QMR 13 OCTOBER 2014

How is the NHS performing?

ABOUT THIS REPORT

Our Quarterly Monitoring Report examines the views of finance directors on the productivity challenge they face, as well as some key NHS performance data to see how the NHS is performing.

REPORT AUTHORS

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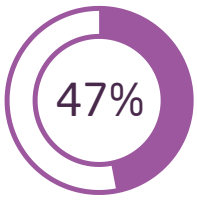
"Financial problems are no longer confined to a small number of organisations; they are now endemic across the health system."

Richard Murray, Director of Policy

1 in 3

1 in 3 trusts forecast ending 2014/15 in deficit - the highest proportion since we began surveying in 2011.



Nearly half of NHS trust finance directors identified staff morale as one of their top 3 concerns.

3.13m

In August 2014, there were 3.13 million patients on waiting lists in England.

6.2k

There are now more than 6,200 additional full-time equivalent nurses, midwives and health visitors than this time last year.

0.8%

Planned NHS spending this year will amount to a real-terms increase of 0.8%.

Headlines

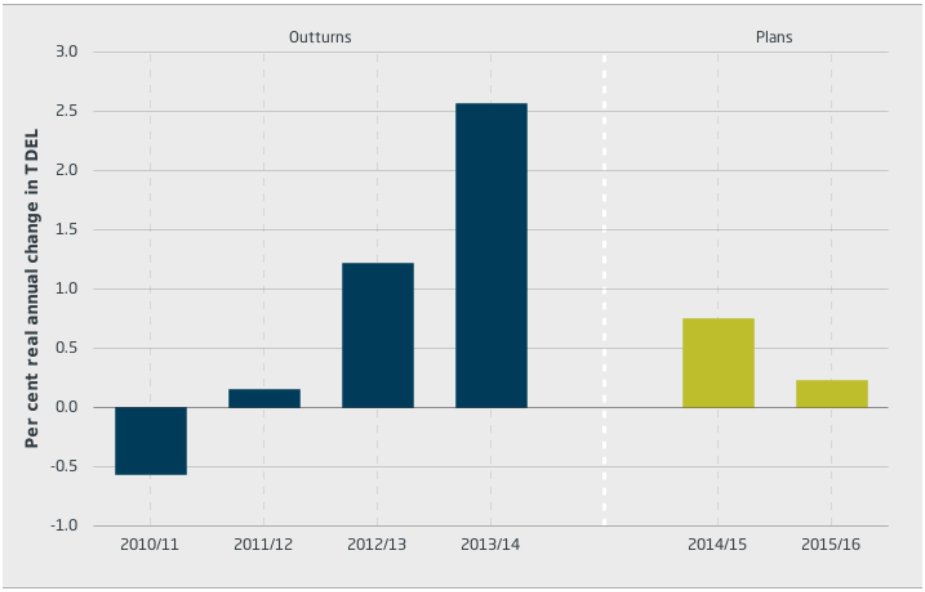
How is the NHS performing?

- Our latest survey of finance directors reveals the highest level of pessimism about the financial position of health organisations since we began surveying in the autumn of 2011. For the first time since we began our quarterly survey, no one expressed any degree of optimism about the financial state of their local health economies over the next year.

The funding context

- Last year was the fourth consecutive year of planned funding constraint. In the end, real funding increased by more than 2.5 per cent in 2013/14. Around 1 percentage point of this increase was due to lower than forecast general inflation and much of the remainder due to near eradication of underspending on both revenue and capital budgets. Despite this, around a quarter of trusts and foundation trusts ended the year in deficit and slightly fewer than one in ten commissioning groups were also in deficit (Dorsett 2014a; NHS Trust Development Authority 2014b; Baumann 2014).
- Planned spending this year – based on the most up-to-date inflation forecasts – will amount to a real increase of just 0.8 per cent. Plans for 2015/16 suggest a real increase of 0.2 per cent (equivalent to around £260 million).

Real annual changes in English NHS Total Departmental Expenditure Limits (TDEL): Outturns and plans: 2010/11 to 2015/16



Data Source: Department of Health annual report and accounts 2013-14, HC14 TSO London Department of Health (2014)

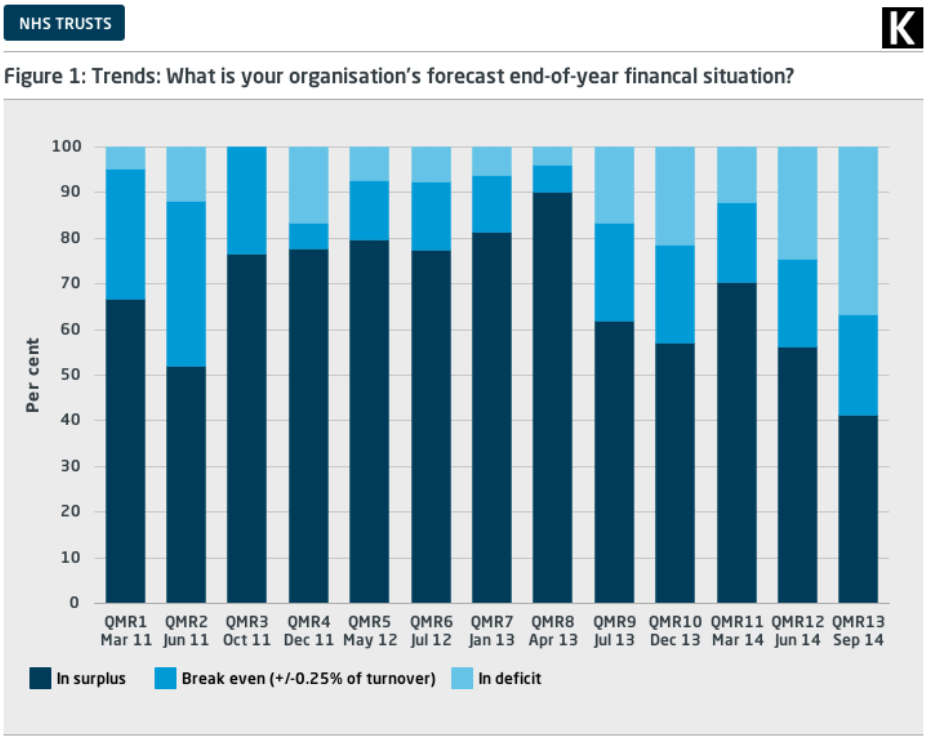
- The recently published *NHS five year forward view* suggests that, in addition to extra funding (as yet unquantified) to enable the NHS to transform services over the next few years, real increases of just under 1.5 per cent per annum will be needed from 2015/16 to 2019/20 to cope with demographic changes. This is dependent on the NHS improving productivity by 2 per cent per annum to 2017/18 and then 3 per cent for the two years to 2019/20 (NHS England, 2014a).

Making ends meet this year and next

- Given the funding context, it is perhaps of little surprise that more than one in three trust finance directors are forecasting an overspend by next March – the largest proportion since our survey began. This includes around half

of all acute trusts in the survey forecasting a year-end deficit. This is also in line with the Trust Development Authority's financial report for the first four months of this year which suggests that 34 per cent of all non-foundation trusts are forecasting an end-of-year overspend (NHS Trust Development Authority 2014b). For foundation trusts, Monitor reports a net overspend for quarter one and overspends by 86 organisations – around 60 per cent of all foundation trusts. Overall, around two-thirds of acute trusts were already in deficit in the first quarter of this year, or are forecasting a deficit position by the year-end. This suggests that financial difficulties have spread beyond those organisations with a history of problems balancing their books and is now endemic across the system.

- While it is possible that the number that are overspending will reduce towards the end of the financial year as effort is put into balancing books in the second half of the year, the financial position for foundation trusts is the worst ever reported (Dorsett 2014b).



Respondent comments

"'We are reliant in large part on growing amounts of non-recurrent resilient funding. The underlying position is a worry but we seem to get money from the centre every year!'"

– Large acute trust

"'This is the first time we will be in deficit since becoming an NHS foundation trust.'"

– Mental health foundation trust

"'Getting more challenging - the risk is towards deficit not surplus.'"

– Acute and community foundation trust

- This quarter's survey also shows around 10 per cent of the 52 CCGs that responded are forecasting an overspend this year (similar to the 10 per cent reported by NHS England at its September board meeting (Wheeler 2014). At a national level, other budgets are also under pressure. For example, the £14 billion specialised services budget

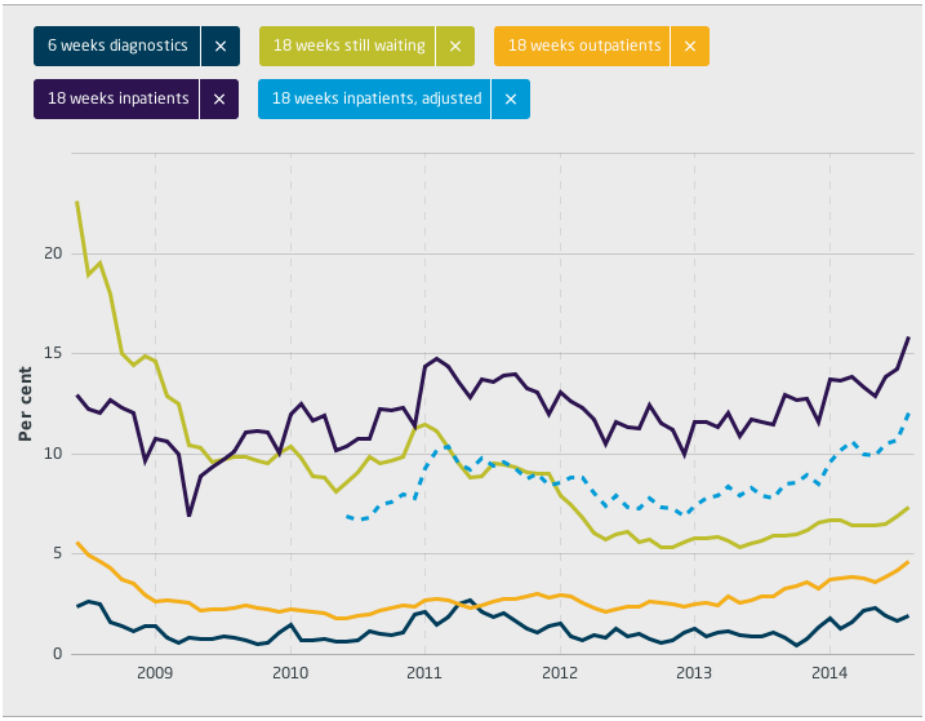
administered by NHS England ended £377 million overspent last year, and plans are being made for 2015/16 to restrict further growth in spending by reducing payments to providers and possibly restricting access to services (Calkin 2014).

- Gloomy financial forecasts are in part a product of, and are reflected in, the most pessimistic outlook we have yet recorded for the prospect of cost improvement programmes (CIP) to be met. Nearly six out of ten trust finance directors are fairly or very concerned about meeting their CIP targets this year (which average around 4.6 per cent of turnover). Concern about making ends meet through CIPs grows to seven out of ten finance directors when asked about next year. This is echoed in the gloomiest view yet recorded of the financial state of local health and care economies over the next year: more than 90 per cent of finance directors are very or fairly pessimistic.

More work, longer waiting times?

- The pressure on waiting times is clear. Since December 2012, there are upward trends in all three stages of the 18-week referral to treatment path – for patients admitted to a bed in hospital, for those seen in outpatients and for those yet to be seen as either outpatients or inpatients.
- Figures for August show a sharp upturn in waits longer than 18 weeks for inpatients and outpatients – possibly attributable to the policy of 'managed breach': as longer waits for those still waiting were tackled, this would automatically increase the number of patients who would have waited for more than 18 weeks.
- However, between May and August, the numbers still waiting for more than 16 weeks (the time targeted under the managed breach initiative) have not fallen as planned, but have increased by more than 71,000 to nearly 321,000 – the highest since the summer of 2011. It is possibly too early to draw conclusions on this waiting times push, but with an uptick in referrals in July (and the seasonal reduction in August), it seems that there is a risk that additional work in August has not kept pace with increases in flows onto waiting lists.

Figure 26: Percentage still waiting/having waited more than 18 weeks (more than 6 weeks for diagnostics)



Data source: Referral-to-treatment waiting times statistics www.england.nhs.uk.

Diagnostic waiting times statistics www.england.nhs.uk.

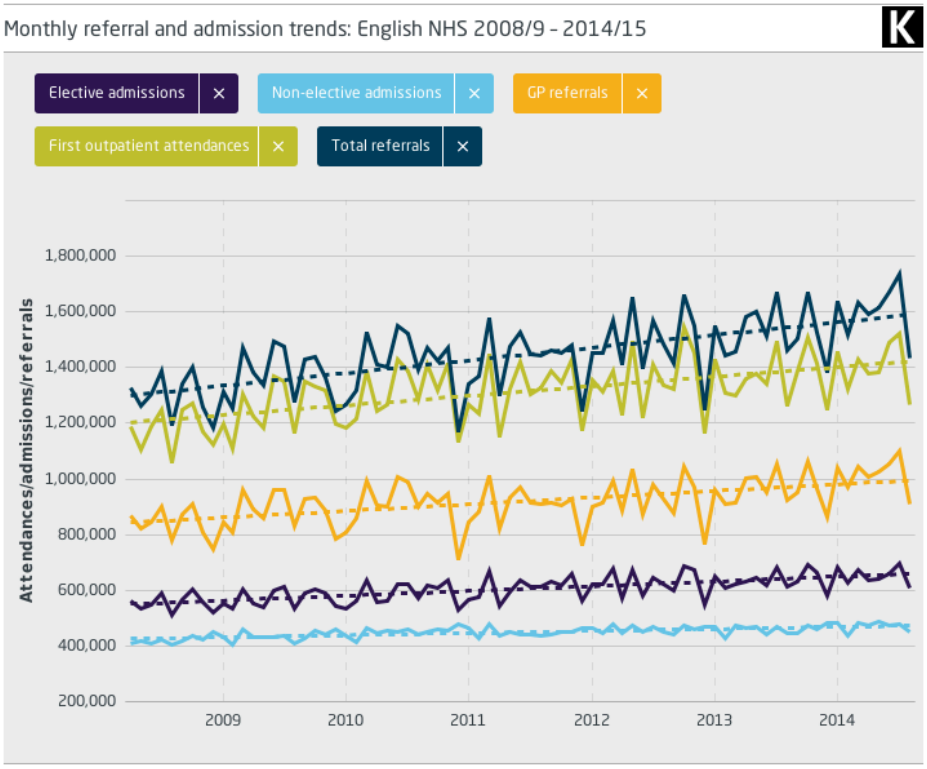
- As we noted in our last QMR, although up to £650 million of extra funding from central budgets and reserves has been announced by the Department of Health and NHS England, focused in part on urgent care services and on improving performance on the 18-week referral-to-treatment waiting time targets, it remains unclear whether

health services can effectively and efficiently deploy these resources at short notice. Although finance directors express a reasonable amount of confidence in meeting all the stages of the 18-week waiting times standard by this December (a key delivery date suggested by the Secretary of State), between a fifth and a quarter of directors remain fairly or very concerned.

- Accident and emergency (A&E) waiting times performance remains under pressure too. With the national 5 per cent target just missed by a fraction of a per cent between July and September, this makes performance during the second quarter of this year the worst for this time of year for more than a decade. The latest weekly data for the week ending 19 October shows that 7 per cent of patients waited longer than 4 hours – 2 per cent above the target level. For major A&E departments, the target has now been missed for the past 66 weeks.
- As with the extra money to tackle elective waiting times, whether the mooted additional £280 million cash (Renaud-Komiya 2014) ensures the national A&E waiting time is met over winter remains to be seen.

Pressures to spend more continue

- Part of the explanation for increasing pressures on waiting times is evident from trends in hospitals' workloads. As the figure below shows, monthly fluctuations aside, trends in referrals have been on an increasing path over the last six years, as are attendances at outpatients, and elective and emergency admissions.



Data source: NHS England, Monthly hospital activity data (commissioner based time series) www.england.nhs.uk

- Increasing workloads and downward pressure on budgets (as well as continued pressure on pay) also underlies a finding from the latest survey – that staff morale is chief among trust finance directors' current concerns. As the NHS planning framework for 2014/15 to 2018/19 notes, '...happy, well-motivated staff deliver better care and ... their patients have better outcomes' (NHS England 2013). As a recent report from The Point of Care Foundation also notes, there is evidence to link staff satisfaction and morale not only with patients' experience of care, but with its clinical quality and labour productivity (The Point of Care Foundation 2014).

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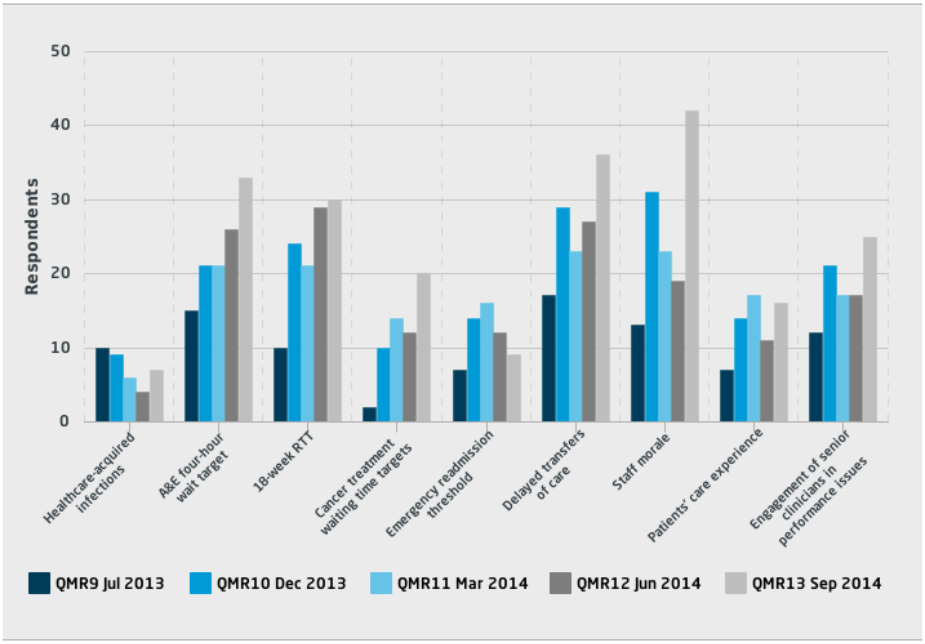
Figure 14: Trends: Which aspects of your organisation's performance are giving you most cause for concern at the moment? Please select top three



Question not asked before QMR9

- It is also clear that there are continuing pressures on beds. Once again, finance directors express concerns about delayed transfers of care. Historically, official statistics (supplied by trusts) have mostly not reflected these concerns. However, trends in delayed transfers over the past six to nine months for acute care suggest an upward trend, with the number of delayed patients reaching their highest since this data was first collected in 2007.

References

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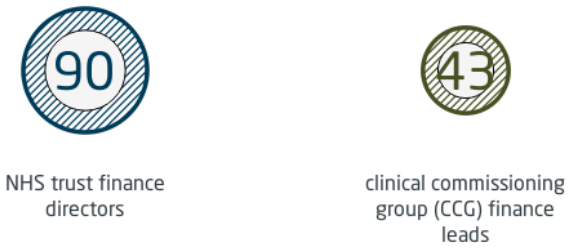
1. Health care surveys

This quarter's report is based on an online survey of the following groups:



This report details the results of an online survey of NHS trust finance directors carried out between 9 September 2014 and 23 September 2014. We contacted 248 NHS trust finance directors to take part and 90 responded (36 per cent response rate).

In addition, we contacted 202 clinical commissioning group (CCG) finance leads and 43 responded (21 per cent response rate). Between them these finance leads covered 52 CCGs (25 per cent of CCGs).

Respondents were asked about the financial situation of their organisation and local health economies over the past financial year; the state of patient care in their area; the £20 billion productivity challenge set for 2014/15 and beyond; the likely achievement of delivering the 18-week referral-to-treatment waiting time target by December 2014; and the likelihood of achieving the maximum 62-day wait from urgent GP referral to first definitive treatment for cancer waiting time standard for quarter two 2014/15.

2. Projected end-of-year financial situation and cost improvement/quality, innovation, productivity and prevention programmes

Projected end-of-year financial balance: 2014/15

More than one in three trusts forecast a deficit for 2014/15 – the highest proportion since we began surveying in 2011 (figure 1). Given the national context, our findings are unsurprising: as at 31 July 2014, 34 per cent of all NHS trusts were forecasting a deficit for 2014/15 (NHS Trust Development Authority 2014a). For foundation trusts, Monitor reports deficits at 86 foundation trusts (close to 60 per cent of the total) adding up to £227 million as at month 3 of 2014/15 (Dorsett 2014b).

CCGs' forecast position is not as bad as providers': around one in ten CCGs forecast ending 2014/15 in deficit (figure 2). Nationally, the picture is similar, with NHS England reporting a similar proportion of CCGs forecasting a deficit in 2014/15 (Wheeler 2014).

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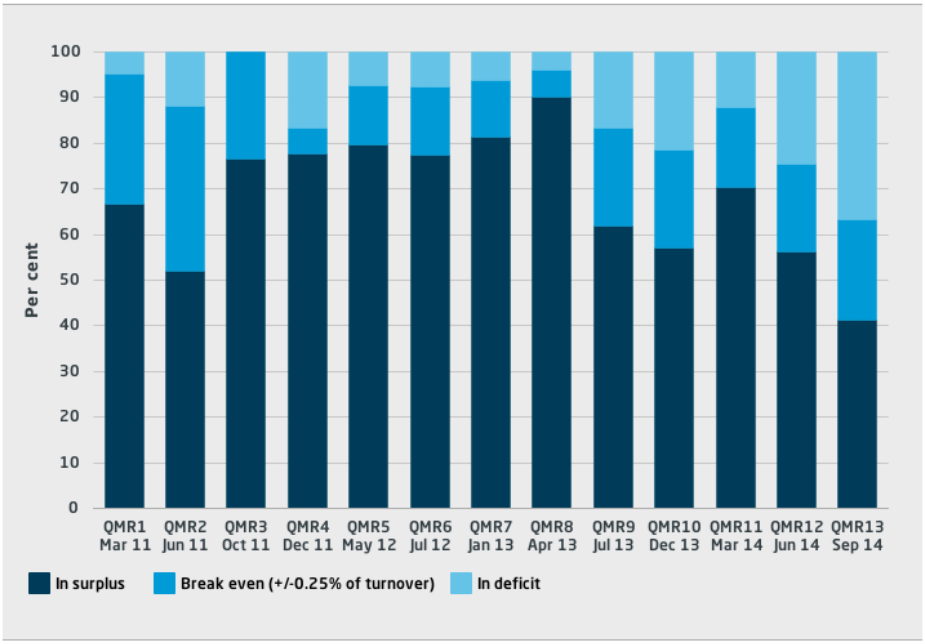
Figure 1: Trends: What is your organisation's forecast end-of-year financal situation?



QMR 1-4 based on a panel of 50 trust finance directors

Respondent comments

"'We are reliant in large part on growing amounts of non-recurrent resilient funding. The underlying position is a worry but we seem to get money from the centre every year!'"

– Large acute trust

"'This is the first time we will be in deficit since becoming an NHS foundation trust.'"

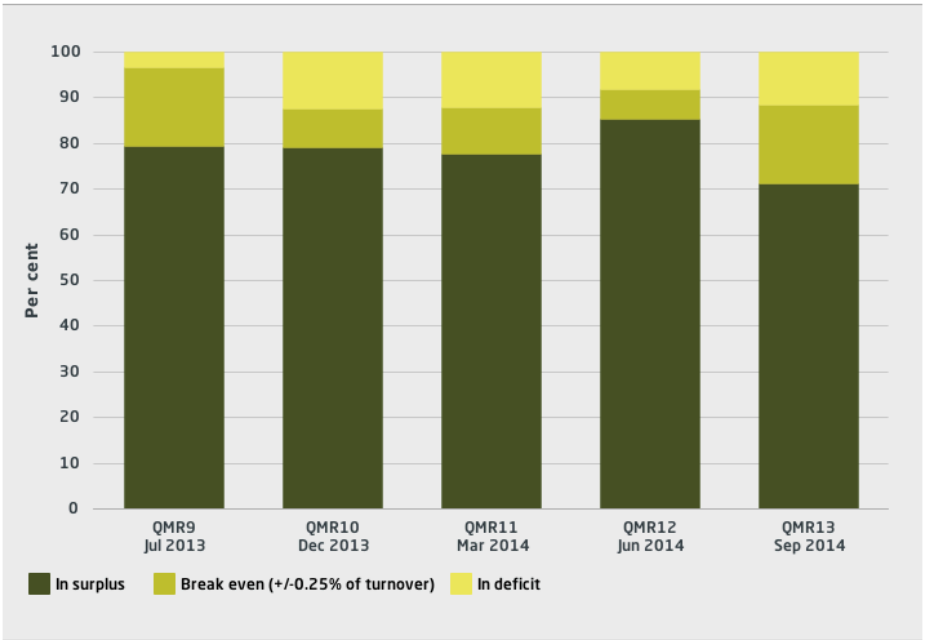
– Mental health foundation trust

"'Getting more challenging - the risk is towards deficit not surplus.'"

– Acute and community foundation trust

CCG LEADS

Figure 2: Trends: What is your organisation's forecast end-of-year financial situation?



43 CCG finance leads answered this question for the 52 CCGs they cover collectively.
CCGs only surveyed since their establishment in April 2013.

Respondent comments

"'It is still possible to achieve the required 1 per cent surplus but there are many risks attached, so the position may deteriorate as the year progresses.'"

"'NHS England requires clinical commissioning groups to plan a surplus.'"

Projected end-of-year financial balance 2014/15 compared to outturn for 2013/14

In addition to asking respondents about the year ahead, we also asked how this compared to outturn compared to 2013/14. The results show a clear deterioration of finances from 2013/14. More than two-thirds of all trusts (71 per cent) reported that their forecast position for 2014/15 will be worse than their outturn for 2013/14 (figure 3). This could mean lower surpluses, or moving from surplus to deficit, or worse deficits.

On the commissioner side, just over half of all CCGs forecast a similar position compared to the outturn for last year. Thirty per cent reported that their forecast position would be worse than their outturn for 2013/14 (figure 4).

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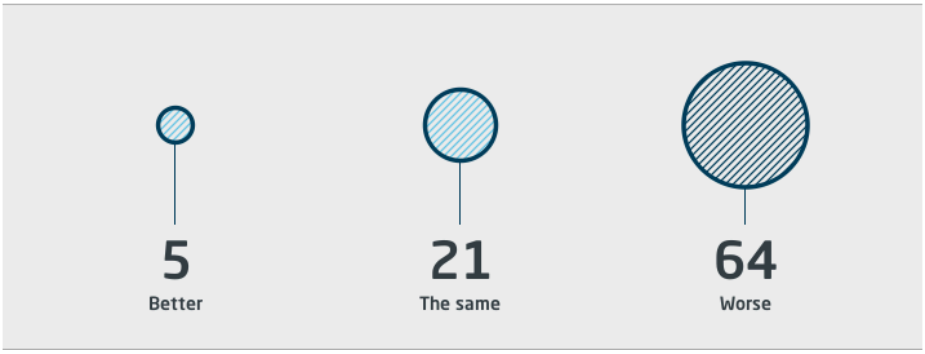
Figure 3: Is your forecast 2014/15 position better, worse, or the same as your outturn for 2013/14?



Respondent comments

"'We set a deficit budget for 2014/15, the first time in the organisation's history.'"

– Acute foundation trust

"'Our position has only improved due to non-recurrent resource from commissioners.'"

– Community and mental health foundation trust

"'Urgent care activity has increased but this activity is only funded at 30 per cent.'"

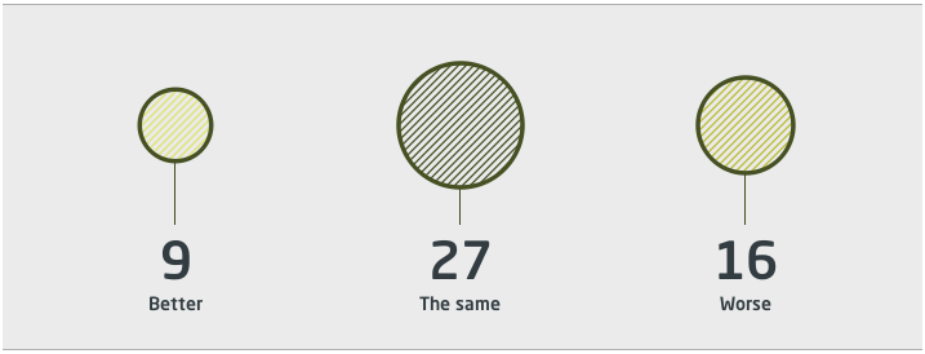
– Acute provider

"'With increased inflationary pressures, income being squeezed through tariff, and continued issues with meeting the 18-week RTT waiting time target at additional costs, our position is less favourable than we had hoped.'"

– Specialist acute trust

CCG LEADS

Figure 4: Is your forecast 2014/15 position better, worse, or the same as your outturn for 2013/14?



43 CCG finance leads answered this question for the 52 CCGs they cover collectively

Respondent comments

"'[The same]....but under pressure.'"

Cost improvement and QIPP programmes (2014/15 and 2015/16)

The average cost improvement programme (CIP) target for trusts in the 2014/15 and 2015/16 financial years is 4.6 per cent, ranging between 1.5 per cent and 8 per cent of turnover (figure 5).

The average quality, innovation, productivity and prevention (QIPP) target for CCGs for the 2014/15 financial year is 2.4 per cent, ranging from 0.5 per cent and 5 per cent of allocation. The average QIPP target for CCGs for the 2015/16 year increases to 3 per cent, ranging from 0.75 per cent to 8 per cent of allocation (figure 5).

Since the end of 2013/14 there has been a marked loss in confidence in achieving planned CIPs/QIPPs. Around 50 per cent of all NHS trust finance directors and CCG finance leads were fairly or very concerned about achieving their CIP/QIPP plans this year – this is the highest level of concern since we began the survey in 2011 (figures 6 and 7).

In terms of plans for 2015/16, two out of three trust finance directors state that they are fairly or very concerned about achieving their CIP, and just over half of all CCGs are similarly concerned about achieving their QIPP targets next year (figures 8 and 9).

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Figure 5: What is your organisation's CIP/QIPP target for this financial year (2014/15) as a percentage of turnover/allocation?

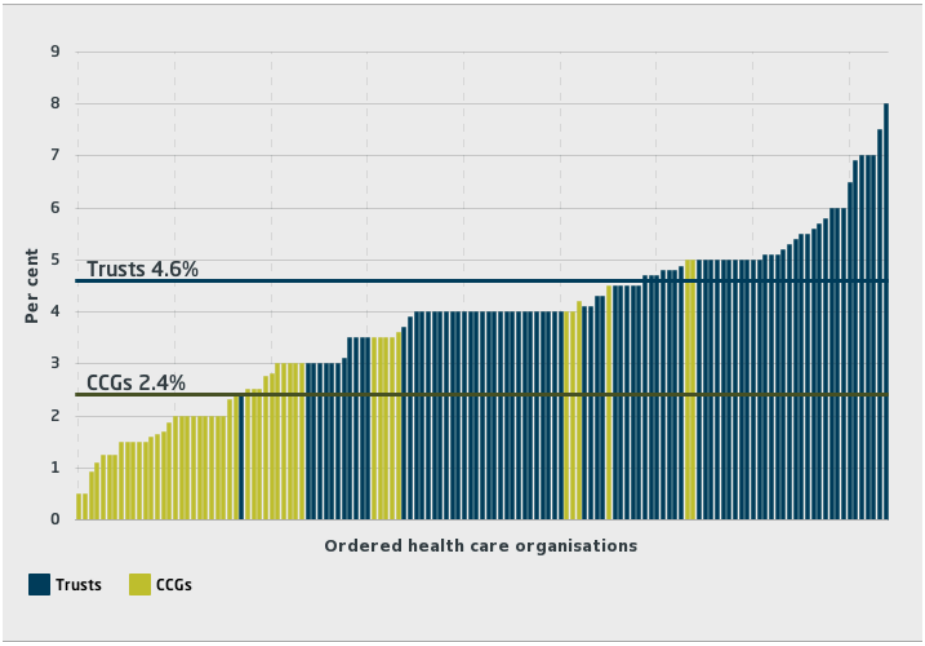

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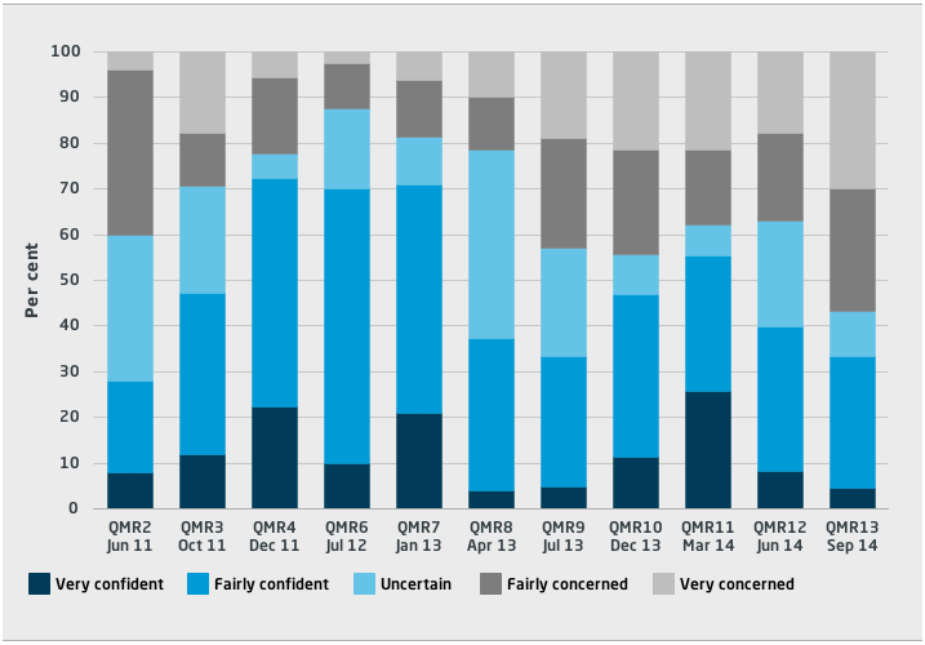
Figure 6: Trends: How confident are you of achieving your cost improvement programme (CIP) target?



QMR 1-4 based on a panel of 50 trust finance directors. QMR1 and QMR5 excluded as wording of responses not compatible with other quarters' data.

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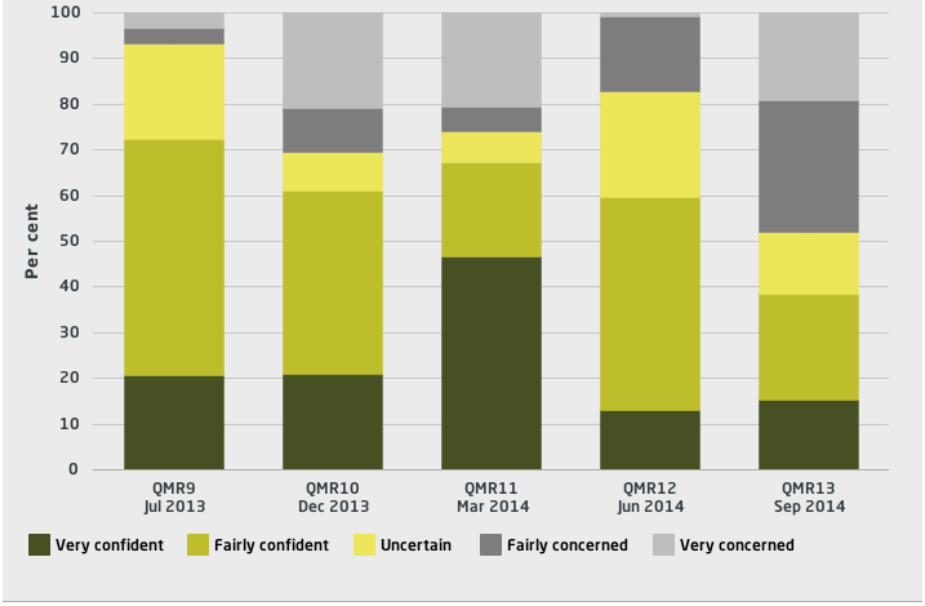
Figure 7: Trends: How confident are you of achieving your quality, innovation, productivity and prevention (QIPP) target?



43 CCG finance leads answered this question for the 52 CCGs they cover collectively.
CCGs only surveyed since their establishment in April 2013.

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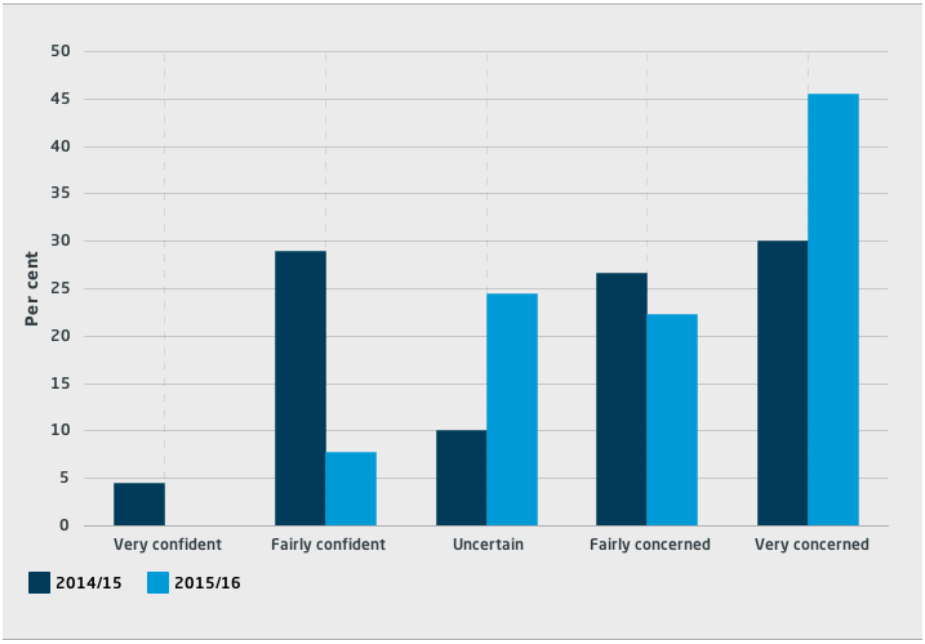
Figure 8: How confident are you of achieving your cost improvement programme (CIP) target in 2014/15 and 2015/16?



Respondent comments

"'Not confident of recurrent delivery but fairly confident of a mix of non-recurrent and recurrent solutions.'"

– Mental health, learning disability and community foundation trust

"'The risk is that it won't be delivered recurrently.'"

– Community and mental health foundation trust

"'As I've said before on this survey, it's important to distinguish between recurrent and non-recurrent of Cost Improvement Plan (CIP) delivery. An organisation achieving part of its CIP non-recurrently simply increases the problem next year. Financial health is indicated by recurrent delivery.'"

– Community trust

"'I am concerned about the ability to reduce costs against a backdrop of rising demand and increased regulatory requirements with a wider system which is in "meltdown".'"

– Acute and community trust

"'Our income position is likely to be severely constrained, as commissioner affordability is compromised in all directions (specialised commissioning overcommitted; Better Care Fund impact wipes out CCG growth). Resulting burden of cost savings is 1.5 times average achieved over the past three years, while there is less "left to go at" with each passing year.'"

– Large university teaching hospital

"'It is getting harder each year.'"

– Acute trust

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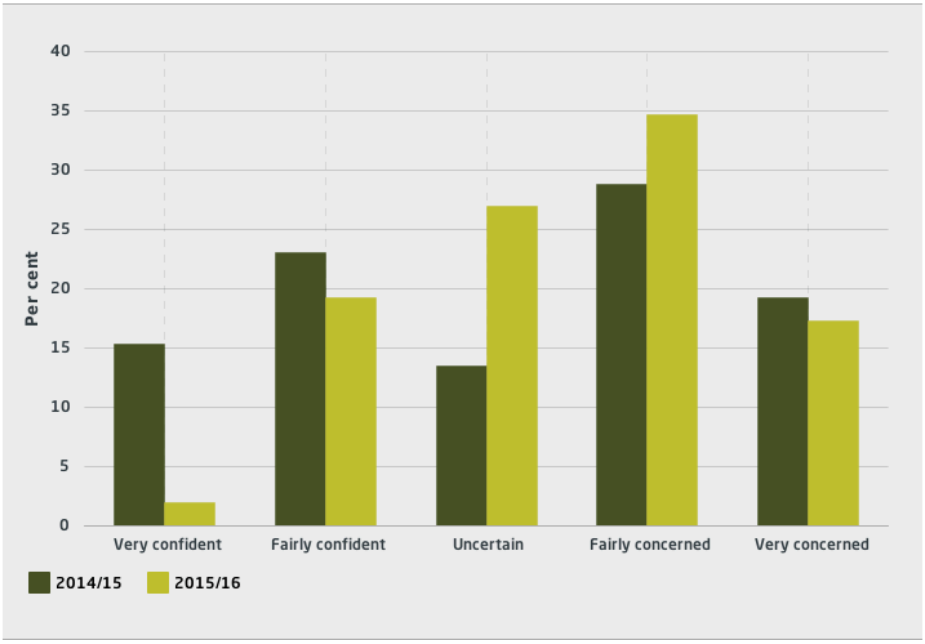
Figure 9: How confident are you of achieving your quality, innovation, productivity and prevention (QIPP) target in 2014/15 and 2015/16?



Respondent comments

"'Approximately 25 per cent of our QIPP (quality, innovation, productivity and prevention) target is dependent upon plans which have yet to begin, therefore there is now growing risk around full delivery.'"

"'The majority of QIPP has been focused on non-elective activity, but we have seen significant over performance in this area.'"

"'The problem is essentially down to pressures through greater activity than planned, rather than the non-achievement of QIPP initiatives.'"

"'We do not have robust schemes worked up right now that would deliver the target.'"

"'Delivering savings of this scale requires co-operation across the local health and social care economy, but I have little confidence that my acute provider will play ball.'"

The £20 billion productivity challenge

With the £20 billion 'Nicholson Challenge' in its final year, views on the risk of achieving this value of productivity improvements are highly pessimistic.

Three-quarters of trust finance directors felt there was a high or very high risk of failure to achieve the productivity challenge (figure 10). CCG finance leads felt fairly pessimistic too – with the majority of respondents assessing the risk of failure as fairly or very high (figure 11).

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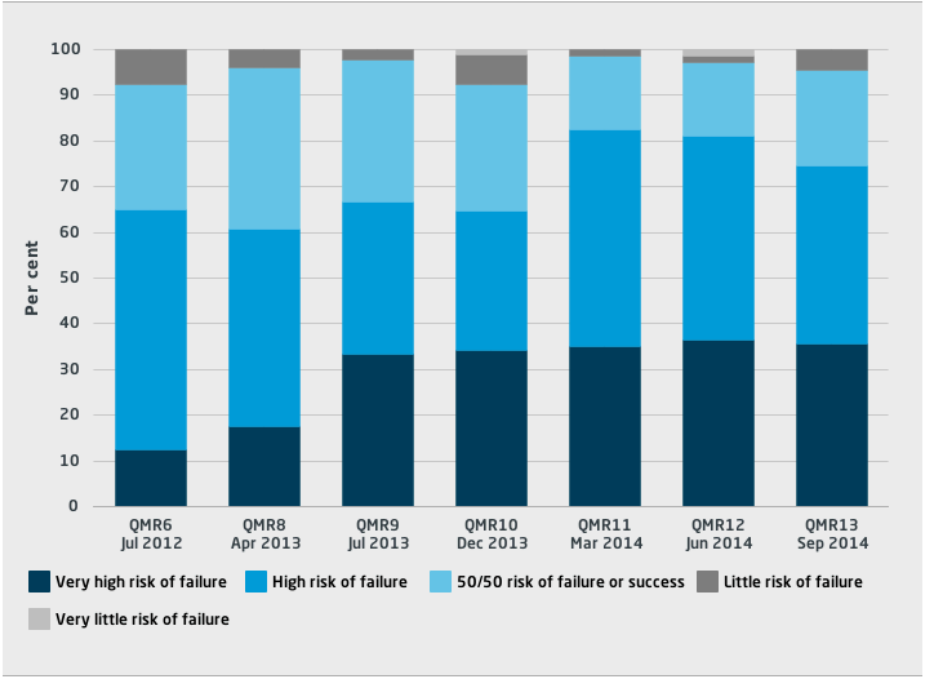
Figure 10: Trends: The NHS is now in its final year of the so-called Nicholson Challenge. What is your estimate of the risk involved in achieving productivity gains of the value of £20 billion by 2014/15?



Question not asked before QMR6 or in QMR7

Respondent comments

"'A large proportion of what is claimed to have been delivered will not be sustainable.'"

– Acute and community provider

"'I suspect at system level we can deliver until 2014/15, but the continuing challenge thereafter looks impossible.'"

– Anonymous

"'The increasingly widespread prevalence of provider deficits indicates that shovelling much of this challenge onto providers through year-on-year tariff efficiencies, has run out of road already in 2014/15.'"

– Large university teaching hospital

"'The risk is huge. The NHS efficiency challenge has been achieved thus far from marginal gains, provider cost reductions, some productivity and of course huge savings from the 2-year pay freeze, and now the 1 per cent rise. I haven't seen any genuine transformation anywhere in the past five years. New forms of commissioning/contacts simply won't deliver savings - an uncomfortable truth.'"

– Mental health foundation trust

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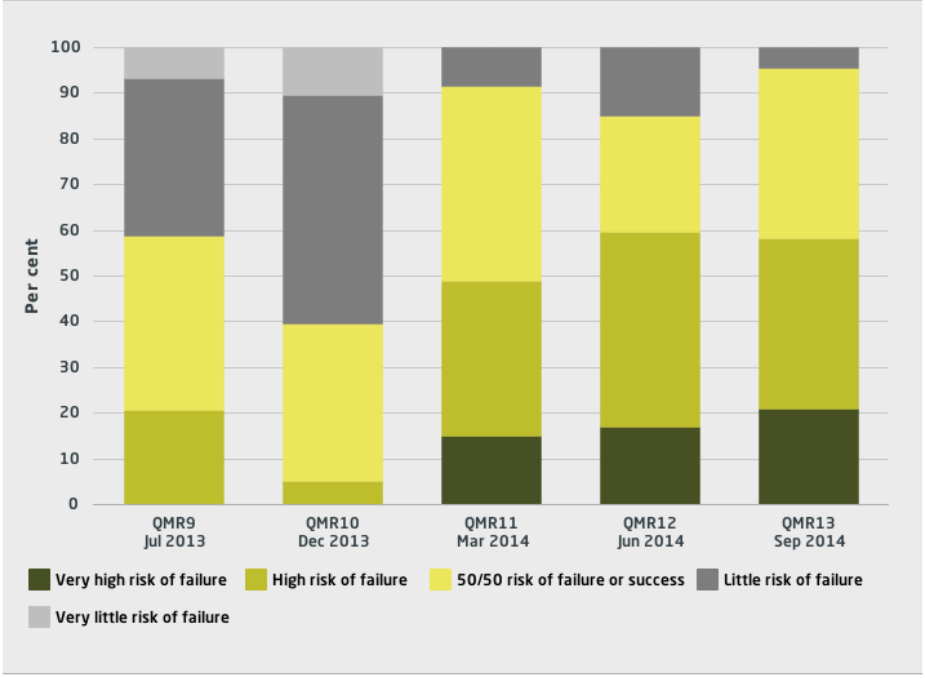
Figure 11: Trends: The NHS is now in its final year of the so-called Nicholson Challenge. What is your estimate of the risk involved in achieving productivity gains of the value of £20 billion by 2014/15?



CCGs only surveyed since their establishment in April 2013

Respondent comments

"'The Nicholson challenge isn't just about productivity. If we focus just on productivity then we will fail.'"

"'The Nicholson Challenge has been overtaken by the Francis / Keogh reports which have effectively reversed around one year's worth of CIPs (Cost Improvement Plans) delivered by providers. I'm not sure that the Nicholson Challenge exists in any shape or form any more.'"

"'The easy productivity gains have already been delivered. There are still significant efficiencies to be delivered but a system-wide approach is needed to ensure changes co-ordinated in the right way.'"

3. The state of patient care

Around 38 per cent of NHS trust finance directors felt care in their local area had got worse over the past year – continuing a trend since the beginning of this financial year (figure 12).

Similarly, around 35 per cent of CCG finance leads felt patient care had worsened in the last year; less than a quarter thought it had got better (figure 13).

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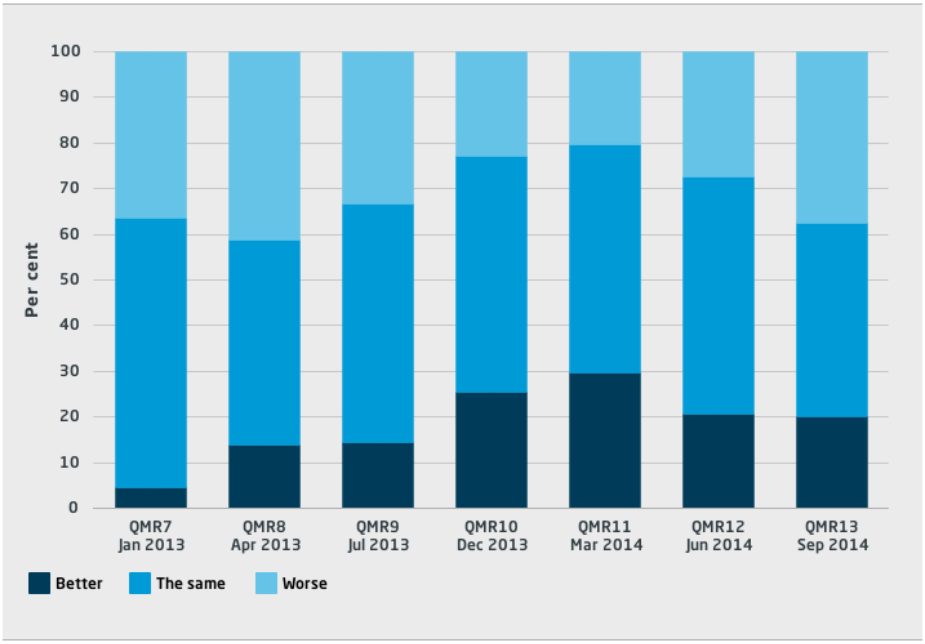
Figure 12: Trends: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



Question not asked before QMR7

Respondent comments

"'Access to GPs is far more difficult, community care is inadequate, DTOCs (delayed transfers of care) have grown, A&E targets are struggling, demand is up but not the required resources (especially with regard to non-elective work), the private sector cherry-picks the more lucrative work through having lower waiting times, we are into escalation beds more frequently, far greater use of agency staff with the safety risks this poses.'"

– Acute trust

"'The integrated health and social care service, single point of access, and rapid response team set up for hospital admissions avoidance are all delivering improved care for the local residents. Care at home is what we are aiming to deliver for our residents with long-term conditions.'"

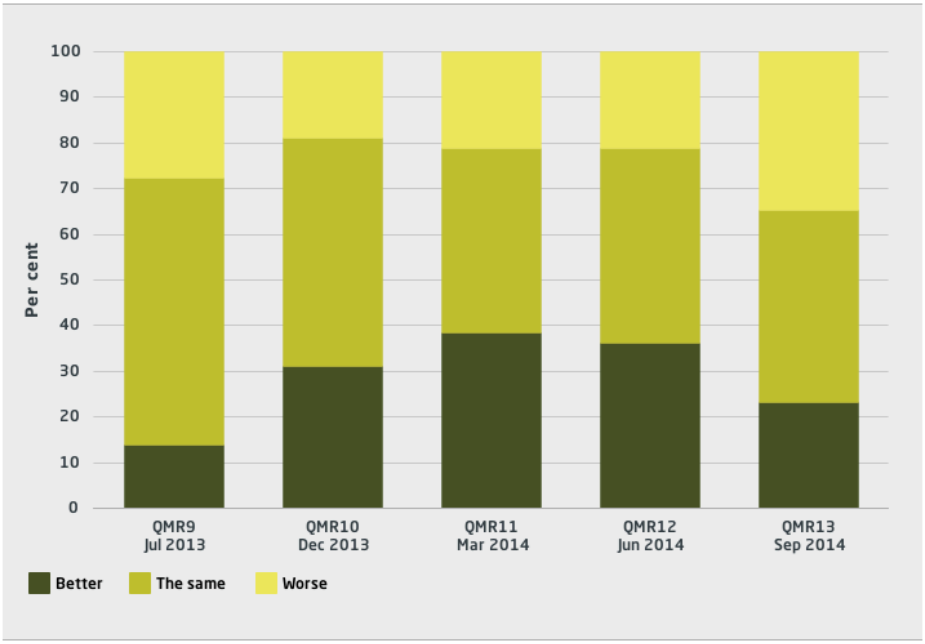
– Social enterprise - community health and social care

"'Overall it has stayed the same although it has deteriorated in some areas, particularly in the local authority commissioned areas where cost reduction takes precedence over quality.'"

– Mental health and community health provider

CCG LEADS

Figure 13: Trends: 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?



CCGs only surveyed since their establishment in April 2013

Respondent comments

"'Better, but at a cost. I think nationally and at local levels leaders are prioritising quality and performance in the face of deteriorating financial positions. So I think the financial positions of many providers and commissioners will get worse.'"

"'There is increased financial pressure on all parties, noticeable increases in demand for health care and increased pressures on areas such as continuing health care caused, we believe, by a continuing shift of financial responsibility from social care to health.'"

"'Better in terms of waiting times but pressures are emerging in terms of quality affected by funding shortfalls across the system (acute, community and local authority).'"

"'Safety is being maintained but waiting lists are increasing, particularly in community and mental health services, as are delayed transfers of care.'"

4. Organisational challenges

For trust finance directors, staff morale returns to the top of the list of concerns along with waiting time targets and delayed transfers of care (figure 14).

CCG finance leads continue to be most concerned about A&E and 18-week referral-to-treatment waiting time targets. Cancer treatment waiting time targets return to the top of their concerns – reflecting perhaps the deterioration in performance against this target (figure 15).

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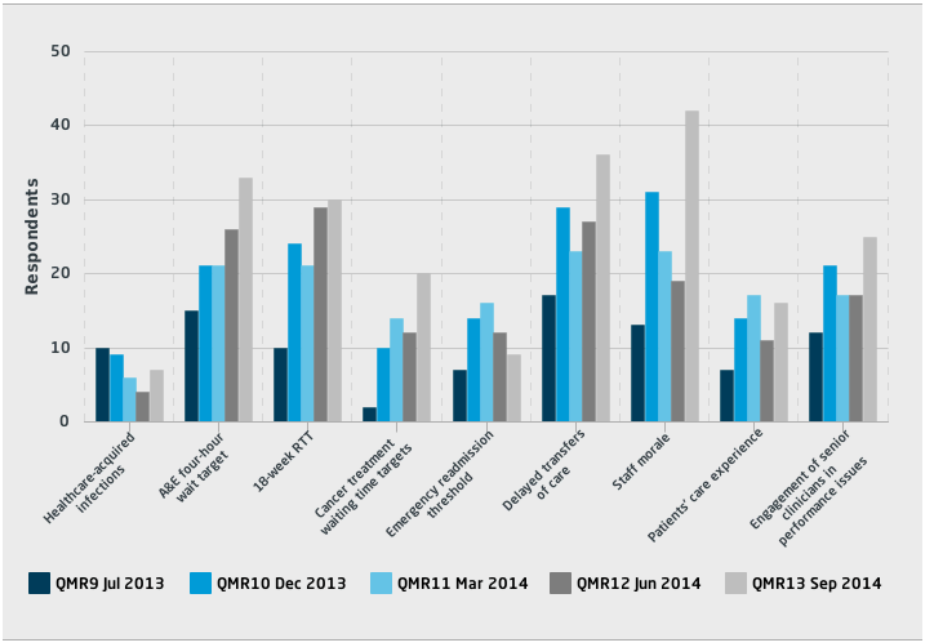
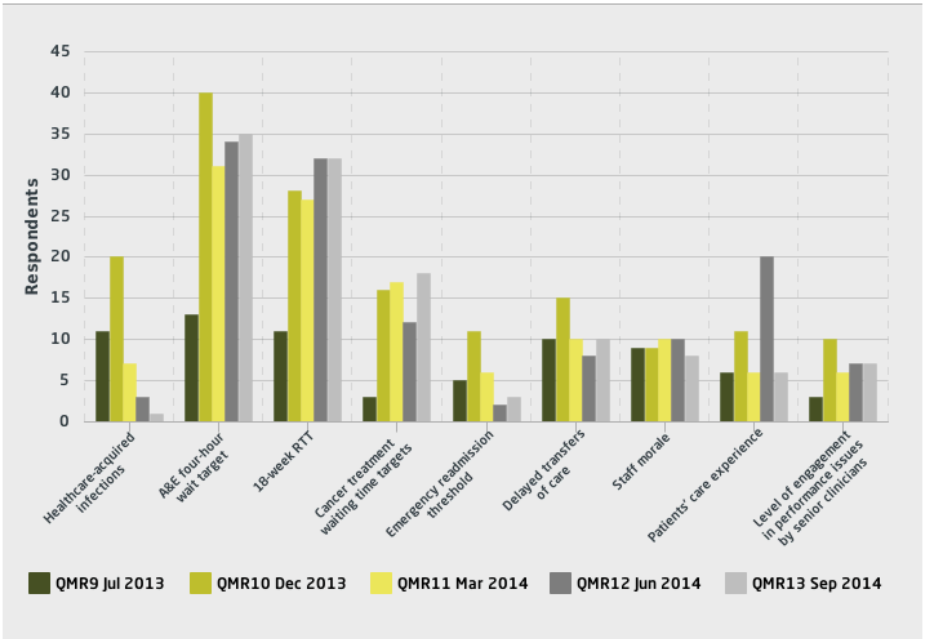
Figure 14: Trends: Which aspects of your organisation's performance are giving you most cause for concern at the moment? Please select top three



Question not asked before QMR9

CCG LEADS

Figure 15: Trends: Which aspects of your organisation's performace are giving you most cause for concern at the moment? Please select top three



Question not asked before QMR9

5. Waiting time targets

Given the Department of Health's push to reduce the number of people still waiting more than 18 weeks, with additional funding to pay for increased activity, we asked finance directors how confident they were in their organisation's ability to deliver on the three main stages of the 18-week referral-to-treatment target – for those still waiting ('incomplete pathways'), outpatients ('non-admitted patient') and inpatients ('admitted patient').

Although this is an improvement on the current position nationally (where a little more than 50 per cent are not meeting the admitted care target), more than a quarter of finance directors surveyed are either fairly or very concerned that their organisation would not be able to deliver this operational standard by December 2014 (figure 16).

For non-admitted patients, national data shows that around 22 per cent are currently not meeting the target. Our survey indicates that 17 per cent were not confident of meeting the target for non-admitted patients (figure 17).

For those still waiting, the proportion of trusts currently not meeting the target (18 per cent) is similar to the proportion (19 per cent) reporting in our survey that they were very or fairly unconfident of meeting this target by December (figure 18).

A key cancer waiting time target – that 85 per cent of patients should wait no longer than 62 days from urgent GP referral to first definitive treatment – has been breached in the last quarter of 2013/14 and again in the first quarter of 2014/15; around a third of trust finance directors and CCG finance leads expect their organisation to breach this standard in quarter two this year (ie, July to September 2014) (figures 19 and 20).

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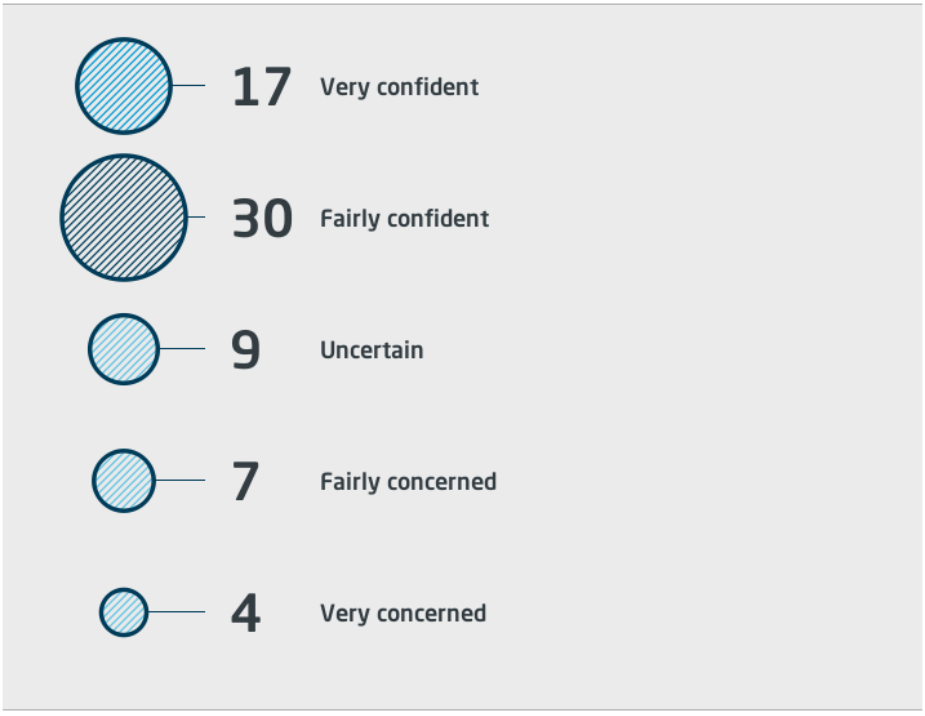
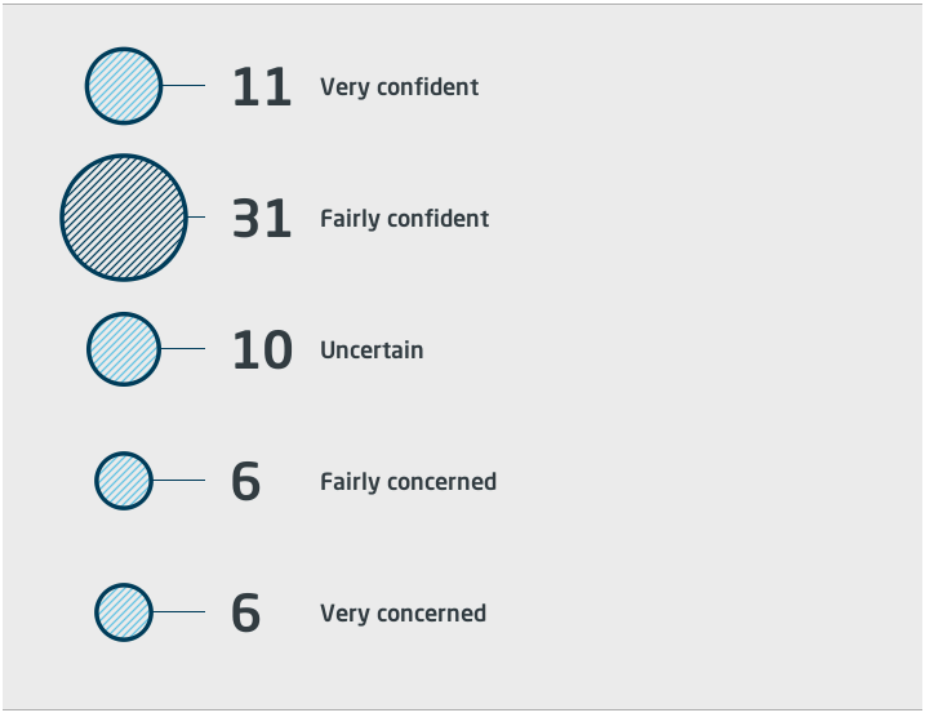
Figure 17: How confident are you that your organisation will be able to deliver the 18 week RTT non-admitted patient operational standard by December 2014?



67 respondents (for whom the question was applicable)

NHS TRUSTS

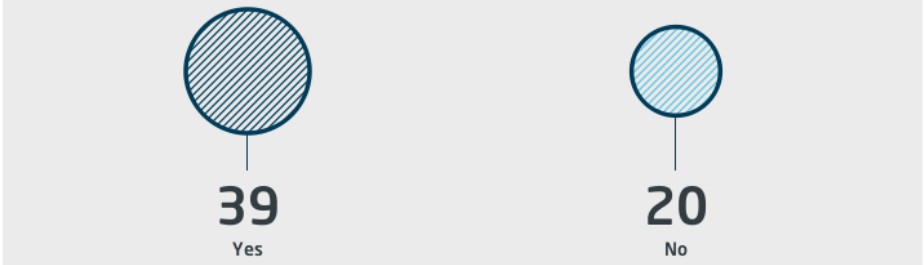
Figure 18: How confident are you that your organisation will be able to deliver the 18 week RTT incomplete pathway operational standard by December 2014?



64 respondents (for whom the question was applicable)

NHS TRUSTS

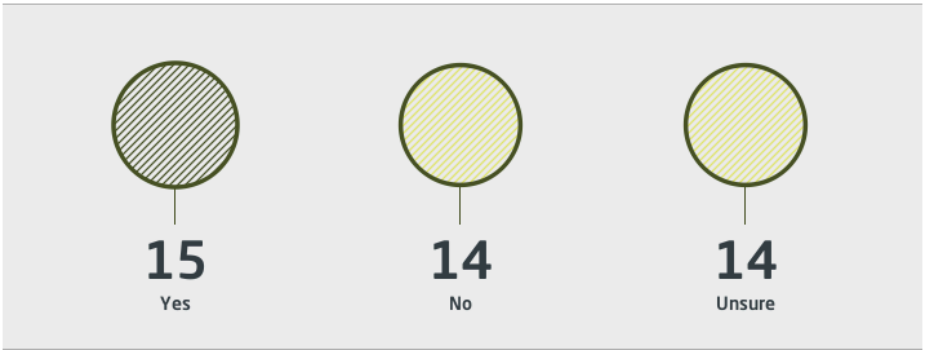
Figure 19: Do you expect your organisation to achieve the maximum 62-day wait from urgent GP referral to first definitive treatment for cancer waiting time standard for Q2 2014/15 (July - September 2014)?



59 respondents (for whom the question was applicable)

CCG LEADS

Figure 20: Do you expect your organisation to achieve the maximum 62-day wait from urgent GP referral to first definitive treatment for cancer waiting time standard for Q2 2014/15 (July - September 2014)?



Respondent comments

"'There are capacity and demand issues in urology which have been caused by the 'blood in the pee' campaign which resulted in a 34 per cent increase in referrals. Vacancies have been recruited into and performance is now improving.'"

6. The financial state of local health and care economies over the next year

When asked how they felt about the financial state over the next year of their wider local health and care economy, 90 per cent of trust finance directors were fairly or very pessimistic (figure 21). This is the least optimistic view recorded by the QMR survey since it started.

CCG finance leads are similarly more pessimistic about the coming year, with 75 per cent of respondents feeling fairly or very pessimistic (figure 22).

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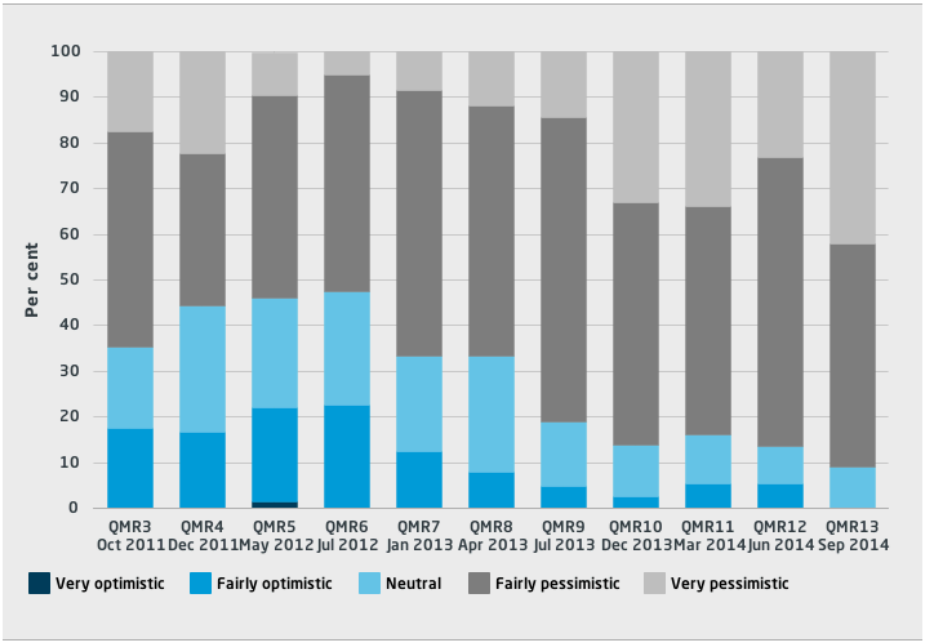
Figure 21: Trends: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next year?



Question not asked before QMR3. QMR 1-4 based on a panel of 50 trust finance directors.

Respondent comments

"'The Better Care Fund is going to cause chaos and probably deliver very little at a high cost. Local authorities are having to make bigger savings than the NHS and this also is not doable.'"

– Acute trust

"'CCG broke, city council halving its workforce and a 7 or 8 per cent CIP for us!!! Looks grim!'"

– Large acute trust

"'There remains a lack of concrete, deliverable schemes to reduce health and care costs. The financial position of all organisations (commissioner, provider and council) has deteriorated significantly in the year to date.'"

– Non-acute foundation trust

"'We are fragmented, and the provider sector, which has the ideas and leadership capability, is still politically excluded from the real process of agenda-setting to drive the transformation process.'"

– Acute foundation trust

"'There is a large acute foundation trust that will probably go in to administration in the next 12 months.'"

– Mental health and learning disabilities foundation trust

"'The health economy is already bust this year and the situation will worsen next year with the Better Care Fund (BCF). The imposed BCF assumption that activity will reduce by 3.5 per cent is not realistic.'"

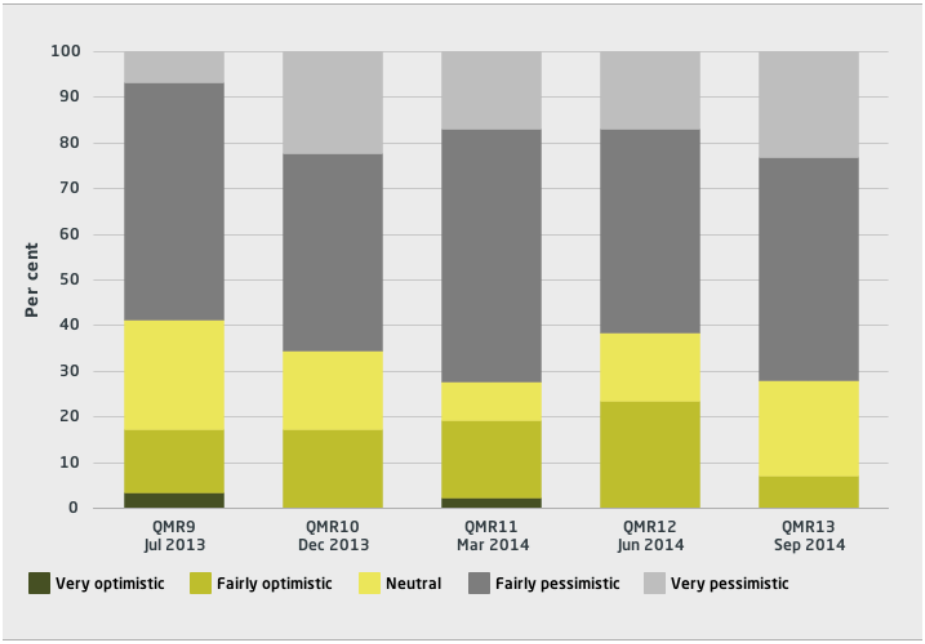
– Acute provider

"'Financial resilience is disintegrating on all sides... The double-count of the Better Care Fund in 2015/16 spending round is going to make this much worse, quickly, as the underlying onslaught on social care budgets and de facto lack of any cash growth in CCG budgets, as well as the unsustainable level of provider efficiency, all combine in to make the 2015/16 outlook a "financial doomsday" for the whole of the health and care economy.'"

– Large university teaching hospital

CCG LEADS

Figure 22: Trends: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next year?



Question not asked before QMR9

Respondent comments

"'The pressures are not necessarily being exposed as yet, but are likely to emerge in the next couple of months.'"

"'The success of the Better Care Fund arrangements is essential in order to deliver financial balance across the patch - but much of the detailed planning remains to be completed.'"

"'There are good working relationships across all partners in health and social care (both commissioners and providers) although financial challenge of local authority in coming years could test these relationships.'"

7. References

- Dorsett J (2014b). *Quarterly report on the performance of the NHS foundation trust sector: 3 months ended 30 Jun 2014*. London: Monitor. Available at: www.gov.uk (accessed on 21 October 2014).
- NHS Trust Development Authority (2014a). *NHS trust service and financial performance report for the four month period ending 31 July 2014*. Paper E for Board meeting 18 September 2014. Available at: www.ntda.nhs.uk

(accessed on 21 October 2014).

- Wheeler K (2014). *NHS performance report in the period to the end of August 2014*. Paper NHSE191404 for Board meeting, 19 September 2014. Available at: www.england.nhs.uk (accessed on 21 October 2014).

1. Health care-acquired infections

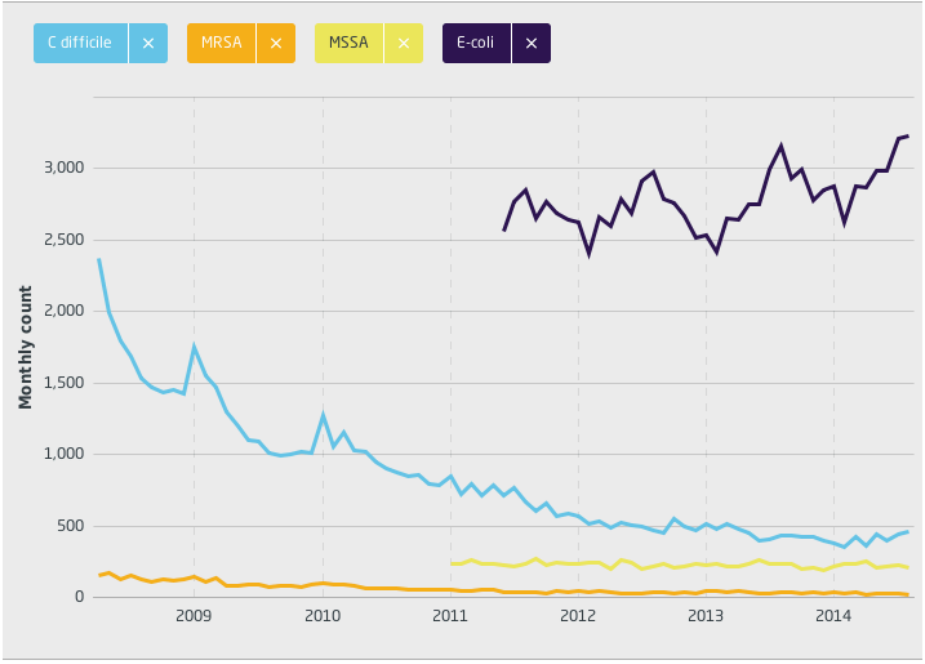
The historic decreases in the number of cases of *C difficile* have remained low over the last year or so. The most recent data for August 2014 shows an apparent upturn in trend, but this reflects the usual seasonal variance for this time of year (figure 23).

August 2014 saw the fifth month in a row for monthly counts of MRSA below 30, a historic low. To put this into perspective, there are more than 2 million patient contacts per month in the NHS in England, which means that infection rates for MRSA are now below 0.001 per cent (figure 23).

Although not part of the national targets, there are many other health care-acquired infections (HCAIs). For example, numbers for MSSA, the strain of *S aureus* which is sensitive to meticillin, remain broadly flat. There were 239 reported cases in January 2011; by August 2014 there were 205 (figure 23).

Monthly counts of *E. coli* appear to be increasing through to August 2014. However, the data is very sensitive to seasonal variations. Additionally the monthly data collection for acute trusts only began in June 2011, so there could be more trusts reporting numbers each month, distorting any real increases (figure 23).

Figure 23: Monthly counts of selected health care-acquired infections



Data source: Clostridium difficile infection: monthly data by NHS acute trust http://www.gov.uk.

Monthly counts of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia by post infection review (PIR) assignment http://www.gov.uk.

Monthly counts of trust apportioned meticillin susceptible Staphylococcus aureus (MSSA) bacteraemia by NHS acute trust http://www.gov.uk

Monthly counts of Escherichia coli (E. coli) bacteraemia by NHS acute Trust http://www.gov.uk

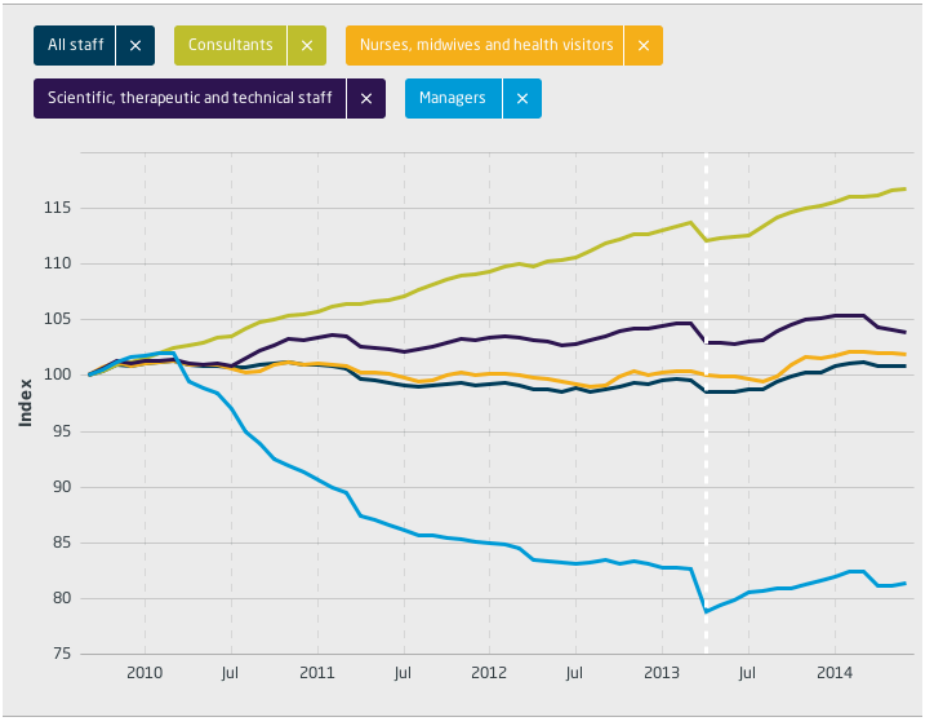
2. Workforce

Total staff numbers have decreased since their peak in March 2014, following a noticeable pattern of decreases at the turn of a new financial year. Since April 2014, total staff numbers have remained broadly flat; full-time equivalent staff now total 1.056 million (figure 24).

Since March 2014 the only staff groups to increase through to June 2014 were consultants and senior managers – though the increase in senior managers is masked as this is combined with managers – both of which were fractionally up. Numbers for all other staff groups fell in the first quarter of 2014/15 (figure 24).

The recent surge in the total number of full-time equivalent nurses, midwives and health visitors since November 2013 had fallen back slightly by June. Following a peak in March 2014 the number of posts in June 2014 has decreased by more than 1,000. The year-on-year change however indicates that there are now more than 6,200 additional full-time equivalent nurses, midwives and health visitors compared to June 2013 (figure 24).

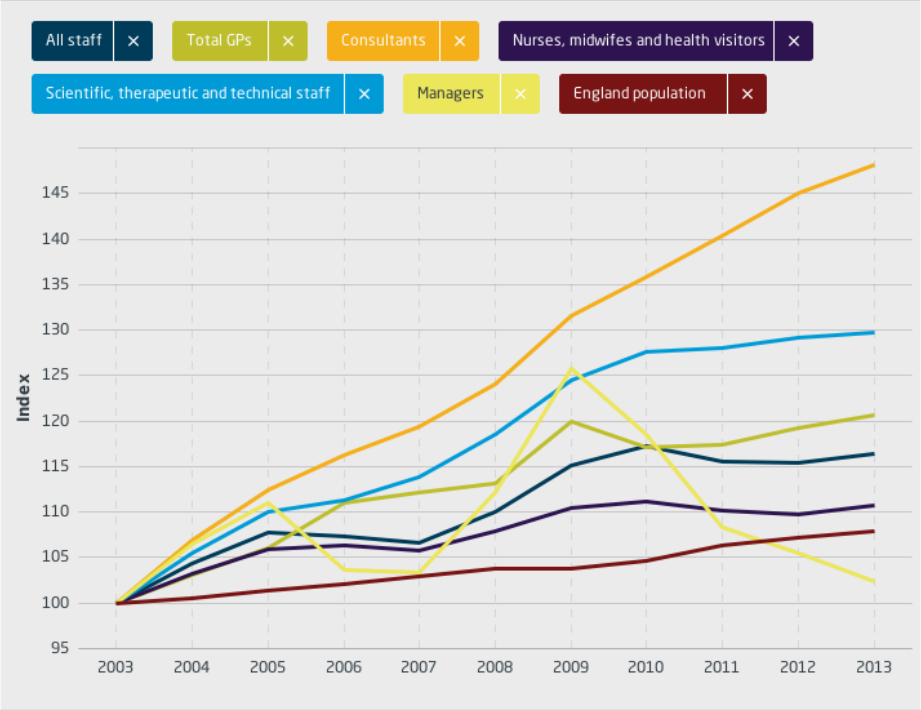
Figure 24: Index change in NHS full-time equivalent staff: September 2009 – June 2014



Data source: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – June 2014, Provisional statistics www.hscic.gov.uk.

Taking a longer view (and including GPs, whose numbers are only recorded annually) shows that the numbers of all health care staff groups have increased since 2003 – although there have been large reductions in managers since 2009, and for all groups apart from consultants, increases occurred mainly up to 2009 or 2010 (figure 25).

Figure 25: Index change in annual counts of NHS full-time equivalent staff and GPs: 2003 - 2013



Data source: NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Summary of staff in the NHS - 2003-2013 www.hscic.gov.uk.

3. Waiting times

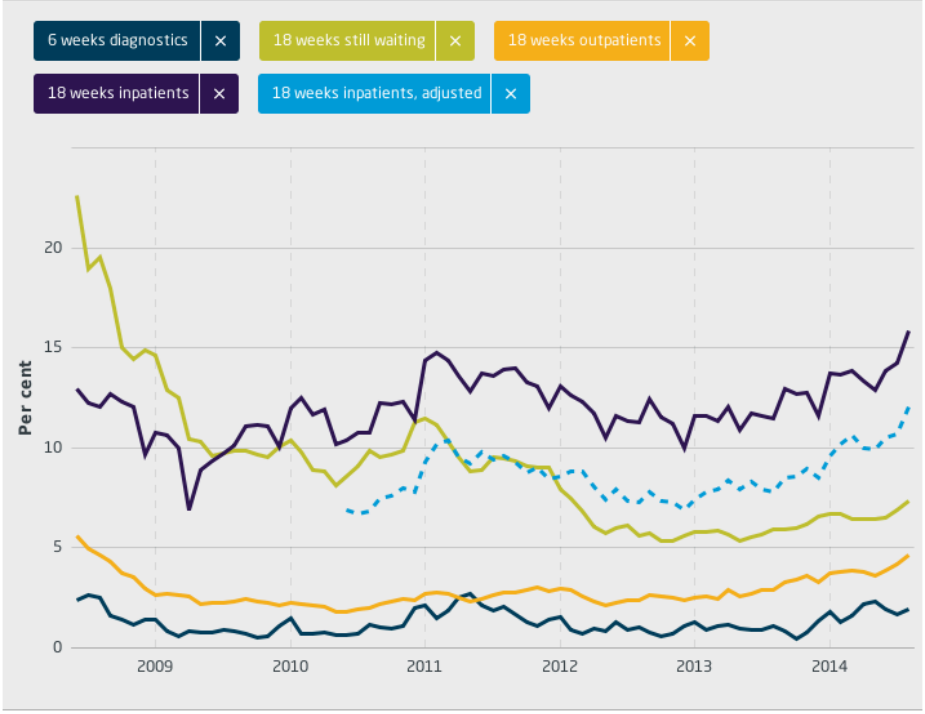
In June, the Secretary of State for Health announced extra funding of £250 million for trusts to carry out additional elective activity during the summer months to reduce the total number of patients waiting for more than 16 weeks by 115,000 nationally, thereby reducing the number of people still waiting for more than 18 weeks to the level in January 2013 (figure 26).

Treating more people who have already waited for more than 18 weeks automatically means increasing the number of breaches of the 18-week target for admitted and non-admitted parts of the target. This 'managed' breach is evident from the latest waiting times figures. The proportion of patients waiting for more than 18 weeks for admitted treatment has increased to more than 12 per cent – the highest proportion since this new adjusted standard was introduced four years ago (figure 26).

However, there has been no compensating decrease in the numbers or proportions of patients still waiting either for admission as an inpatient or for their first attendance at outpatients. Indeed, the numbers still waiting for more than 16 weeks (the time targeted under the managed breach initiative) has increased by more than 71,000 to nearly 321,000 – the highest since the summer of 2011 (figure 26).

The number of patients waiting more than six weeks for a diagnostic test has now missed its performance target for the past nine months in a row. The proportion of patients waiting for non-admitted treatment has increased to its highest level for six years. The number of people still waiting for more than 18 weeks for treatment has increased to its highest level for two-and-a-half years – despite the targeted push to reduce this number (figure 26).

Figure 26: Percentage still waiting/having waited more than 18 weeks (more than 6 weeks for diagnostics)

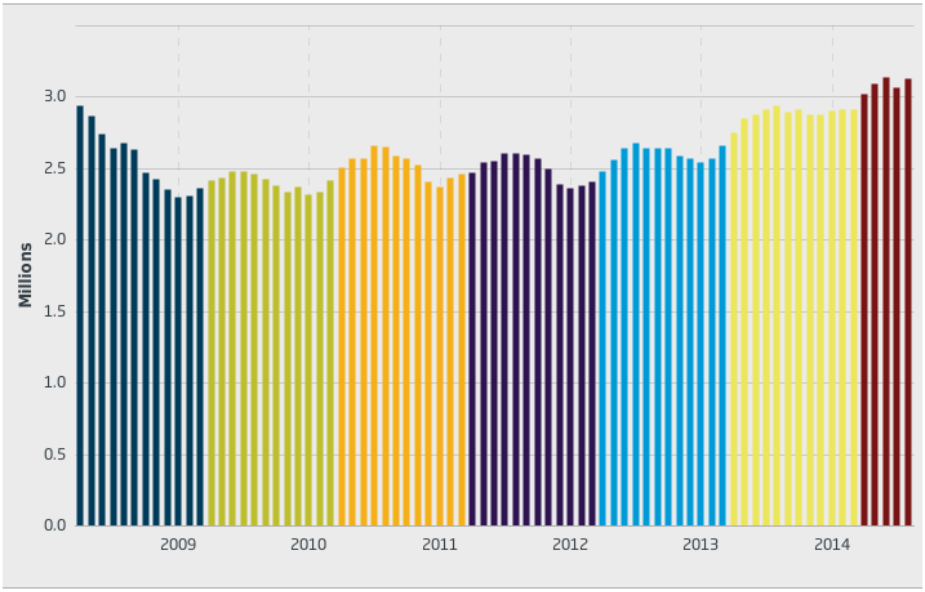


Data source: Referral-to-treatment waiting times statistics www.england.nhs.uk.

Diagnostic waiting times statistics www.england.nhs.uk.

In August 2014 the total waiting list in England stood at 3.13 million patients, an increase on the previous month and only a small decrease from June (figure 27). Furthermore, NHS England has estimated that the total waiting list size could be up to 3.3 million patients if all non-reporting trusts submitted their missing data (NHS England, 2014c).

Figure 27: Referral-to-treatment total waiting list size in millions, England

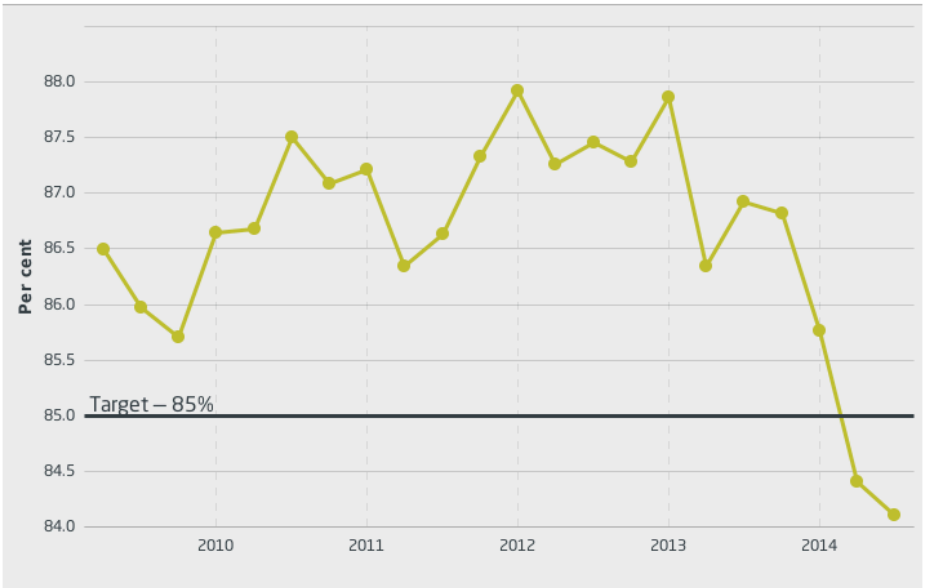


Data source: Referral-to-treatment waiting times statistics www.england.nhs.uk.

4. Cancer

The target that 85 per cent of patients should wait no longer than 62 days from an urgent GP referral to first definitive treatment for cancer was missed for the second consecutive quarter in a row in quarter one 2014/15 (figure 28).

Figure 28: Maximum 62-day wait for first treatment: all cancers (urgent GP referral to treatment)



Data source: Provider-based cancer waiting times www.england.nhs.uk.

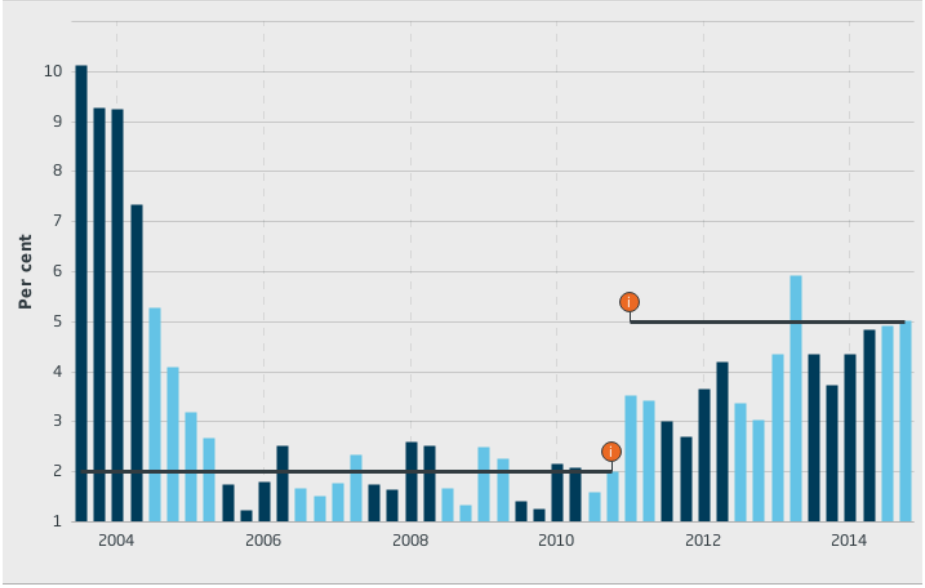
5. Accident and emergency

The proportion of patients waiting more than four hours from arrival to admission, transfer or discharge in the second quarter of 2014/15 was 5.02 per cent – fractionally missing the 5 per cent target, and the highest second quarter level since the introduction of the revised target (figure 29).

Of all the organisations reporting against the A&E standard, 28 per cent reported missing the four-hour target in this quarter, the highest second quarter figure proportion for a decade, and counter to the usual trend for a reduction against the previous first quarter figure.

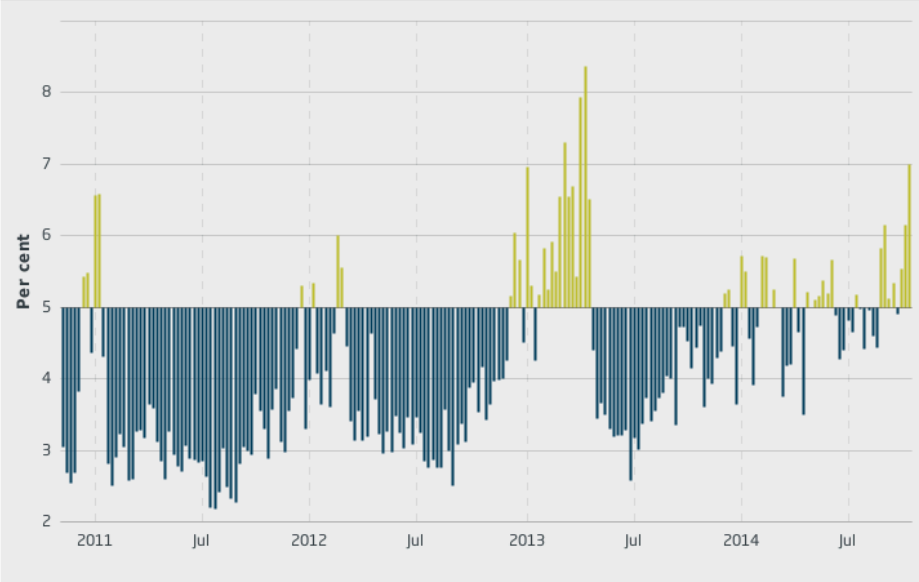
The latest weekly A&E waiting times data (for the week ending 19 October) shows that across all types of departments, 7 per cent of patients waited more than four hours (figure 30). However, for major A&E departments (which treat around 65 per cent of all patients), the four-hour target has now been missed for the past 66 weeks.

Figure 29: Waiting times: Percentage waiting more than four hours in A&E from arrival to admission, transfer or discharge



Data source: Weekly A&E SitReps 2014-15 www.england.nhs.uk.

Figure 30: A&E weekly performance against target that no more than 5 per cent of patients wait longer than four hours from arrival to admission, transfer or discharge. Weekly data: November 2010-October 2014



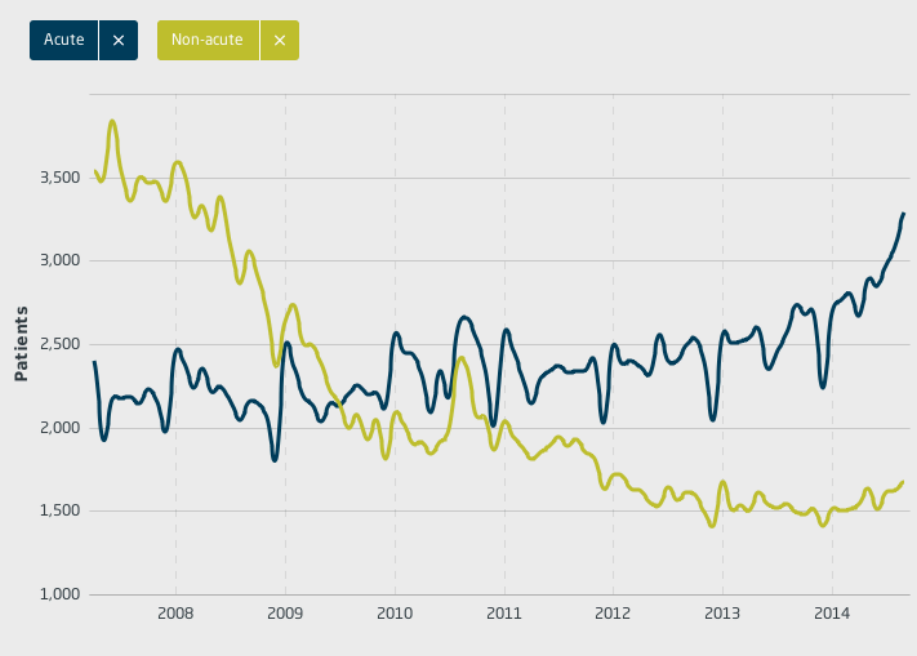
Data source: Weekly A&E SitReps 2014-15 www.england.nhs.uk.

6. Delayed transfers of care

Seasonal variations are still apparent in the delayed transfers of care data. But following month-on-month increases from July to September this year there were 17.5 per cent more patient delays and 16 per cent more delayed days compared to September last year. Splitting this by the type of care patients were receiving shows that acute delays continue to increase while delays for non-acute have flattened over the last year (figures 31 and 32).

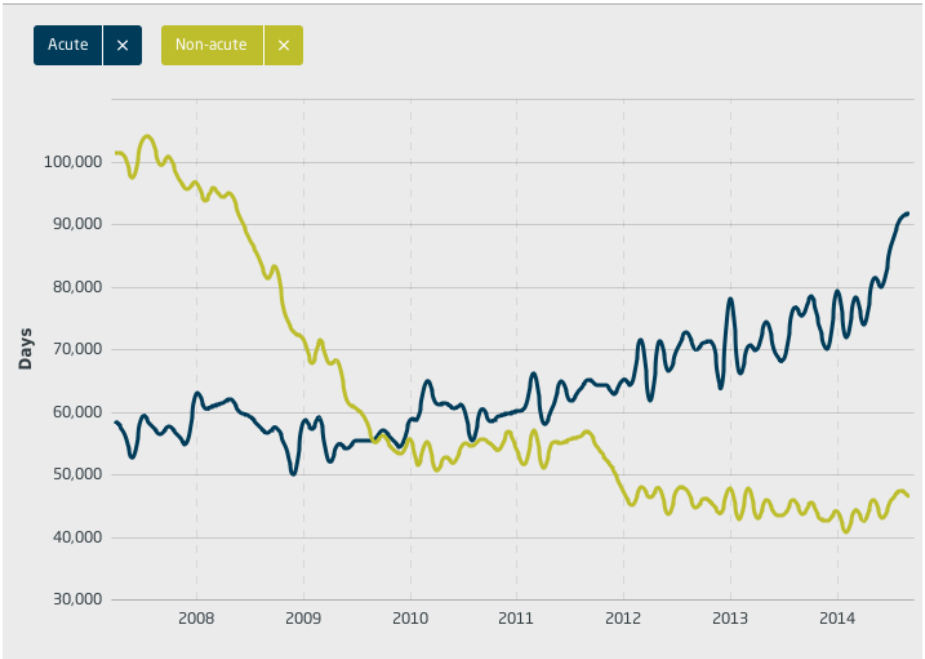
This change in the data now reflects a longstanding trend with our survey of finance directors, who have reported that delayed transfers of care have been a problem since we started asking them about their main concerns for their organisation.

Figure 31: Delayed transfers: Average number of patients delayed per day each month



Data source: Acute and non-acute delayed transfers of care, patient snapshot, 2014/15 www.england.nhs.uk.

Figure 32: Delayed transfers: Total number of days delayed each month



Data source: Acute and non-acute delayed transfers of care, total delayed days, 2014/15 www.england.nhs.uk.

7. References

- NHS England (2014c). *Referral-to-treatment waiting times statistics*. London: NHSE. Available at: www.england.nhs.uk (accessed on 21 October 2014).

About the QMR

What is The King's Fund's quarterly monitoring report?

Our quarterly monitoring report (QMR) reveals the views of NHS trust finance directors and clinical commissioning group finance leads on the productivity challenges they face, and examines some key performance data for the NHS in England.

It provides a regular update on how the NHS is coping as it grapples with the evolving reform agenda and the more significant challenge of making radical improvements in productivity.

What is different about the digital QMR?

Our first nine issues were produced as longer PDF documents and can be found on The King's Fund website at kingsfund.org.uk/qmrproject. The new QMR features digital versions of the survey results and interactive performance data charts showing the key findings for this quarter.

Where does the data come from?

The quarterly monitoring report combines publicly available data on selected NHS performance measures with views from NHS trust finance directors and clinical commissioning group finance leads. These views are collated through a survey run by The King's Fund data team.

Making the most of the digital QMR

- **Filtering the survey by respondents**

  Filter the survey results by respondent group (financial directors of NHS trusts, financial directors of clinical commissioning groups, and financial directors in social care in applicable quarters) by clicking them on or off at the top of the survey page.

- **Comments from survey respondents**

  Read selected comments from the survey respondents by clicking on the speech bubble

- **Survey charts**

  The area of the bubble in the survey charts represents the value shown. The sizes of the bubbles are comparable between the charts.

- **Sharing and saving charts**

  Share charts on social media sites by clicking on the share logo
  You can also download the charts as images by clicking on the save logo

- **Changing the date range of the NHS performance data charts**

  See the data in a different date range by moving the sliders on the x-axis.

- **Printing the QMR**

  Print the report by clicking on the print icon