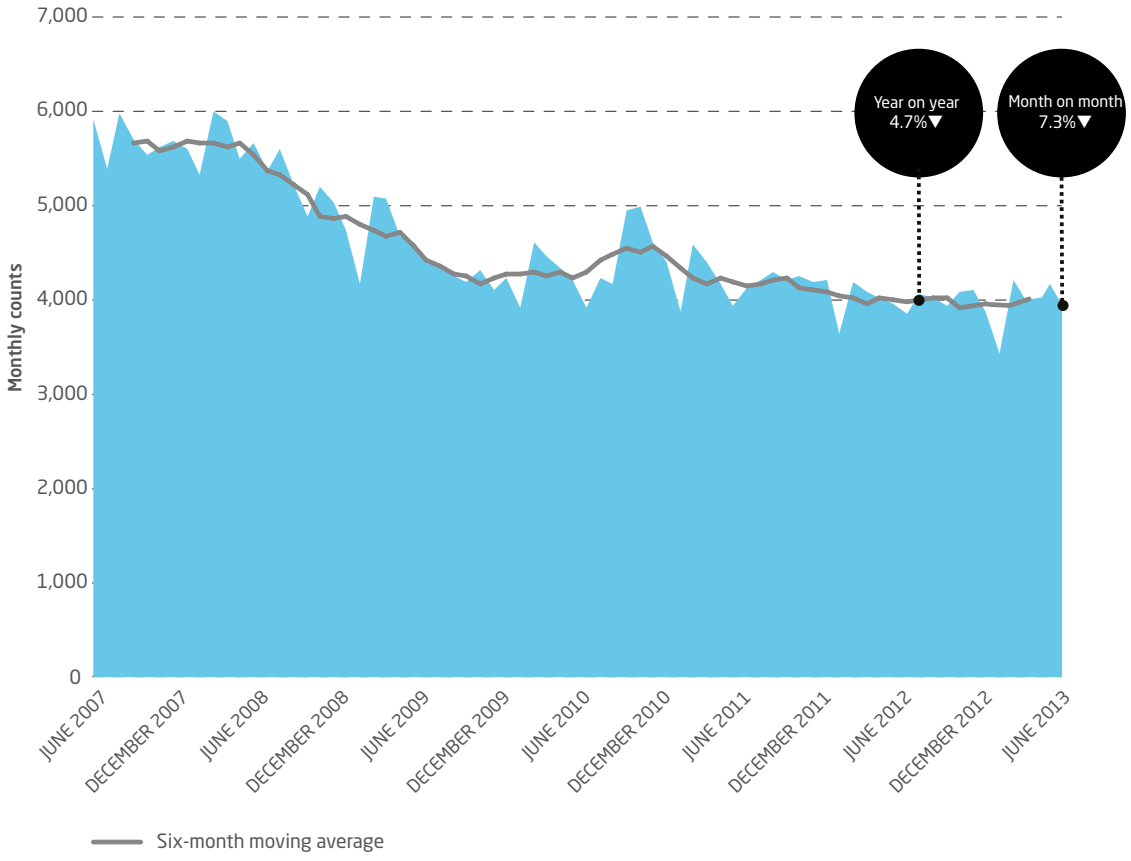
Data source: Emergency admissions through accident and emergency
www.england.nhs.uk/statistics/ae-waiting-times-and-activity/

Delayed transfers of care

The total number of acute and non-acute delayed transfers of care for June 2013 decreased on the previous month by more than 7 per cent and decreased on June 2012 by almost 5 per cent. The six-month moving average appears to have flattened off compared to its previous trend of slow decline between August 2010 and February 2012. Over the past year there were on average 3,999 patients delayed each day – similar to the previous year.

There remains some dissonance between these national aggregate figures and this quarter's NHS trust finance directors' survey, which identified delayed transfers as their top performance concern (see figure below).

Delayed discharges: Monthly counts of patients

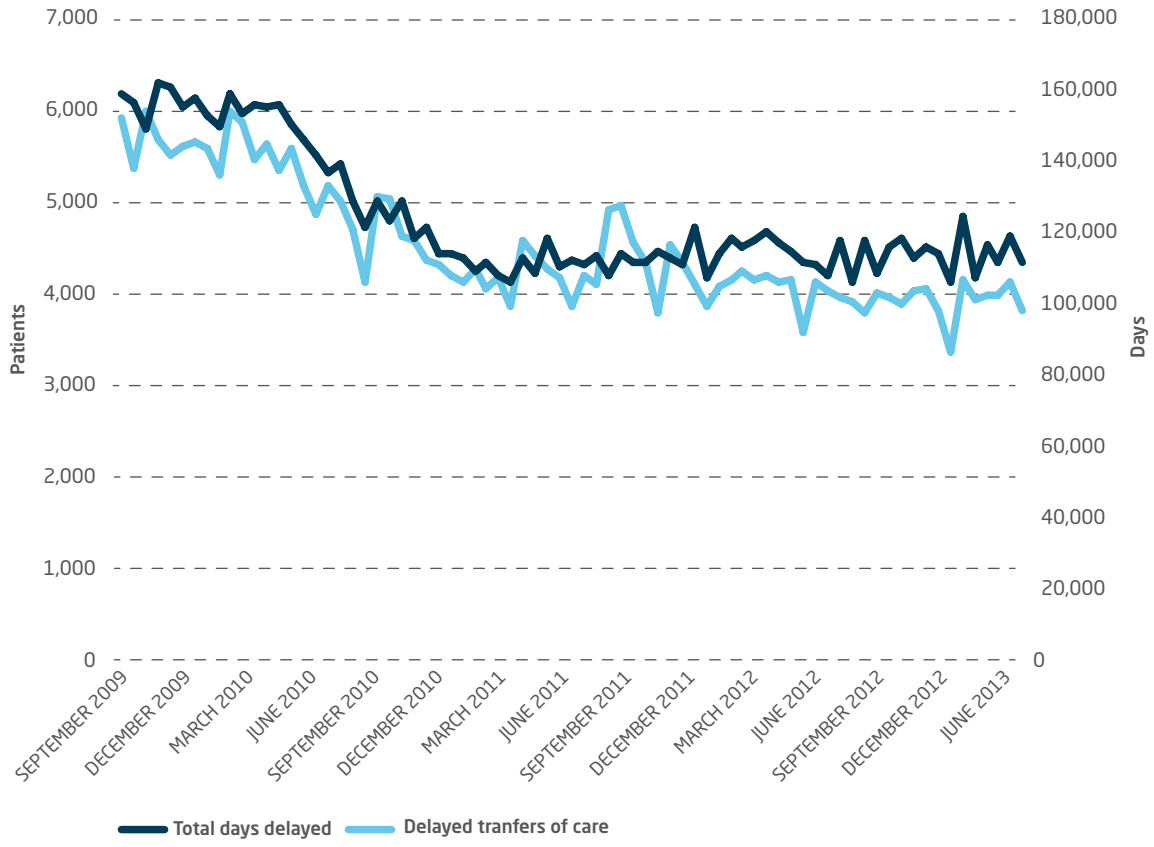


Data source: Acute and non-acute delayed transfers of care, patient snapshot, 2013/14
www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2013-14/

Another way of viewing delays is by the number of bed days accounted for by patients whose transfer is delayed; although the count of patients can remain stable, bed days may change depending on how long each patient is actually delayed. The figure below shows the number of days associated

with delayed discharges as well as the number of patients delayed. The latest figures reveal that the month-on-month reductions in November and December 2012 have not been maintained, with numbers returning to levels similar to those seen since January 2010 – though with high variation.

Delayed discharges: Patients and days delayed



Data source: Acute and non-acute delayed transfers of care, patient snapshot and total days delayed, 2013/14
www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2013-14/

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The King's Fund

Ideas that change health care

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2400

Registered charity: 1126980
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