



How is the health and social care system performing?

Quarterly monitoring report

June 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 eighth report and aims to take stock of what has happened over the past year and assess the state of the health and care system 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 finance directors (see box below). To obtain a local authority perspective on care services and the financial pressures currently facing local authorities, we have drawn on the annual survey of social care budgets carried out by the Association of Directors of Adult Social Services (ADASS). This is based on responses from 145 of the 152 local authorities with adult social care responsibilities.

NHS FINANCE DIRECTORS' SURVEY

This quarter we carried out an online survey for finance directors between 16 April 2013 and 29 April 2013. One hundred and thirty-six finance directors were contacted to take part and 51 were available to give their views (a response

rate of around 38 per cent). Around 51 per cent of the finance directors who responded work in acute or combined acute and community trusts. Others work in mental health, ambulance and specialist trusts.

Overview

HEADLINES

- A clear message from this quarter's survey of NHS finance directors is their concern about the performance of accident and emergency (A&E) departments - particularly on the four-hour maximum wait target.
- The survey also shows that virtually all organisations will have ended the last financial year in surplus. However, around a third achieved less on their savings programmes than planned. Nearly two-thirds were either very concerned, fairly concerned or uncertain about achieving this year's savings targets - averaging 5 per cent of their organisation's turnover.
- As in last quarter's survey, there is general pessimism that the NHS as a whole will meet its £20 billion productivity target by 2014/15; 94 per cent thought there was a 50/50 chance of failure or worse on this programme.
- Pessimism about the financial state of local health and care economies over the next year is worse than a year ago. Now, only 8 per cent of finance directors report any degree of optimism about the coming year compared to 25 per cent a year ago. Two-thirds remain fairly or very pessimistic.
- Prospects for adult social care are bleak. Councils are planning to reduce their budgets by another £800 million this year, a cumulative cut of 20 per cent since 2010. Nearly a third of directors of adult social services think this will place more pressure on the NHS, and more than half think it will place care providers in financial difficulty.
- The disruptive impact of the government's reforms to the NHS over the past year is clearly reflected in the views of finance directors: just 3 thought there had been a positive impact compared to 35 (out of 51) who felt there had been a negative impact.
- The concern expressed by finance directors over the performance of accident and emergency departments is reflected in the latest quarter's waiting times figures: between January and the end of March this year the target

that no more than 5 per cent of patients should wait more than four hours was exceeded nationally, with 5.9 per cent waiting more than four hours. This is equivalent to more than 313,000 patients - the highest proportion since the last quarter of 2003/4 - with nearly four out of ten trusts reporting breaches. Weekly data for the end of April and the first weeks of May show some recovery in performance.

- 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 major A&E departments - which reached nearly 7 per cent in the last quarter and, again, was the highest proportion since 2003/4. However, in the three weeks to 12 May, the proportion of 'trolley waits' has started to fall, almost back to the low of August last year.
- Median waiting times for inpatients, outpatients, patients still on waiting lists, and diagnostics all remain steady within the usual fluctuations from month to month.
- Similarly, referral-to-treatment time waits remain within current targets nationally, although the six-week maximum wait for diagnostic tests was fractionally breached in March and in five out of the past twelve months.
- On the basis of official statistics, the number of delayed transfers of care across England remains steady at around 4,000 per day - more or less unchanging since December 2010. As we noted in our previous report, this trend seems at odds with ad hoc local reports of problems with delayed transfers and merits further investigation of the usefulness of the definitions used for delays for official purposes.

Summary

NHS funding over the past financial year (2012/13) has remained virtually flat in real terms – although for parts of the service, such as secondary care, financial pressures have been tougher as a result of continued downward pressure on payment tariffs. Local government too faces a continued parsimonious financial environment as a result of the government’s deficit reduction strategy.

Our latest survey of 51 finance directors in NHS provider organisations reports optimism about the financial outturn for 2012/13 with the vast majority reporting a surplus. For some organisations, however, surpluses have arisen from handouts from local purchasers either as late winter monies or to prevent primary care trust (PCT) surpluses being lost to local health economies. We need to wait for final accounts to be completed to see the size of surpluses across the NHS and must remember that surpluses are needed to fund future service developments.

The NHS in England is now at the halfway stage of the so-called Nicholson Challenge, which is designed to generate extra productivity improvements in terms of freeing cash for reinvestment and improvements in service quality of around £20 billion over the four years to 2014/15 to compensate for little or no real increase in funding. This translates into a target of around 5 per cent of turnover per year on average, and although our survey suggests that the bulk of the 4.9 per cent target last year was achieved, the majority of finance directors expressed a high degree of uncertainty or concern in achieving the current financial year’s target (averaging 5 per cent).

Concern locally is also reflected in views about the risk of failure for the NHS as a whole in achieving its global productivity plans by 2014/15. Thirty-one out of 51 finance directors thought there was a very high or high risk of failure and 18 that there was a 50/50 risk. Only two thought there was little risk of failure. Nevertheless, in the face of the 2010 Spending Review settlement and a likely continuation of near-zero real funding growth there seems little option other than to pursue ways to extract greater value and health benefits for patients per pound.

So far, a large proportion of the savings delivered have been the result of an ongoing pay freeze for staff, reductions in prices paid to hospitals and cuts in management costs. With these savings increasingly difficult to sustain, further productivity improvements will become harder to deliver. This is compounded by the need to maintain staffing levels following the shocking failures of care highlighted by the Francis report. With staff costs making up the bulk of the NHS budget, this will leave little room for manoeuvre -

significant changes to services will be required if the NHS is to meet its target of delivering £20 billion in efficiency savings.

The challenge is to make progress with service changes when organisational changes have, so far, proved more of an obstacle than a facilitator; 35 out of 51 finance directors think the changes arising from the government's reform programme have had a negative impact on their organisation's performance, while only three think there has been a positive impact.

This assessment of the impact of the reforms coupled with the funding environment will have contributed to the fact that 4 out of 10 directors thought that patient care in their local area had got worse over the previous 12 months. When asked to pick just one immediate concern, 21 directors identified the four-hour maximum A&E waiting times target as their main problem. This concern is reflected in recent official data, not just on the four-hour target, but also the proportion of patients waiting more than four hours to be admitted to a hospital bed from a major A&E department. Both are up in the last quarter (to the end of March 2013), with the former breaking the national 5 per cent target and both reaching levels not seen since 2003/4. Nationally, more than 313,000 patients waited more than four hours in A&E departments in the last quarter, nearly 40 per cent more than the same quarter a year ago. Weekly data in the three weeks up to 12 May (and beyond the quarterly data period) show that performance has improved, with less than 5 per cent waiting longer than four hours in the first weeks of May. However, it remains to be seen if this recovery continues.

While demand for A&E services has risen considerably over the past 15 years or so, nearly all of this is attributable to increasing activity in walk-in centres and minor injuries units, and for the past two and a half years growth has slowed considerably to just over 1 per cent per year (Appleby and Thompson 2013).

The problems in accident and emergency departments have rightly prompted national action to address the issues they pose (NHS England 2013) and builds on the national review of urgent and emergency care being undertaken by Sir Bruce Keogh (NHS Commissioning Board 2013). While the temptation may be to focus on accident and emergency departments in isolation – their organisation, the balance between supply and demand, funding, staffing, etc – understanding the problems manifesting themselves in growing delays in A&E will require a much wider analysis that takes in the rest of the urgent care system and the rest of the secondary care sector, as well as out-of-hospital care (Edwards 2013).

Our survey also found an increasing degree of pessimism about the financial

state of local health economies over the coming year. More than two-thirds of finance directors were either very or fairly pessimistic and just four (8 per cent) were fairly optimistic. From comments we received, in addition to the overarching financial situation, there is also a clear link between these results and concerns about the reorganisation of commissioning following the abolition of PCTs.

The state of local health economies, and in particular health organisations, are also affected, of course, by the funding and activities of local authorities. Our survey of NHS finance directors revealed that 34 out of 51 were affected in some way by the tough funding settlement for their local councils, for the most part in a negative way. Problems were identified with delays in the ability of hospitals to discharge patients, reduced access to social services and, because of funding cuts, less responsive social care services and, in some cases, fewer social care staff. On delays in discharging patients, trends in transfers of care remain broadly flat nationally at around 4,000 cases per day reported by the NHS. However, as we noted in our previous *Quarterly Monitoring Report*, there seems to be some dissonance between official data on delayed transfers and anecdotal evidence from hospitals (Appleby *et al* 2013).

This year's financial survey of directors of adult social services by ADASS confirms problems, with around 28 per cent identifying increased pressure on the NHS as a result of their savings programmes to date, and 36 per cent stating there would be pressures on the NHS over the next two years (ADASS 2013). Local authorities are benefiting from a transfer of funds from the NHS. ADASS noted that this financial year around a third of the £807 million (out of a total of £859 million) allocated to councils in their survey will be used to prevent cuts in services, 14 per cent for demographic pressures and 18 per cent for investment in new services, with the remaining third yet to be allocated. The government's decision to implement the proposals of the Dilnot Commission will not address the longer-term pressures on social care funding (Humphries 2013).

More generally, NHS performance across a range of selected measures again looks broadly good, although, as noted, there are clearly problems emerging in accident and emergency performance.

On the two measures of health care-acquired infection highlighted by this report – *Clostridium difficile* (*C difficile*) and methicillin-resistant *Staphylococcus aureus* (MRSA) – performance has generally flattened in the past few months. Year on year the number of *C difficile* cases is down by nearly 3 per cent and by 19 per cent for MRSA (although numbers are now very low and small fluctuations in absolute numbers of cases can cause big swings in percentage changes).

On the crucial measure of waiting times across the entire referral pathway from GP to hospital, median waiting times nationally remain steady (within usual month-to-month fluctuations) and the referral-to-treatment target waits of a maximum wait of 18 weeks were all met. The only target not reached at a national aggregate level was for diagnostics; in five of the past twelve months (including March this year) more than 1 per cent (the target) of patients waited more than six weeks for diagnostic tests.

NHS finance directors' survey

In part the surplus has been created by CCGs giving us significant sums of unexpected monies very late in the year. The system is broke[n] when investment for winter pressures is handed down in January!

Acute trust

The ability to balance the conflicting demands for cost reductions and investments in response to quality concerns following the Francis report has the potential to place trust finances under severe strain.

Acute foundation trust

[The surplus is...] Purely based upon a March handout of PCT surplus above the control total that would have been lost to the local health economy!

Acute foundation trust

This quarter's report is based on an online survey of 51 finance directors. The panel were asked about: the impact of the health reforms on their organisation's performance; the financial situation of their organisation and local health economies over the past financial year; outturns on savings plans; the state of the care in their area; whether their local authorities' funding settlement is affecting them; and their assessment of key current concerns for their organisation.

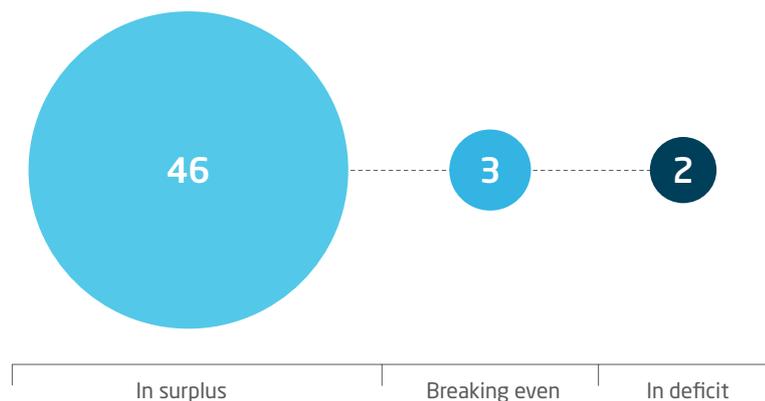
END-OF-YEAR FINANCIAL SITUATION AND COST IMPROVEMENT PROGRAMMES

End-of-year financial balance (2012/13)

In terms of financial balance, the end-of-year situation appears to be a positive one for the second year in a row, with 90 per cent (46) of finance directors reporting a surplus and 6 per cent (3) breaking even (see figure below). Only 2 (4 per cent) out of 51 finance directors cited a deficit. At this point last year, 82 per cent of finance directors reported surpluses at year end, 12 per cent broke even, and 6 per cent reported a deficit.

While most NHS organisations are reporting a surplus for 2012/13, the size of the surplus is as yet unknown and may well be smaller than planned. Moreover, surpluses do not simply represent unspent money, but necessary accumulations required to meet planned future spending on service developments.

What was your organisation's end-of-year (2012/13) financial situation?



However, a number of the reported surpluses had been achieved from either support from non-recurrent funding sources or receipt of historic PCT surpluses or unexpected clinical commissioning group (CCG) surpluses.

We have 'protected' clinical services by using extra income/margin to support the CIP – although the margin should be funding cost of capital. One of the other challenges with the CIP is that CCGs want to take a direct saving from their contract from some of our 'service redesign' CIPs, which we need to deliver to meet our internal 4 per cent efficiency, arising from pay and price inflation, cost pressure and the negative tariff. We can't make the savings twice.

**Mental health
foundation trust**

Cost improvement programmes and the £20 billion productivity challenge

2012/13 was the second full year of the £20 billion productivity challenge for the NHS. So how have the NHS organisations in the survey panel fared?

Across the whole panel, the average cost improvement programme (CIP) target for the past financial year (2012/13) was 4.9 per cent, ranging from 3.1 per cent to 7.5 per cent of turnover. The average CIP target for 2011/12 was very similar (5.1 per cent).

Setting targets is one thing but achieving them another. From the panel, nearly half (24) achieved their planned CIP target in 2012/13, similar to the proportion achieving their CIP target the previous year (2011/12).

Among the 21 (42 per cent) who did not meet their target for 2012/13, the average shortfall was -0.8 per cent, ranging from -2 per cent to -0.1 per cent. A similar proportion missed their targets at the end of the 2011/12 year, but the average shortfall at this time last year was -1.1 per cent.

Six organisations (10 per cent) over-achieved their target and ended the financial year with an average of 0.3 per cent more than planned, ranging from 0.5 per cent to 0.1 per cent.

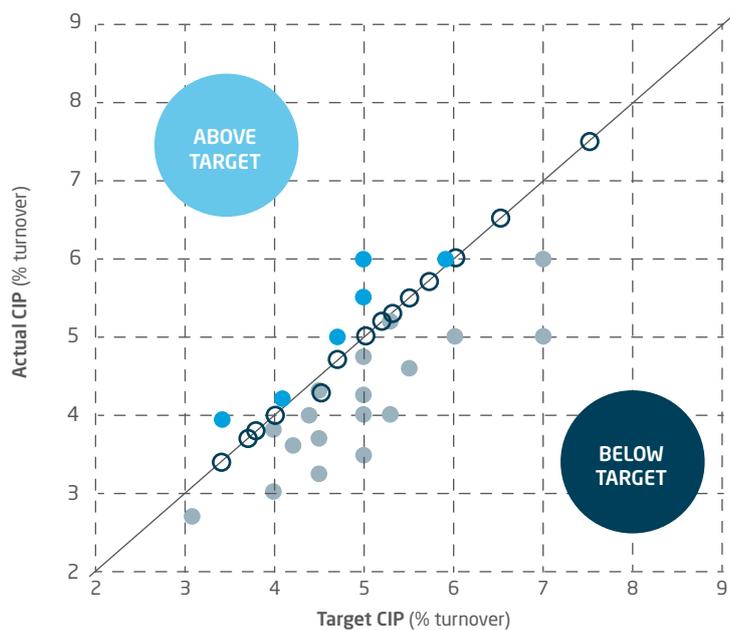
The comparisons between organisations' *target* and *achieved* CIP for 2012/13 are set out in the figure overleaf.

Across all organisations, on average, CIPs achieved amounted to 4.6 per cent of turnover compared with an average plan of 4.9 per cent – a shortfall of 0.3 per cent. The shortfall in 2011/12 was of a similar magnitude, with an average CIP achievement of 4.7 per cent of turnover compared with an average plan of 5.1 per cent.

We hit the plan we had agreed with Monitor. However it was achieved by additional work generating surpluses rather than achieving our CIP target.

Specialist acute trust

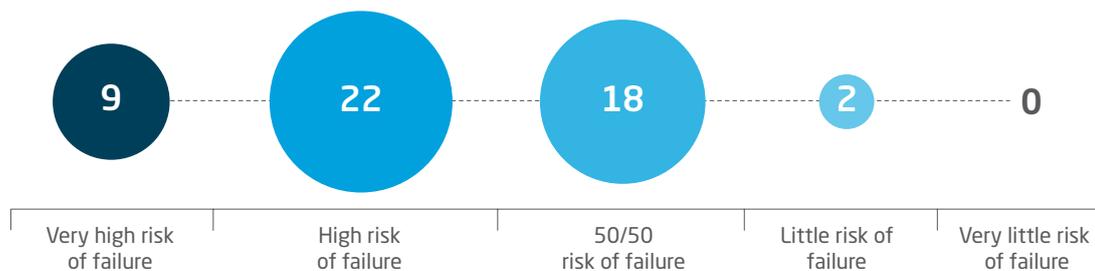
Comparison of CIP targets and actual CIP achieved in 2012/13



The Department of Health has reported that between April and December 2012, 72 per cent of planned savings across the whole NHS system had been achieved, leaving slightly more than a quarter of the planned savings of £5.1 billion to be made in the last quarter of the year (Flory 2013). It remains to be seen to what extent the contribution of the NHS front line to this plan will be achieved for 2012/13.

The panel were also asked to estimate the risk involved in achieving the £20 billion Nicholson Challenge productivity drive by 2014/15 (see figure below). The panel almost exclusively rated the level of risk involved in achieving the productivity challenge at 50 per cent or above, ie, most respondents thought the NHS is likely to fail to achieve £20 billion of productivity savings by 2014/15. A similar proportion of finance directors this quarter as in our last survey in February – around six out of ten – believe there is a very high or high risk of failure.

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



The panel made a number of comments about their experiences of working within the context of the Nicholson Challenge, and these provide a somewhat depressing picture (see box below).

SELECTION OF COMMENTS ABOUT THE RISK INVOLVED IN ACHIEVING THE £20 BILLION NICHOLSON CHALLENGE BY 2014/15.

Savings to date have been largely achieved through pay restraint at a national level. As the political will for this approach diminishes, a greater emphasis will be placed on service transformation which takes much longer to achieve and is less likely to deliver the savings needed.

Mental health foundation trust

To be honest, the bulk of the 'savings' were achieved through the two-year pay freeze. The next element of saving is, let's be frank, capacity/service reductions. The NAO [National Audit Office] report to the PAC [Public Accounts Committee] was spot on! NHS is a pay-based system and around £75 billion of the £100 billion is spent on pay, pensions and taxation. There isn't £10 billion of savings to be had in miserly control over paperclips and sterile wipes.

Mental health foundation trust

At the highest political level the NHS currently appears to be in denial; at the operational level (including CCGs) I see a realisation that real-terms cuts to services are the next stage.

Ambulance trust

There have been no real service changes or service reconfigurations. The chances of this happening recede as we get closer to 2015 election.

Acute trust

Most areas of trust operation have plans formulated that will deliver the required savings although increases in patient referrals and activity are resulting in some plans being reviewed in terms of scope and timescale.

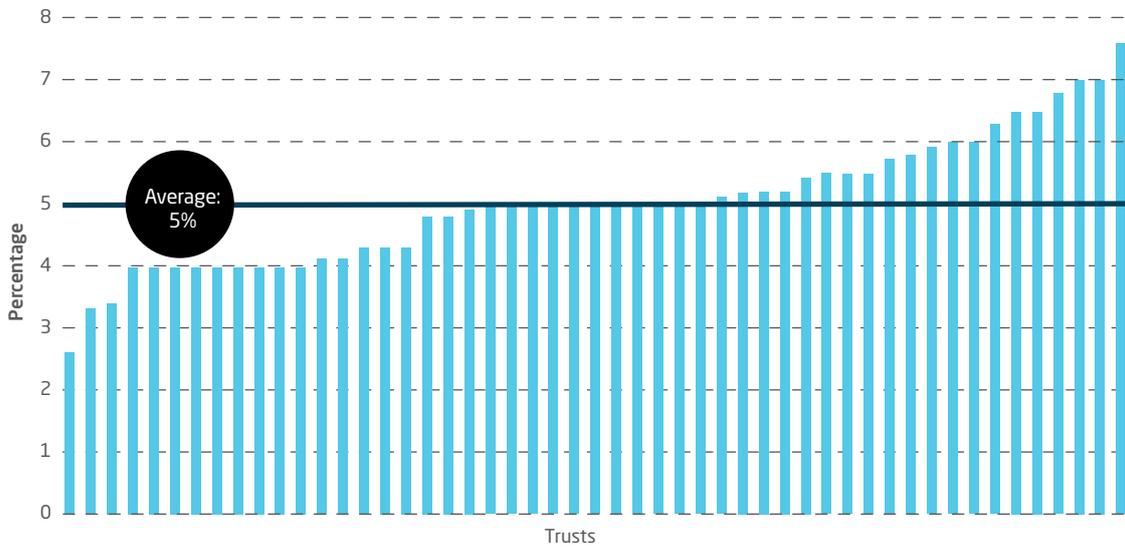
Mental health foundation trust

It seems clear that the next two years are going to be much tougher when it comes to stretching the NHS budget to meet the demands for service change to meet growing health care needs.

Looking forward: savings in 2013/14

Organisations are again setting challenging CIPs for 2013/14, averaging 5 per cent (see figure overleaf). Previous years' efficiency savings have benefited from the public sector pay freeze, a number of one-off savings in centrally held budgets and local gains made in 'quick win' areas (National Audit Office 2012). Maintaining the momentum over 2013/14 will become increasingly difficult as these options are exhausted and efficiencies need to be found from other areas of organisations' business.

What is your organisation's cost improvement programme (CIP) target for 2013/14 as a percentage of turnover?



THE STATE OF PATIENT CARE

Increases in emergency activity have led to practices such as nursing patients in corridors... It is not accepted at our hospital and should not be accepted but because of pressures [it] has become accepted practice in some areas.

Acute trust

Meeting cost improvement targets and ensuring financial balance remain absolutely 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.

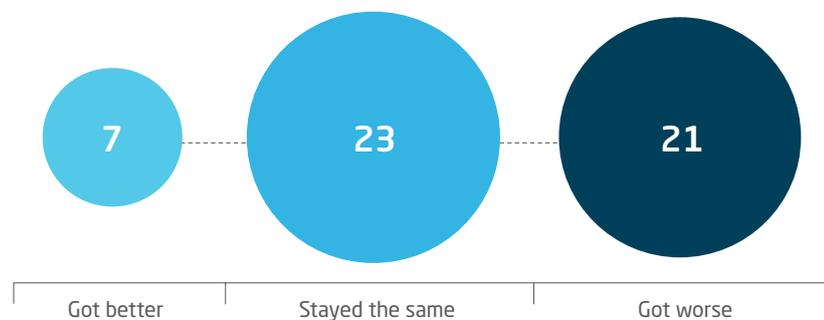
When asked about the state of patient care in their area, 30 finance directors (59 per cent) expressed the view that it had got better or stayed the same over the past 12 months. Twenty-one (41 per cent) stated it had got worse (see figure below). Compared to the previous quarter, there has been an increase in the number of finance directors who think the state of patient care is getting worse; in February's report 33 per cent said that patient care had got worse in the previous 12 months.

NB. Comparisons between our surveys do need to be treated with caution as the respondents vary from survey to survey (the overlap between this and the last survey is around 53 per cent).

Emergency demand has increased significantly, especially in the last quarter. We have the highest ever level of emergency admissions, which impacts on our ability to deliver elective waiting time targets as well as A&E and other emergency care targets. The commissioners are powerless in addressing this and the acute sector bears the brunt of the pressure, not only via the 30 per cent tariff rate but also financial penalties when performance is not delivered.

Acute trust

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



This is a significant rise in pessimism, coinciding with the end of the extended winter period in which demand on health care services has been higher than during other seasons of the previous year and with the reorganisation taking place in the run-up to the launch of the 'new system' in April.

It is clear from additional comments we have received from finance directors that increased demand in emergency activity has exceeded capacity in a number of organisations, and this is leading to inconsistencies in the quality of care delivered to patients.

ORGANISATIONAL CHALLENGES

Levels of demand for community mental health and inpatient services... We are knee-deep in a recession with no upturn in sight. All the evidence confirms that society's mental health tracks the economy's health... Meanwhile, we have CCGs saying, 'You have too many beds and send everyone to IAPT service', which in some areas are woefully under-funded and non-compliant with NICE standards.

Mental health foundation trust

Virtually every hospital in our region is handling a significantly more difficult winter than it was 12 months ago, this has to impact on quality. Just look at the numbers of 12-hour 'trolley waits' across the country.

Acute trust

Finance directors also cited organisational changes and the impacts of the new structures arising from the abolition of strategic health authorities and primary care trusts as factors contributing to the delivery of poorer patient care.

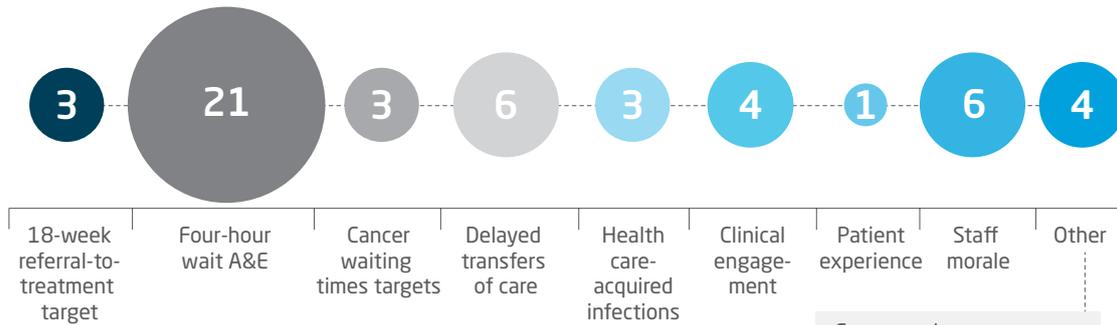
The scale of the current system reform, overlaid on an unprecedentedly parsimonious financial settlement and the associated and equally unprecedented productivity target, continues to present a particularly challenging environment for NHS organisations.

To understand how this was affecting them, finance directors were asked to state just one aspect of their organisation's performance that was giving them most concern. In contrast to the responses given in the last quarter, where no one particular issue dominated, this time meeting the four-hour A&E department waiting time target appeared as the clear top concern (21 out of 51 finance directors (41 per cent)). This reflects a complicated set of circumstances, not just the organisation and funding of A&E departments, but pressures on, for example, the ability to discharge patients elsewhere within hospitals as well as a slow but steady increase in demand over the past two to three years. We have explored some of the issues and statistics associated with the urgent care system in recent publications (for example, Appleby and Thompson 2013; Edwards 2013).

Accident and emergency performance, such as increasing problems with meeting the four-hour maximum waiting time target and a rising proportion of 'trolley waits' (see p 29), has spurred a national response from NHS England with an announcement on 9 May of an A&E improvement plan (NHS England 2013) to tackle the deterioration in waiting times – a problem it candidly admits it does not fully understand. Understanding the factors causing current problems will be a vital first step in tackling the issue.

Delayed transfers of care and staff morale were also cited as issues concerning finance directors about their organisation's performance.

Which single aspect of your organisation's performance is giving you concern at the moment?



We have had a stable PCT to CCG transition but the impacts of NHSE [NHS England] and LA [local authority] commissioning are just beginning to impact. Currently this feels very negative. Fragmentation feels dangerous.

Acute foundation trust

It's all very depressing... Confusion reigns with too many senior staff moves, CCGs getting 'gung-ho', CSUs [commissioning support units] in a flap, struggling to act commercially and to meet CCG customer needs. Area teams seem to be adopting old-style SHA, bully tactics... What an expensive mess... Attention to high-quality care seems to be the last thing anyone in CCG/CSU land has any time for. Providers are holding it all together, delivering care, day in and day out.

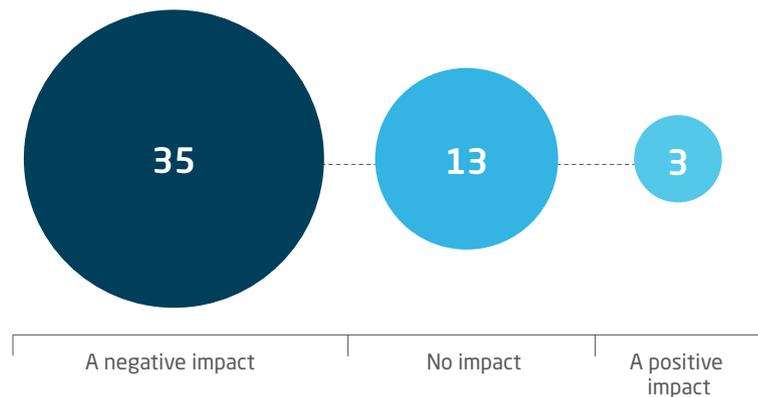
Mental health foundation trust

For example:
levels of demand
ambulance response times
111 implementation

Impact of the NHS reforms on organisational performance

The panel were asked to assess the impact the changes brought in as a result of the Health and Social Care Act have had on their organisation's performance. Slightly more than two-thirds of respondents (35) thought that the reforms had had a negative impact on performance; only three (6 per cent) finance directors cited positive changes to their organisations resulting from the reforms (see figure below). Slightly less than a third of respondents (13) thought the changes taking place in the NHS had had no impact on how their organisation was performing.

Reflecting on the past year, do you think the changes in the NHS have had an impact on your organisation's performance?



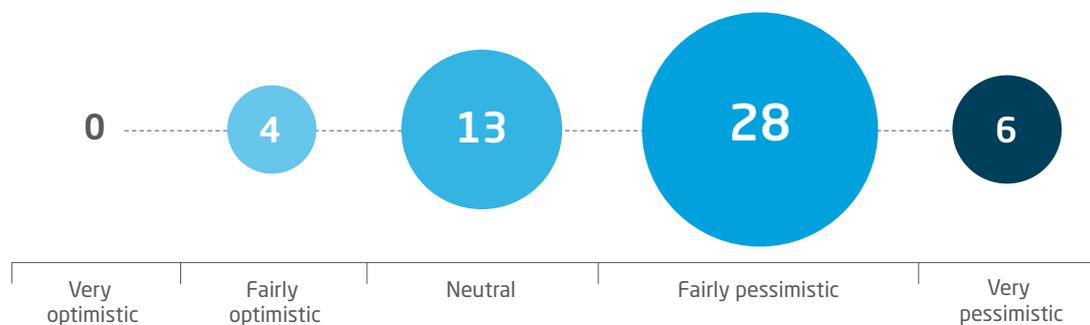
The ability to generate savings by doing more for less is wearing thin given the level of demand, coupled with the financial penalty regime for poor performance and the rigidity in which this is applied.

Acute trust

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, around two-thirds (34) were fairly or very pessimistic (see figure below). This picture is exactly the same as it was for the previous quarter. Interestingly, there was less pessimism at this time last year, when a smaller proportion, 53 per cent, of the panel were fairly or very pessimistic. Similarly, at the end of 2012/13, only 8 per cent of finance directors surveyed were fairly optimistic about the year ahead (none were very optimistic), whereas at the end of 2011/12, 23 per cent reported some degree of optimism.

Overall, how do you feel about the financial state of the whole health and care economy in your area over the next 12 months?



The reasons for pessimism given this time appear to relate in part to the changes to the re-organisation of commissioning at both the local and the national level and, inevitably, funding. A number of reflections from finance directors on these issues are captured in the box below.

FEELINGS ABOUT THE OVERALL STATE OF THE HEALTH AND CARE ECONOMY OVER THE NEXT 12 MONTHS

With 2.6 per cent uplifts for CCGs we should be able to manage. Unfortunately, the system has taken a lot of that from CCGs and I fear for their sustainability. The money of course is sitting somewhere else in the system and we'll no doubt have another mad quarter 4 when money is thrown at the system in a haphazard way.

Acute trust (fairly pessimistic)

The local CCGs have lost allocation heavily (under a skewed formula) to NHS England for specialist care. In localities with a heavy specialist hospital presence CCGs have gained at the expense of CCGs in the provinces. This gives local CCGs a major affordability problem.

Acute foundation trust (very pessimistic)

New structures will delay change for a period. The split of services into specialist commissioning looks odd. I can understand that as a tertiary hospital; close to

50 per cent of our clinical income will now move to specialist (from less than 10 per cent just over a year ago). But when I was told that our local community provider trust will see its contract value split such that more is specialist-commissioned than local CCG-commissioned I do wonder what this might mean for transformation and integration, but the signs are not good I fear.

Acute foundation trust (fairly pessimistic)

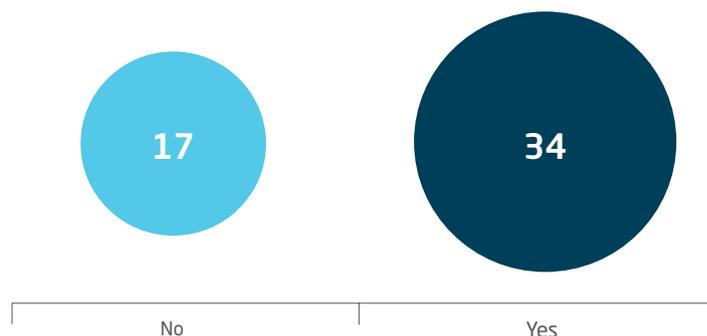
...we expect significant effects from the local authorities' need to cut back on social services, reduce housing benefit payments, the benefit cap, coupled with rising local unemployment (worsened through public sector job losses). We are working with local authority partners to assess the impact both on them and the mental health services we provide at the trust.

Mental health and social care foundation trust

Impacts of local authority funding settlements/spending

As in our last quarter's survey, we asked NHS finance directors 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 (34) said there had been an impact on their organisation. This figure is up from slightly more than half of respondents who reported an impact in the previous quarter.

Has there been any impact on your trust of your local authorities' funding settlement/spending so far this financial year?



The main negative impacts cited were:

- delayed discharges and reports of delayed transfers
- reduced access to social care services
- local authority funding cuts, leading to less responsive social care services in some cases, and less social care staff in others.

One director was uncertain about the impact, stating that their organisation was grappling with the potential implications of the Section 75 legislation. Another cited positive improvements in collaborative working across the local authority and NHS, which was leading to 'smarter' responses to care needs.

Further comments and issues are summarised in the box below.

If it was in the private sector our local authority would be in financial administration, and this has further exacerbated the pressures on the NHS with providers increasingly squeezed and blamed for the problems.

Specialist acute trust

Delayed discharges and transfers

- Around 40 per cent increase in delayed discharges.
- Major increase in delayed discharges at critical times in January to April, resulting in very high occupancy, cancelled elective surgery and poor A&E performance at times due to bed availability for admitting promptly.
- There are increasing signs of displacement of patients who previously received care in local care homes; bed blocking is on the rise.

Reduced access to services

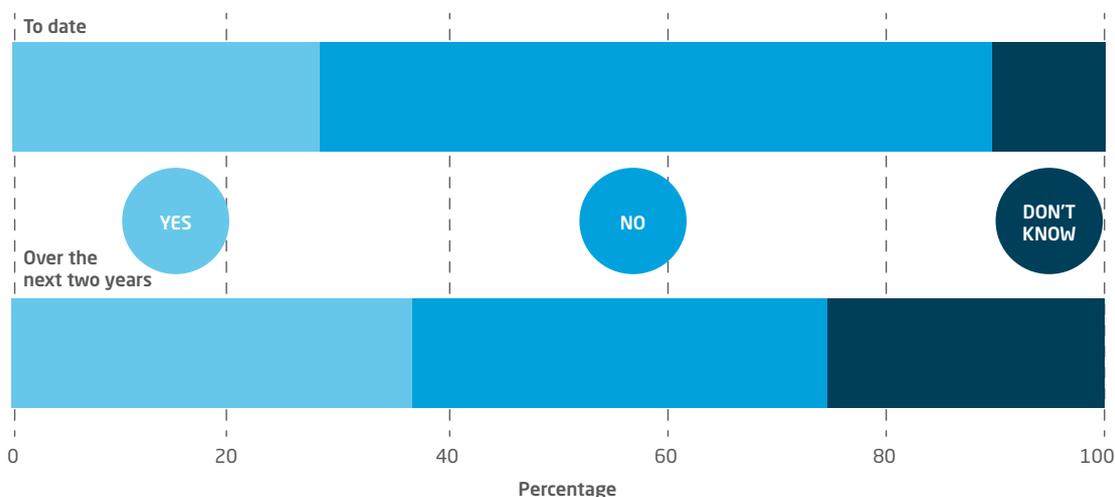
- Increased difficulty in accessing social services packages of care.
- Reduction in adult social care beds.

Local authority funding cuts

- Significant reductions in social care expenditure of about 25 per cent.
- The local children’s mental health services funding was cut by 25 per cent.
- There have been reductions in former grant funding for services as local authorities reduce investment in health.
- Although managed this year there is an increasing diversion of NHS spend of local authorities either through direct funding transfer or cost shunt.
- More evidence of cost shunting, social services becoming less responsive.
- Reductions in spend on commissioning services for people with learning difficulties and social care/input to key support services has impacted upon the trust and the people who use our services.
- The local authority was unable to flex social care capacity for winter pressures without funding support from the NHS. The position is worse in 2013/14.
- We saw significant reductions in social work posts – piling pressure back onto NHS.

A concurrent survey by the Association of Directors of Adult Social Services (ADASS) also reveals the impact of local authority savings programmes on the NHS, with increasing numbers of directors of adult social services stating that the NHS will be under pressure over the next two years (see figure below).

Directors of adult social services: ‘As a result of the savings you have made, is it true that there is increased pressure on the NHS?’



Source: Association of Directors of Adult Social Services (2013)

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.

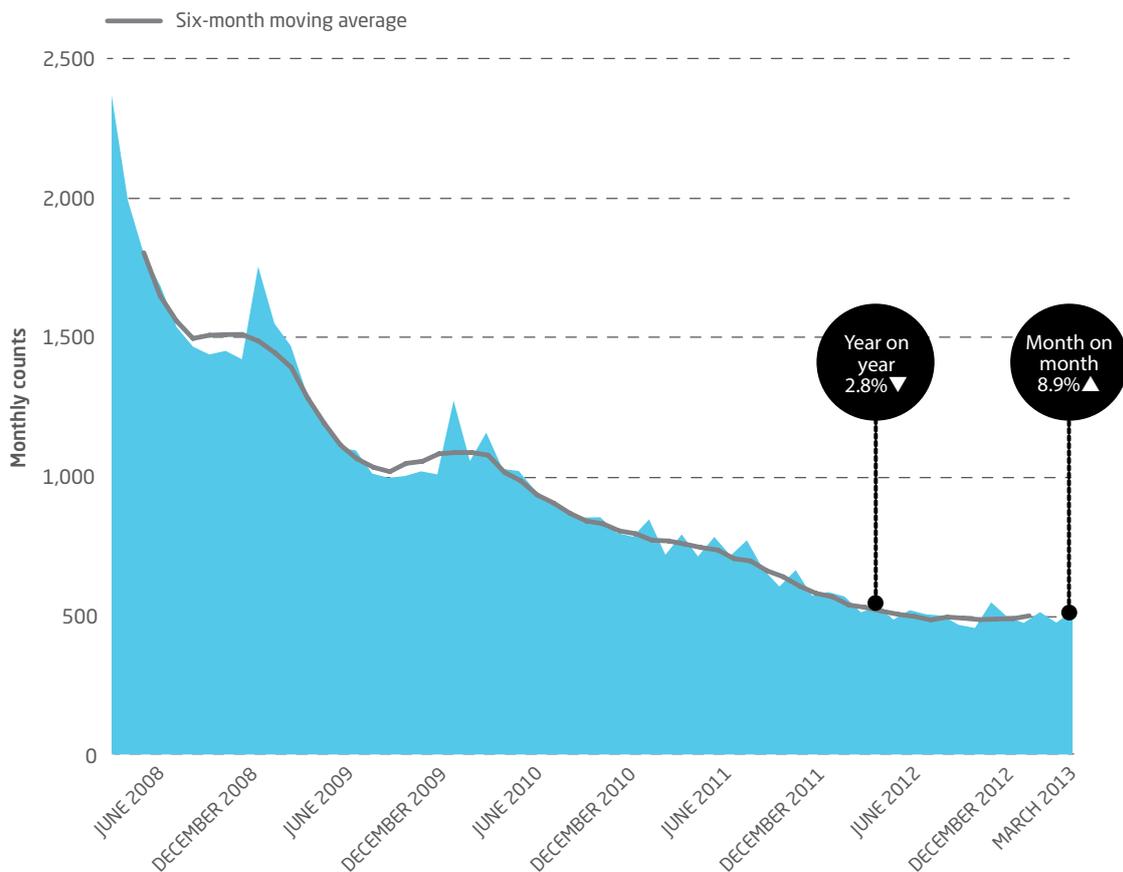
Health care-acquired infections

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.

C DIFFICILE

Monthly counts of *C difficile* infection have fallen substantially since April 2008 – from more than 2,350 cases per month to 516 in March 2013. Counts for March 2013 show an increase on the previous month of nearly 9 per cent and a drop year on year of 2.8 per cent.

The 2012/13 NHS Operating Framework (Department of Health 2011) set an objective annual reduction in *C difficile* cases of 26 per cent (measured as April to March 2012/2013 compared with October to September 2010/11). The NHS managed to reduce numbers of *C difficile* by 34 per cent, easily meeting the national objective.

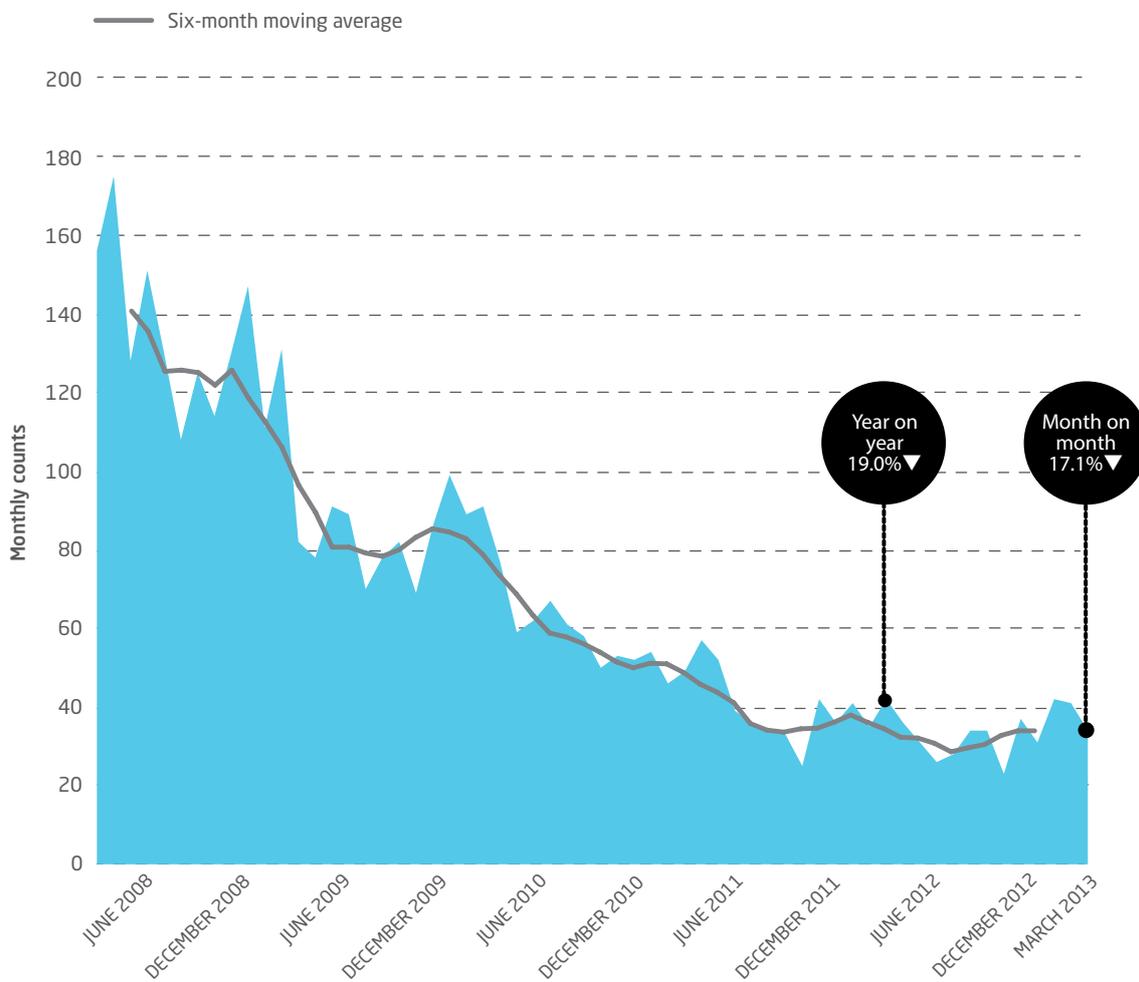


Data source: Trust-apportioned monthly counts of *C difficile* infection
www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510678961

MRSA

The general trend in the numbers of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) infection has been falling over the past three years. The count of 34 in March 2013 was 19 per cent less than a year previously and a fall of more than 17 per cent month on month. Current annual rates of MRSA are now running at around 397 cases, just around one-quarter of the cases in 2008/9.

The 2012/13 NHS Operating Framework (Department of Health 2011) set an objective annual reduction in MRSA cases of 38 per cent (measured as April to March 2012/13 compared with October to September 2010/11). The reduction of MRSA counts over this period was 28 per cent, thereby missing this national objective.

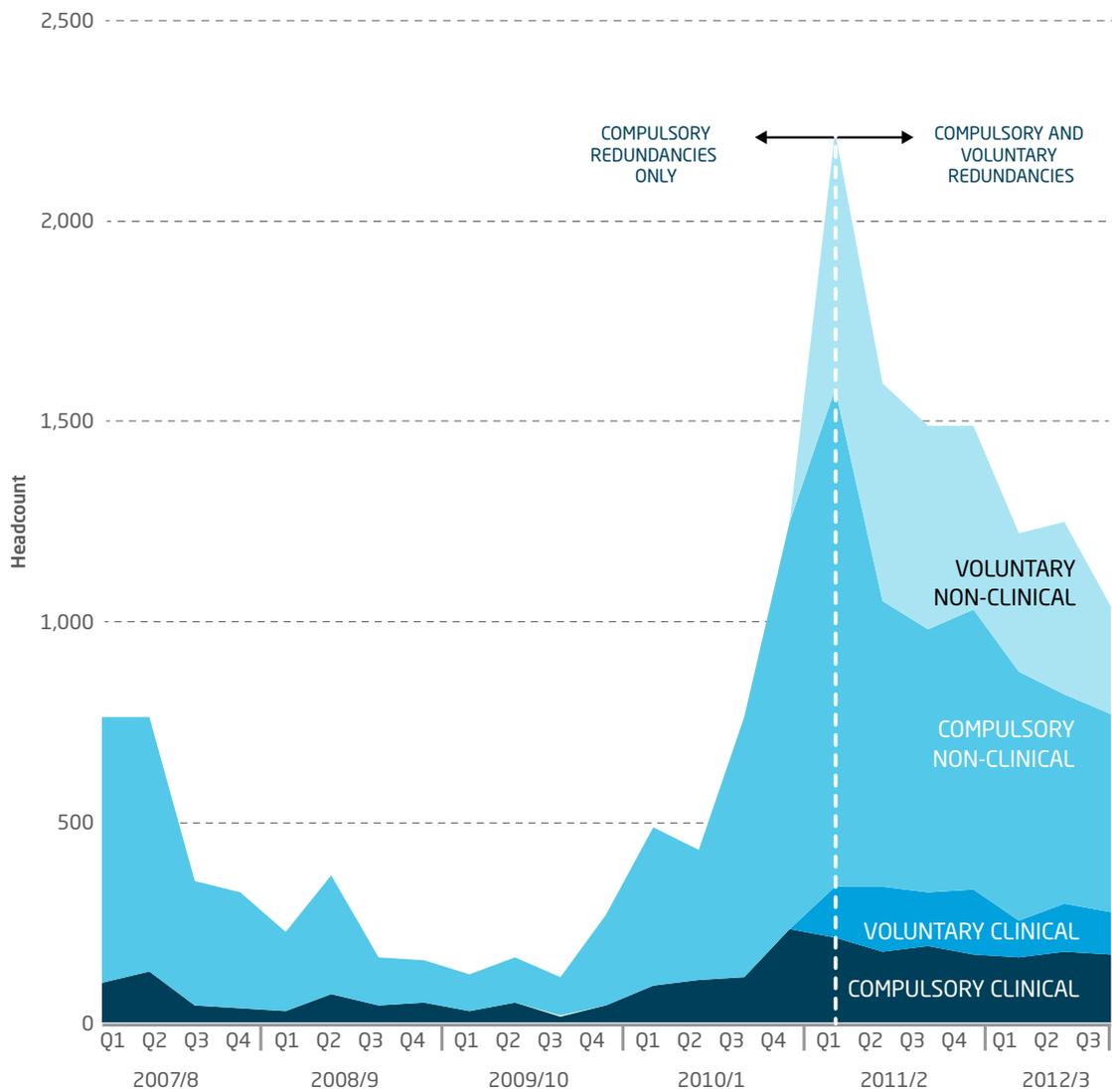


Data source: Monthly counts of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia
www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510675444

Workforce

REDUNDANCIES

The latest NHS redundancy data shows both voluntary and compulsory redundancies. In quarter 3 2012/13 there were a total of 280 clinical redundancies, of which 174 (62 per cent) were compulsory and 106 (38 per cent) voluntary. There were 762 total non-clinical redundancies in the same period, of which 494 (65 per cent) were compulsory and 268 (35 per cent) voluntary. The figures include data from strategic health authorities, primary care trusts, trusts and foundation trusts.



Data source: Quarterly redundancies time series

www.hscic.gov.uk/searchcatalogue?productid=11436&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top

STAFF NUMBERS

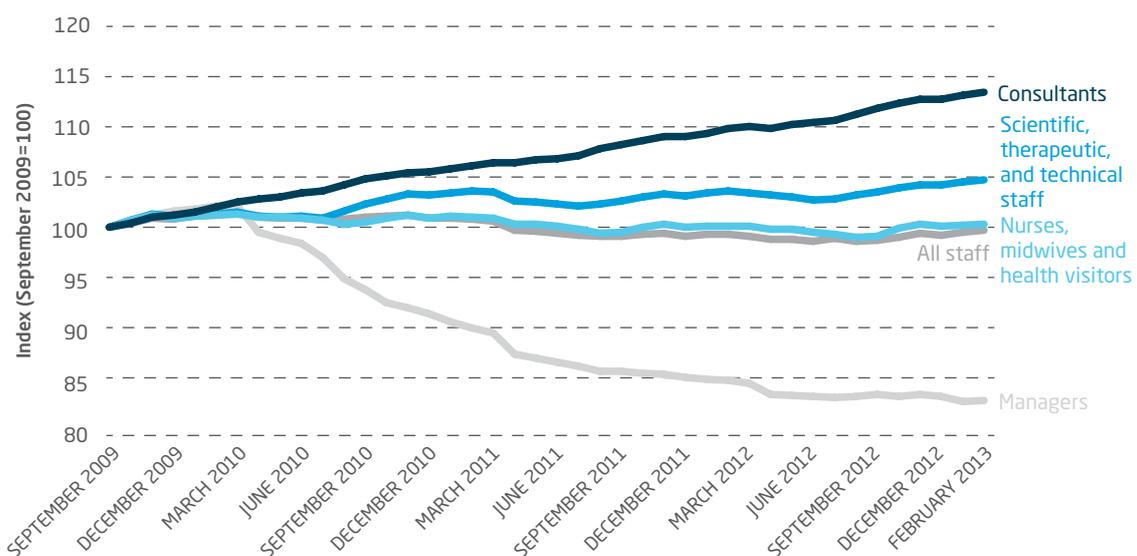
Rates of employment for all staff groups in the NHS decreased by 0.3 per cent between September 2009 and February 2013, a reduction of around 2,350 full-time posts. Changes have varied for different NHS staff groups.

There has been a modest increase of 0.3 per cent in the number of qualified nurses, midwives and health visitors, which is now fractionally above its September 2009 level, but in such a large workforce this still equates to an increase of more than 1,050 posts.

The number of consultants and scientific, therapeutic and technical staff continues to increase. The number of consultant staff has risen continuously since September 2009 – from 34,156 to 38,746 in February 2013, a 13.4 per cent rise over this period. This is likely to be the highest number of consultants the NHS has ever seen and equivalent to a 4 per cent increase per year. The number of scientific, therapeutic and technical staff has increased by more than 6,000 posts since September 2009, an increase of almost 5 per cent.

The impact of the decision 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 is 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 17.2 per cent – from 42,722 to 35,373.

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



Data source: Monthly NHS HCHS workforce statistics in England

www.hscic.gov.uk/searchcatalogue?productid=11436&topics=0%2fWorkforce&sort=Most+recent&size=10&page=1#top

Waiting times

MEDIAN WAITS

Median waits in March 2013 compared to the previous month decreased for inpatients and increased for all other lists. These changes are broadly in line with seasonal variations. Compared to the beginning of the year (April 2012) median waits had increased for inpatients and diagnostics, reduced for outpatients and remained the same for those still waiting.

Overall, trends over the past four years in waiting times for diagnostics, outpatients and inpatients remain generally constant despite fluctuations.



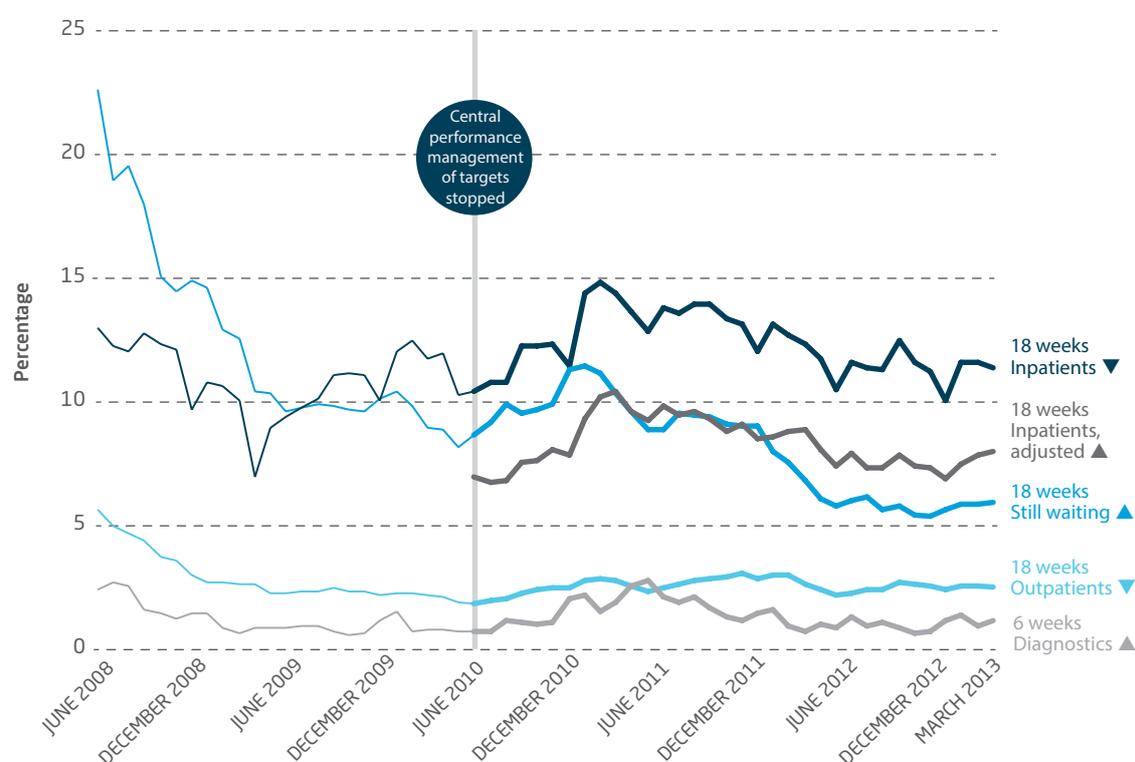
Data sources: Referral-to-treatment waiting times statistics
www.england.nhs.uk/statistics/rtt-waiting-times/
 Diagnostic waiting times statistics
www.england.nhs.uk/statistics/diagnostics-waiting-times-and-activity/

REFERRAL-TO-TREATMENT TARGET WAITS

Compared to the beginning of the year (April 2012) the proportions of patients waiting longer than the operational standards (as defined by the 2012/13 NHS Operating Framework (Department of Health 2011) and NHS Constitution (Department of Health 2012)) have increased slightly for diagnostics and outpatients and reduced for all other waiting lists. Month-on-month changes show increases for diagnostics, inpatients and those still waiting while outpatients has reduced. These changes broadly reflect seasonal variation for this time of the year.

The increase in the proportion of patients waiting longer than six weeks for a diagnostic test has taken this target above its 1 per cent operational standard (1.01 per cent in March 2013). Over the past year the diagnostic waiting times target was breached in 5 out of the 12 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.

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



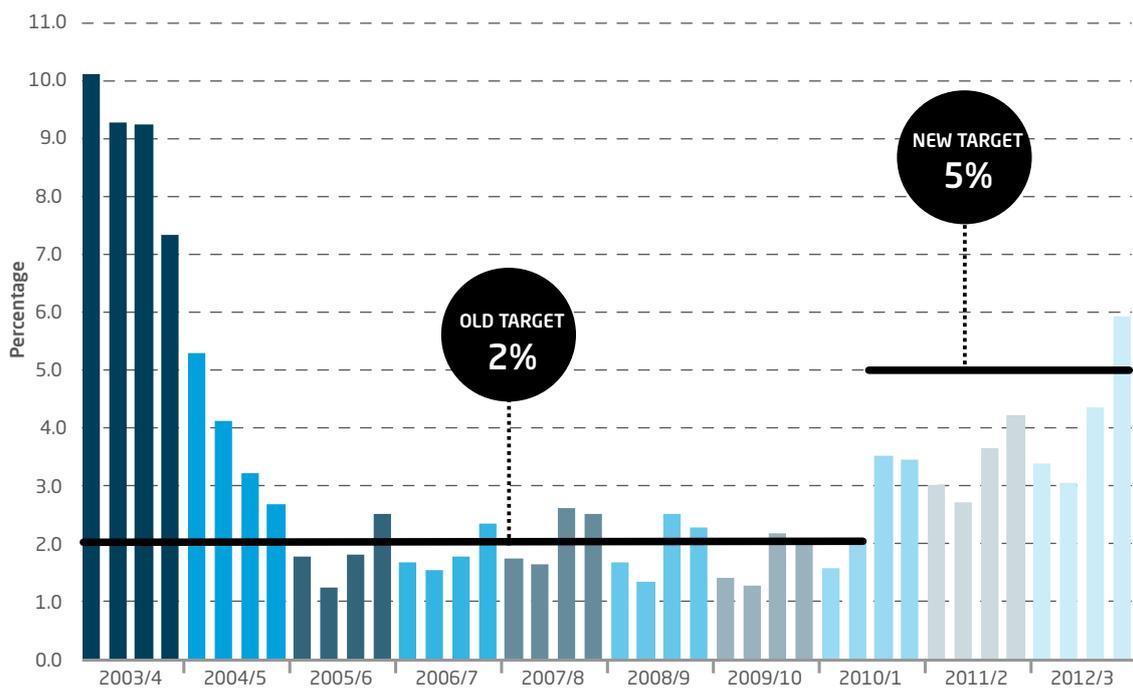
Data sources: Referral-to-treatment waiting times statistics
www.england.nhs.uk/statistics/rtt-waiting-times/
 Diagnostic waiting times statistics
www.england.nhs.uk/statistics/diagnostics-waiting-times-and-activity/

ACCIDENT AND EMERGENCY

The latest data for four-hour A&E waits (quarter 4, 2012/13) shows an increase in the proportion of patients waiting longer than four hours in A&E compared to quarter 3 2012/13. This is in line with previous seasonal patterns. At 5.9 per cent, however, this is outside the 5 per cent target set out in the 2012/13 NHS Operating Framework (Department of Health 2011). It is also the highest proportion since quarter 4 of 2003/4 and confounds the Prime Minister's pledge articulated in a speech in June 2011 that reiterated the government's commitment to keeping waiting times low – including A&E waits (Cameron 2011).

In total more than 313,000 patients waited more than four hours in A&E in quarter 4 of 2012/13 – an increase of 35 per cent over the previous quarter, and a 39 per cent increase over quarter 4 in 2011/12.

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



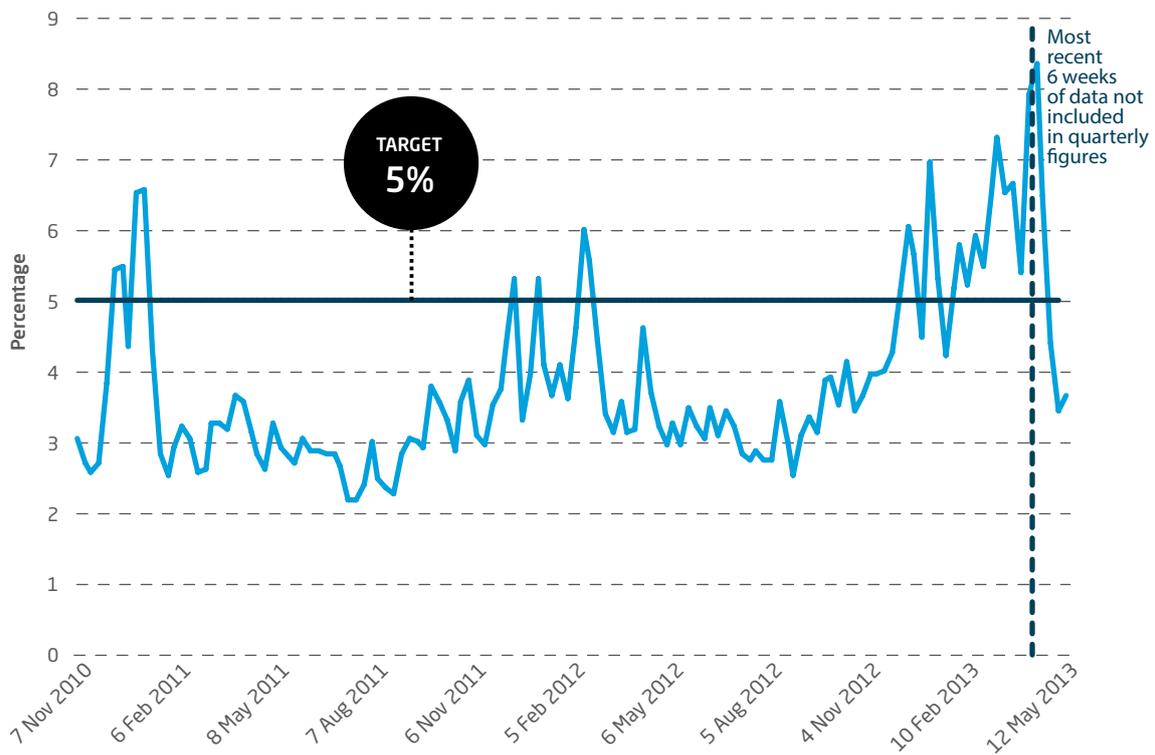
Data source: Weekly A&E SitReps 2012-13

www.england.nhs.uk/statistics/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/

While the quarterly trends go up to the end of March this year, the data for the percentage of patients waiting longer than four hours are published weekly and show that in the six weeks to 12 May there has been some recovery in

the four-hour wait position, with just 3.7 per cent waiting longer than four hours in the week ending 12 May. Whether this recovery continues remains to be seen.

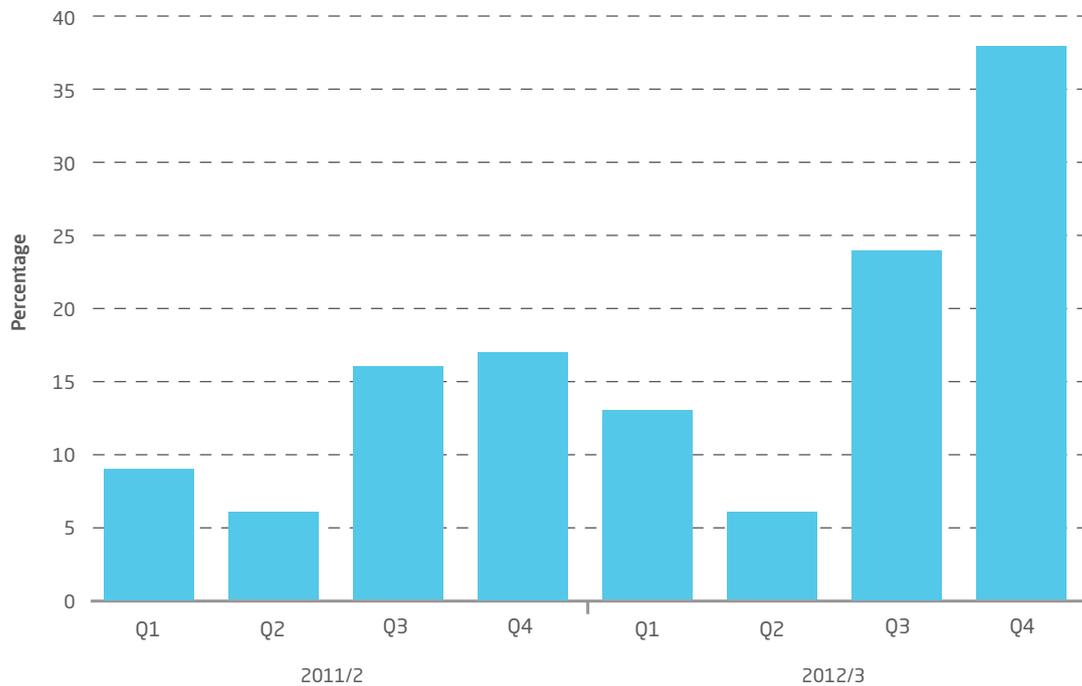
Percentage waiting more than four hours in A&E from arrival to admission, transfer or discharge: Weekly data: November 2010-May 2013



Data source: Weekly A&E SitReps 2013-14
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 4 2012/13, 94 trusts (38 per cent) reported breaches in the proportion of patients waiting longer than the four-hour target. The chart overleaf 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

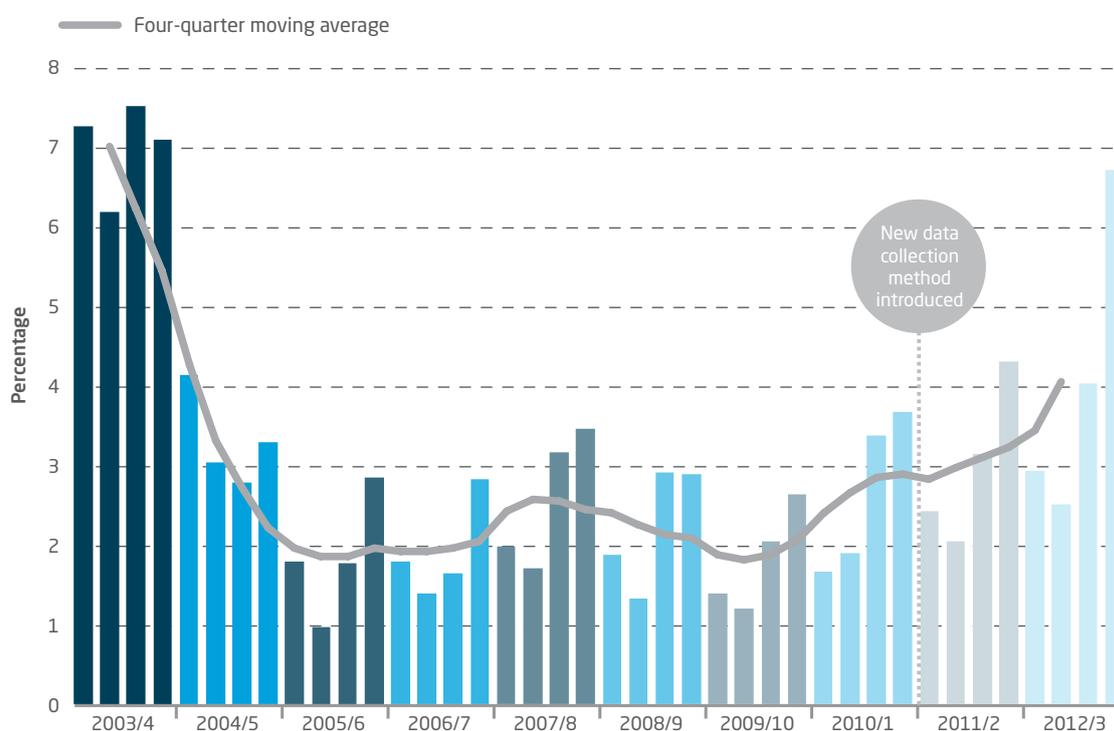


Data source: Weekly A&E SitReps 2012-13
<http://www.england.nhs.uk/statistics/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/>

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 4 2012/13 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 4 figures to show an increase over the previous quarter. However, quarterly fluctuations aside, from quarter 1 2009/10, there is the emergence of an upward trend; the proportion of patients waiting more than four hours for admission has risen from 1.4 per cent in 2009/10 to almost 7 per cent in the latest quarter. This is the highest proportion since quarter 4 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 percentage of patients spending more than four hours in major A&E departments from decision to admit to admission into hospital

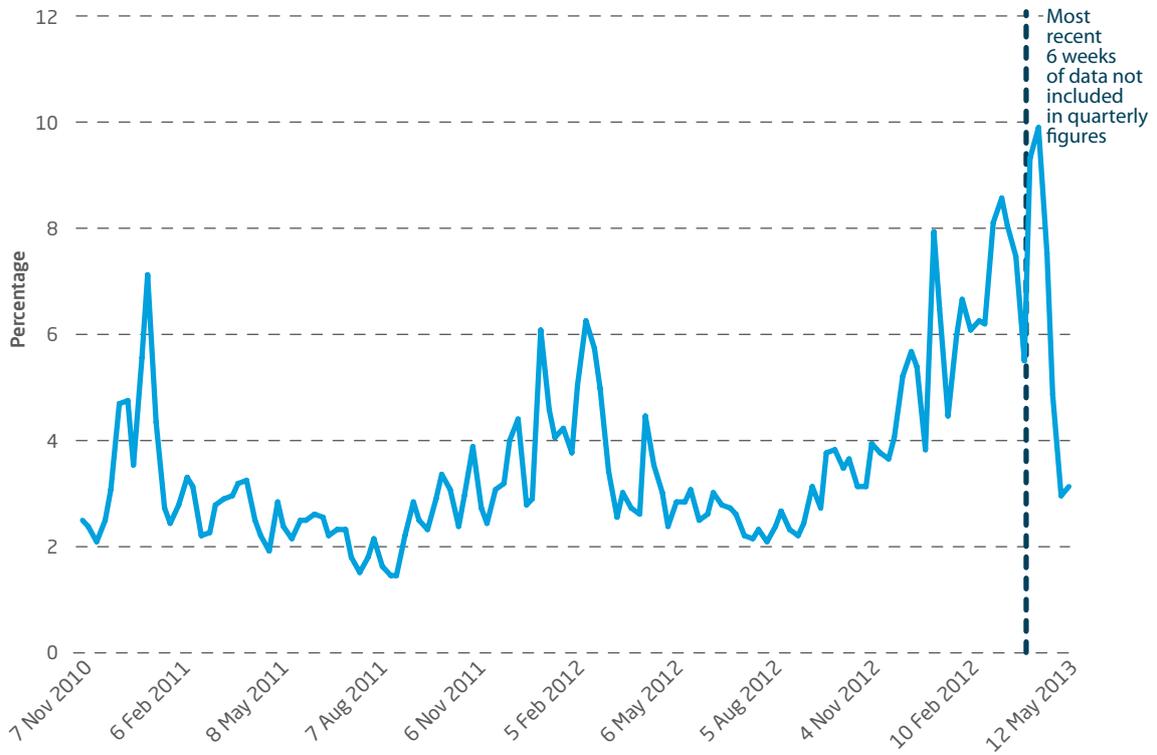


Data source: Weekly A&E SitReps 2012-13
www.england.nhs.uk/statistics/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/

As with the data for patients waiting more than four hours to be seen in A&E departments, weekly data beyond the quarterly data detailed above is available from November 2010 to the week ending 12 May 2013 – an additional six weeks. The figure overleaf shows that the proportion of patients waiting more than four hours to be admitted into a hospital bed from a major accident and emergency department has been on a rising trend since August 2012. However, since the middle of April 2013 it has fallen to just 3.1 per cent – close to the position last summer.

Again, it will be important to monitor whether this fall is sustained.

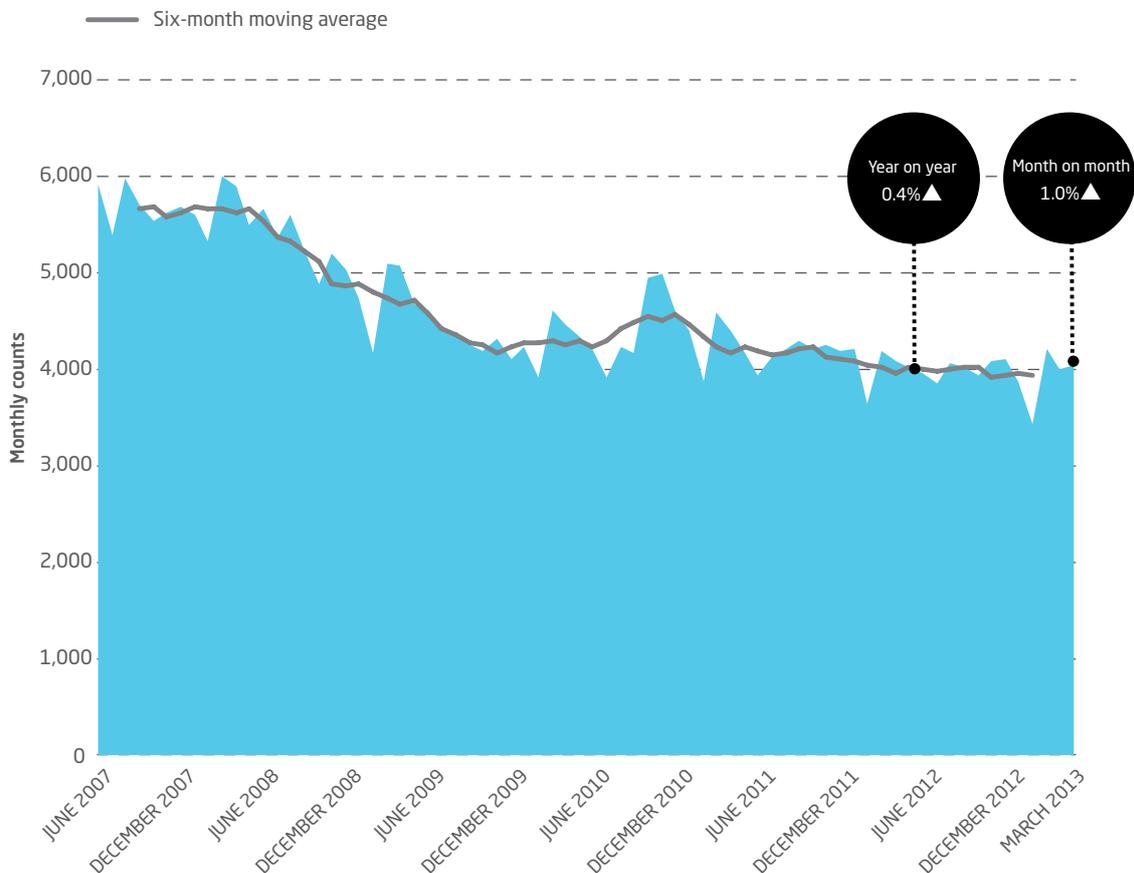
'Trolley waits': The proportion of patients spending more than four hours in major A&E departments from decision to admit to admission into hospital: Weekly data, November 2010 to May 2013



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

Delayed transfers of care

The most recent data shows that the total number of acute and non-acute delayed transfers of care for March 2013 increased on the previous month by 1 per cent, reversing the seasonal trend for this month. Furthermore, compared to March 2012, the number of delays was also up slightly (by less than 1 per cent). The six-month moving average looks as though it might have slowed down from its previous trend of continuous decline. Over the last year on average 3,982 patients were delayed each day, which is not too dissimilar from the 4,125 patients on average that were delayed each day the previous year.

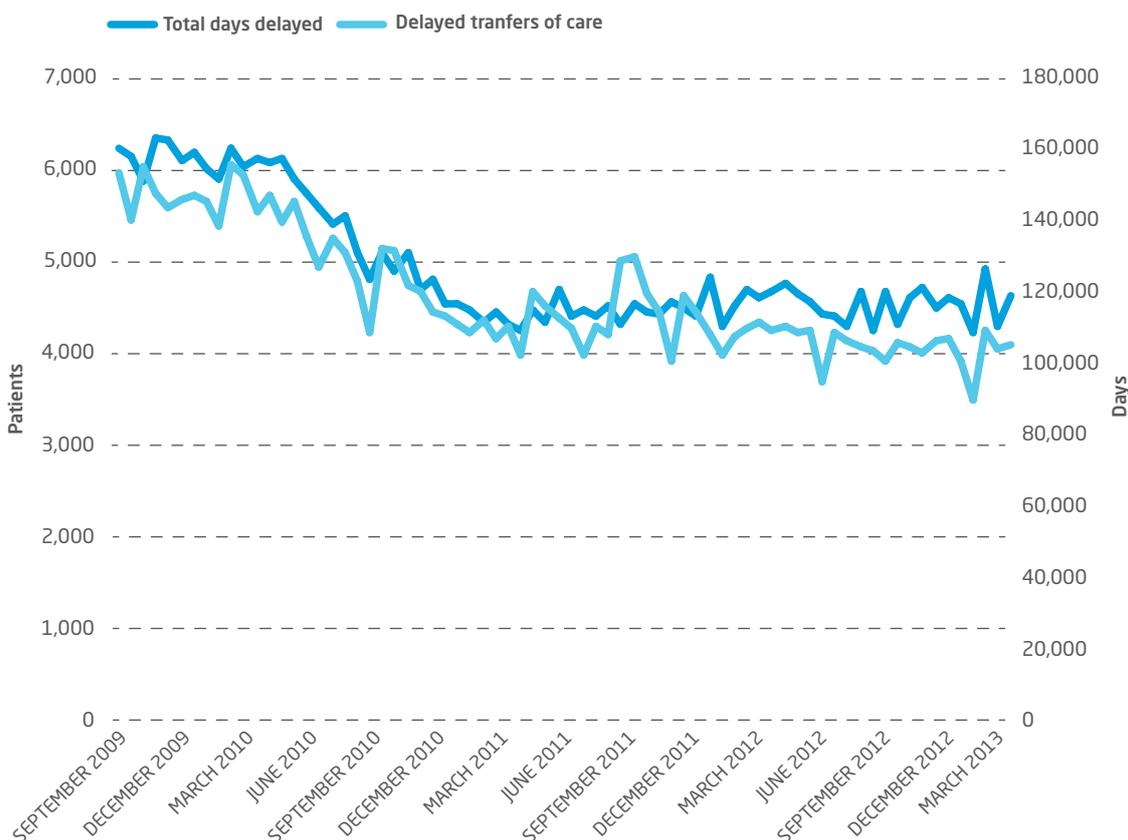


Data source: Acute and non-acute delayed transfers of care, patient snapshot
www.england.nhs.uk/statistics/delayed-transfers-of-care/dtoc-data-2012-13/

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 overleaf shows the number of days associated with delayed discharges as well as the number of patients delayed. The latest figures reveal large degrees of monthly variation, with a notable

seasonal decrease in December. In November and December 2012 there were month-on-month reductions in both the number of patients and total days delayed to the lowest levels in recent times, but figures have returned to their previous levels since then.

Delayed discharges: Monthly count



Data source: Acute and non-acute delayed transfers of care, patient snapshot and total days delayed
www.england.nhs.uk/statistics/delayed-transfers-of-care/dtoc-data-2012-13/

References

- Appleby J, Humphries R, Thompson J, Galea A (2013). *How is the Health and Social Care System Performing?* Quarterly Monitoring Report, February 2013. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/how-health-and-social-care-system-performing-february-2013 (accessed on 13 May 2013).
- Appleby J, Thompson J (2013). 'Are accident and emergency attendances increasing?' Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing (accessed on 13 May 2013).
- Association of Directors of Adult Social Services (2013). 'Social care funding: A bleak outlook is getting bleaker'. Press release. Available at: www.adass.org.uk/index.php?option=com_content&view=article&id=914:social-care-funding-bleak-outlook-bleaker&catid=160:press-releases-2013&Itemid=489 (accessed on 22 May 2013).
- Cameron D (2011). Speech on the NHS at University College Hospital, 7 June. Available at: www.politics.co.uk/comment-analysis/2011/6/14/david-cameron-nhs-speech-in-fulls (accessed on 16 May 2013).
- Department of Health (2012). *The NHS Constitution for England*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961 (accessed on 22 May 2013).
- Department of Health (2011). *The Operating Framework for the NHS in England 2012/13*. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf (accessed on 22 May 2013).
- Department of Health (2010). *Equity and Excellence: Liberating the NHS*. Cm 7881. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 (accessed on 22 May 2013).
- Edwards N (2013). 'Can we keep up with the demand for urgent and emergency care?'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2013/04/can-we-keep-demand-urgent-and-emergency-care (accessed on 13 May 2013).
- Flory D (2013). *The Quarter*. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/175648/The_Quarter_3_Q3_2012-13.pdf (accessed on 13 May 2013).
- Humphries R (2013). *Paying for social care: Beyond Dilnot*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/paying-social-care (accessed on 22 May 2013).
- National Audit Office (2012). *Progress in making efficiency savings*. Available at: www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf (accessed on 13 May 2013).

- NHS Commissioning Board (2013). 'Sir Bruce Keogh to lead review of urgent and emergency services in England'. Press release. Available at: www.england.nhs.uk/2013/01/18/service-review/ (accessed on 13 May 2013).
- NHS England (2013). 'NHS support plan launched to help hospital and A&E departments keep waiting times in check'. NHS England website. Available at: www.england.nhs.uk/2013/05/09/sup-plan/ (accessed on 22 May 2013).

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