The King's Fund

Ideas that change health care

How is the NHS performing?

Quarterly monitoring report

July 2011

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Over the next few years the NHS faces two unprecedented challenges: coping with the tightest funding settlement for decades and implementing the coalition government's revised reforms of the system.

This is the second *Quarterly Monitoring Report* published by The King's Fund (the first was published in April this year). It aims to provide a regular update on how the NHS is coping as it grapples with the evolving reform agenda as well as the more significant challenge of making radical improvements in productivity.

The reports combine publicly available data on selected NHS performance measures with views from a panel of finance directors on the key issues their organisations are facing. It complements our monthly waiting times tracker (www.kingsfund.org.uk/waitingtimes)

The performance measures tracked in this report are important to the public and patients and provide indicators of the impact of tackling the productivity and reform challenges confronting the NHS. For this quarter, the views of the panel of finance directors have been supplemented with interviews with a small number of finance directors to get a more in-depth view of current and future finance and performance issues.

PANEL OF FINANCE DIRECTORS JULY 2011

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

Forty-nine finance directors were invited to join the panel; 29 were available to give their views, which were collected via an internet survey between 9 and 22 June 2011.

For this quarter, the majority of the panel members (seventeen) were from acute trusts (seven of whom were from foundation trusts; two from combined community; and one from specialist). Of the remainder, five members were from commissioning organisations; four from mental health trusts (two foundation trusts, one combined mental health and community); and one from a community trust. Two did not give their organisation type. There was a reasonable spread across regions with at least one panel member from each region.

The internet survey was supplemented with interviews with five finance directors (two of whom also completed the internet survey). Three of the finance directors interviewed were from acute trusts, one was from a mental health trust and one from a PCT cluster. Summaries of the interviews are presented in boxes throughout the first half of the document.

Finance Directors' Panel

COST IMPROVEMENT PROGRAMMES AND END-OF-YEAR FINANCIAL SITUATION

In order to meet growing demand and improve the quality of its services to patients at a time of effectively no real increase in funding, the NHS needs to improve its productivity by an estimated value of around £20 billion over the next four years. Across the whole NHS this is equivalent to a productivity gain of between 4 and 5 per cent. Of course, at the front line, in different sectors of the NHS and in individual NHS organisations the challenge will vary. In part, this is to do with the tactics adopted to incentivise productivity – for example, real cuts in the prices that trusts are allowed to charge for their services and differences in the financial legacies hospitals need to tackle.

Variations in the task facing NHS organisations are evident from our finance directors' panel. **All but one of the provider organisations on the panel have a productivity target of 4 per cent or more, and over half have a target of 6 per cent or more**. This confirms a recent *Health Service Journal* survey of 131 trusts conducted in April, which found a similar range of targets with an average target of 6 per cent (www.hsj.co.uk/news/finance/trusts-set-unlikely-savings-targets-for-2011-12/5028911.article).

These high cost improvement programme (CIP) targets are in part due to Department of Health policy, as well as local factors, such as requirements to become a foundation trust and the need to meet in-built pay rises due to staff movement up pay scales.

The policy decision taken by the Department of Health to make 40 per cent (£8 billion – or £2 billion per year) of the national savings required of the NHS through real reductions in the tariff in the acute sector is a key contributor to the high CIP targets (www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51208.htm#n79). As the tariff currently covers around £30 billion of trust income a year, this effectively implies a productivity gain of nearly 7 per cent (£2 billion out of £30 billion). While income derived from services subject to the Payment by Results tariff does not cover all trust income, there are also local issues for many providers – including requirements to become a foundation trust and productivity targets not met in the previous year which will push up their productivity targets. There is also pressure from the trend to reduce the volume of care provided by hospitals and, despite the pay freeze for NHS staff (which effectively increases real resources for trusts), the need to meet in-built pay rises due to staff movement up the pay scale.

Comments from several provider-based finance directors confirmed local requirements on PCTs to hold back some spending as a reserve buffer to deal with costs arising from reforms and to meet targets for surpluses to carry over to next year. In effect, PCT spending will be less than the headline 2.2 per cent cash increase in their budgets this year. Productivity targets seemed lower for the five commissioning organisations in the panel – though they may not be representative of all commissioners. This may be indicative of risk shifting to providers; the extent of similar pressure on commissioners to work with their partners to meet productivity improvements is unclear. This may reflect the instability facing commissioners with PCT reorganisation and clinical commissioning groups still being formed, and therefore an assessment by the Department of Health that providers are better placed to handle risk than commissioners during the transition.

From our interviews with finance directors it emerged that two acute trusts planned to increase activity in order to meet productivity improvement targets in future. This is unlikely to be a realistic solution in the long term for many acute providers. Moreover, while increasing income may close the gap between costs and revenue, this is not a productivity gain.

When asked how confident they are of achieving their CIP target in 2011/12, about half of those with a target of 4 per cent or more were uncertain of meeting it. A higher proportion of those with a target of 6 per cent or more were uncertain of meeting it (eight out of 13).

Despite this uncertainty about meeting CIP targets, over half of the finance directors said that their organisation was likely to end the year in surplus, and most of the rest said they are likely to break even. However, three said they anticipate a deficit. Of those anticipating a surplus, some described this as a necessity if they are to meet requirements from their SHA or to become a foundation trust and that tough CIP targets would have to be met to achieve the surplus.

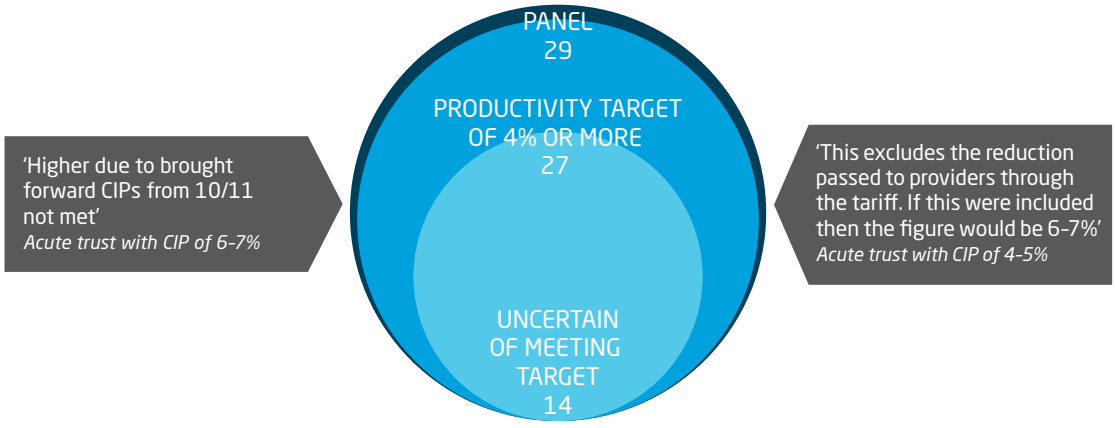
INTERVIEW 1

AN URBAN ACUTE HOSPITAL TRUST

Productivity target: 7.5 per cent

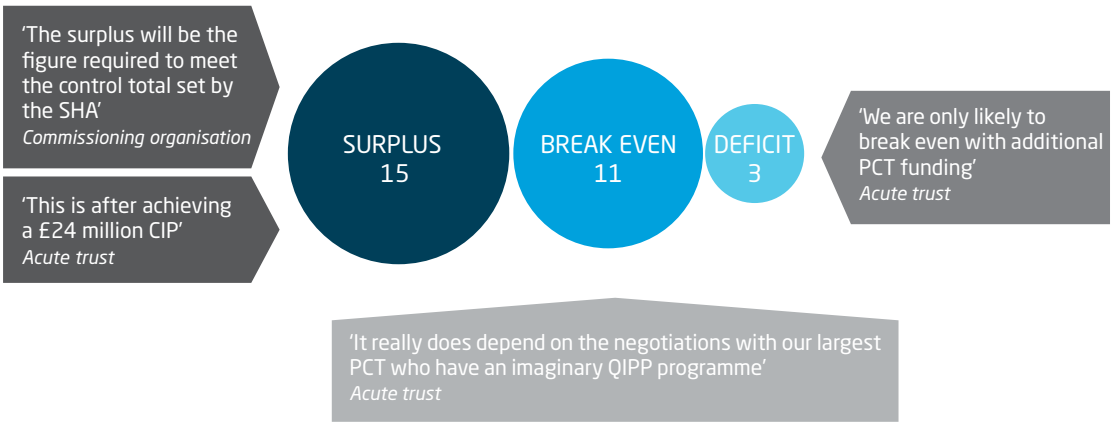
The trust has been investing in community services to reduce hospital admissions and ensure that patients can be discharged promptly once their treatment has been completed, allowing it to remove bed capacity. It is able to do this because it is effectively under a block contract this year; a return to payment-by-volume next year may make this more difficult.

In certain specialties that have strong clinical leadership, the trust is radically changing ways of working to significantly reduce costs while raising quality. The productivity target is greater than the 6 per cent cost reduction the trust needs to make to break even on its budget, so the finance director anticipates making a surplus at the end of the financial year even if the ambitious productivity target is not met.



This optimism seems in contrast to the numbers uncertain of meeting their CIP, but cost improvement plans may stretch beyond what is necessary to break even, and several said that it was still too early in the year to be precise about their financial situation next April. For example, one finance director we interviewed (see box Interview 1) was aiming for a productivity target of 7.5 per cent, but also stated that their trust would break even with a 6 per cent improvement. Although they anticipated a surplus, they were fairly concerned about meeting the productivity target.

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



INTERVIEW 2

ACUTE FOUNDATION TRUST IN AN URBAN AREA

Productivity target: 9.0 per cent

The trust plans to reduce bed capacity in line with local PCT's plans to reduce demand for care and the finance director also aims to reduce costs by sharing back-office functions with other NHS organisations nearby. However, central to the trust's future plans are drives to achieve additional specialist service designations and to attract new patients. These will require significant initial investment, which accounts in part for the high productivity target.

The finance director says that the scale of the desired productivity gains means that the trust will need to implement more radical changes than it has done in the past. She is confident that her organisation can make the necessary savings while increasing the quality of care, but this will require a profound re-think of how the hospital works, including changes to the physical delivery of services.

IMPACT OF COST IMPROVEMENT PROGRAMME MEASURES ON CLINICAL QUALITY

Reducing production costs through, for example, reducing the time patients need to spend in hospital, frees up resources for other uses. However, of paramount concern is that quality is not compromised in the process. On this, most of the finance directors reported that they are very or fairly confident that measures to achieve their productivity target will not harm clinical quality. However, some qualified this, for example, acknowledging that there could be a negative impact on patients' experience of their care (but not on the health outcomes of care).

'Inevitably quality will get hit at some stage. If you think about some of our medical wards, which have got high throughput, high numbers of patients in them, it's constant high pressure for the staff and we have to look at cutting the staff – that has to impact on quality somewhere along the line.'

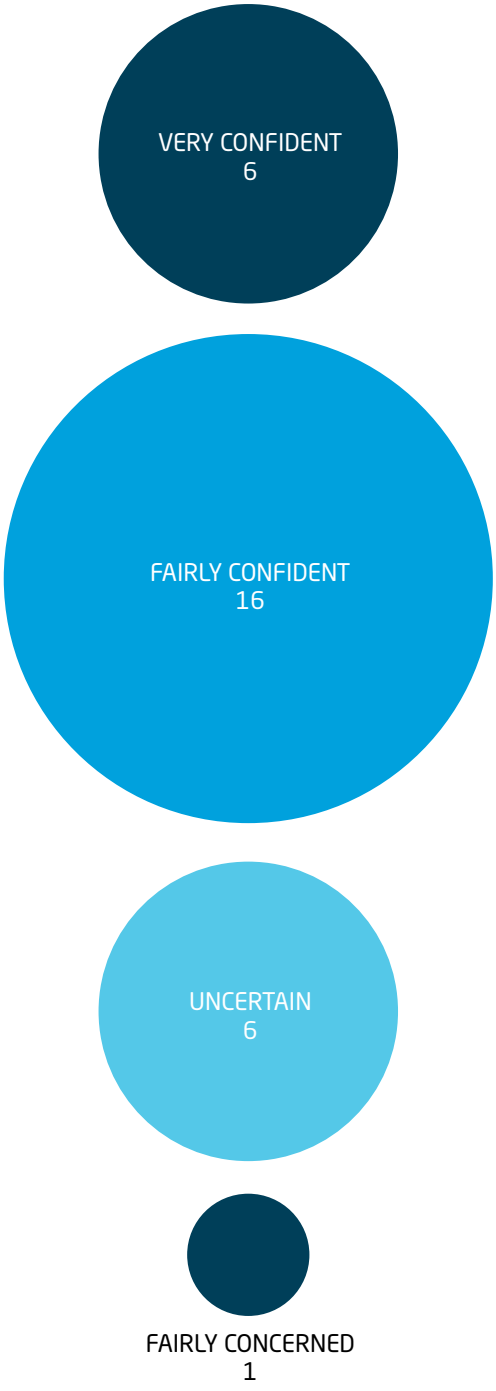
Acute trust
INTERVIEW 3

INTERVIEW 3

ACUTE FOUNDATION TRUST IN A LARGE TOWN SERVING A RURAL AREA

Productivity target: 7.1 per cent

The trust plans to increase productivity across the hospital by undertaking a series of projects, including one based on the NHS Institute's Productive Operating Theatre programme. A potential risk to quality of care from the productivity drive was recognised. Local PCTs want to reduce hospital activity but so far patient admissions have been rising. The trust sees increasing activity to meet this demand as a viable option to increase the trust's income and would also reduce waiting times, but the PCT is not supportive. The finance director highlights the difficulty of identifying savings while patient numbers are rising. He suggests that there is a need for greater honesty about what the NHS will be able to deliver with the resources it has been allocated.

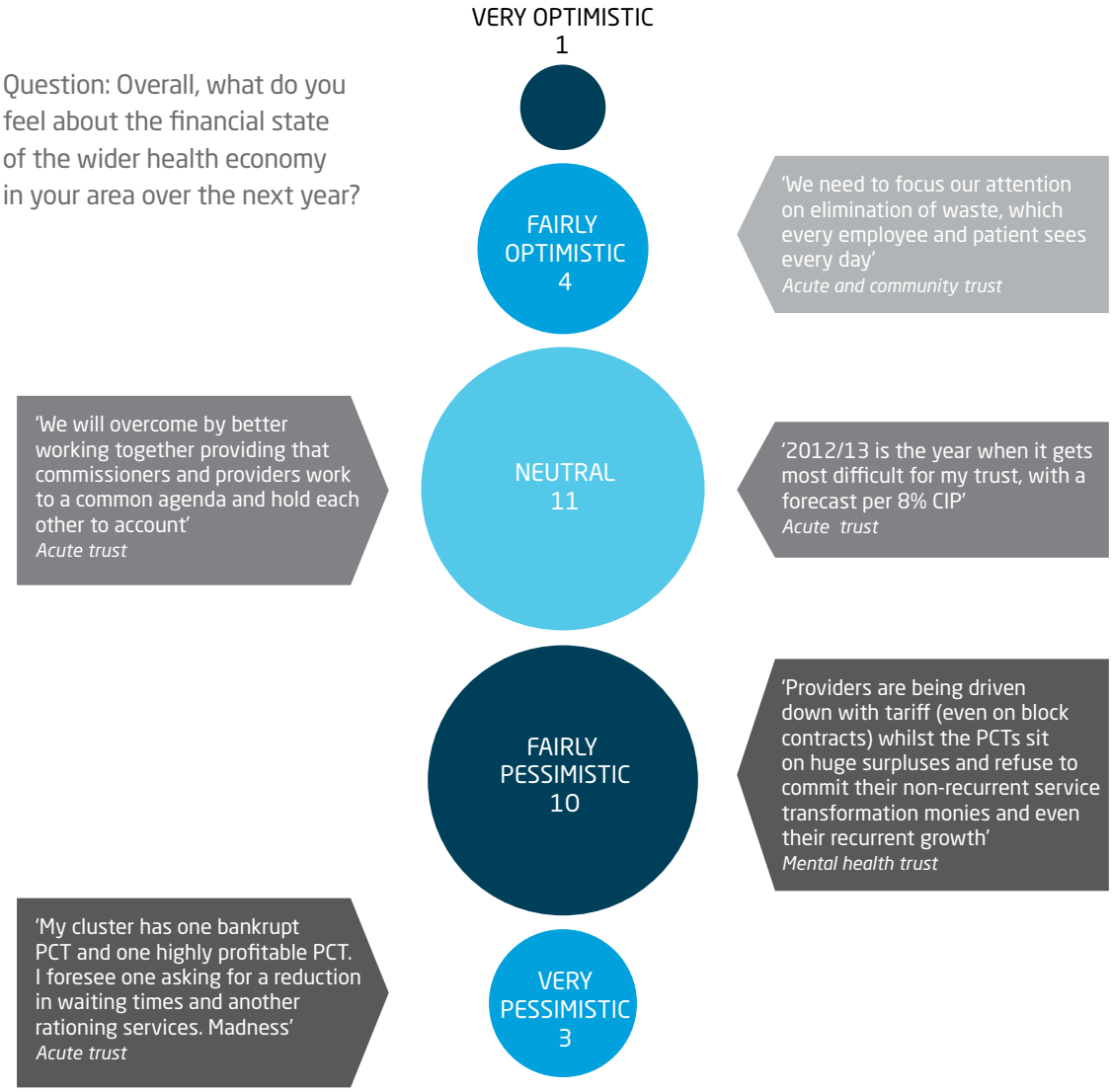


Question: How confident are you that measures to achieve your CIP target will not harm clinical quality?

OPTIMISM ABOUT LOCAL HEALTH ECONOMY FINANCES

In local areas the finances of NHS organisations – trusts and PCTs – are highly interdependent; difficulties in one organisation have the potential to impact on others. Optimism about the finances of a single organisation may be tempered by pessimism of the situation facing others. On this subject, there were some optimists, with many on the panel being neutral on this issue. But just under half of the finance directors reported that they were either fairly or very pessimistic about local health economy finances.

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



INTERVIEW 4

PCT CLUSTER

Productivity target: 2.0 per cent

The PCT cluster aims to meet its target primarily by changing patient pathways with a view to reducing demand for high-cost care. For example, GP practices will be offered incentives to work with patients to see how primary care can be changed to take pressure off A&E departments.

The finance director is concerned about having sufficient time to put in place all the necessary measures to ensure that the planned changes are carried through successfully. He does not detect much resistance on the part of provider organisations to the PCT cluster's plans and believes the real challenge will lie in co-ordinating efforts across these organisations.

'What stands out about the teams which are succeeding in taking out costs while improving the patient pathway is that they've got a really clear clinical strategy, a good leader and they've got volume and critical mass, so they are a big national player.'

Acute trust
INTERVIEW 1

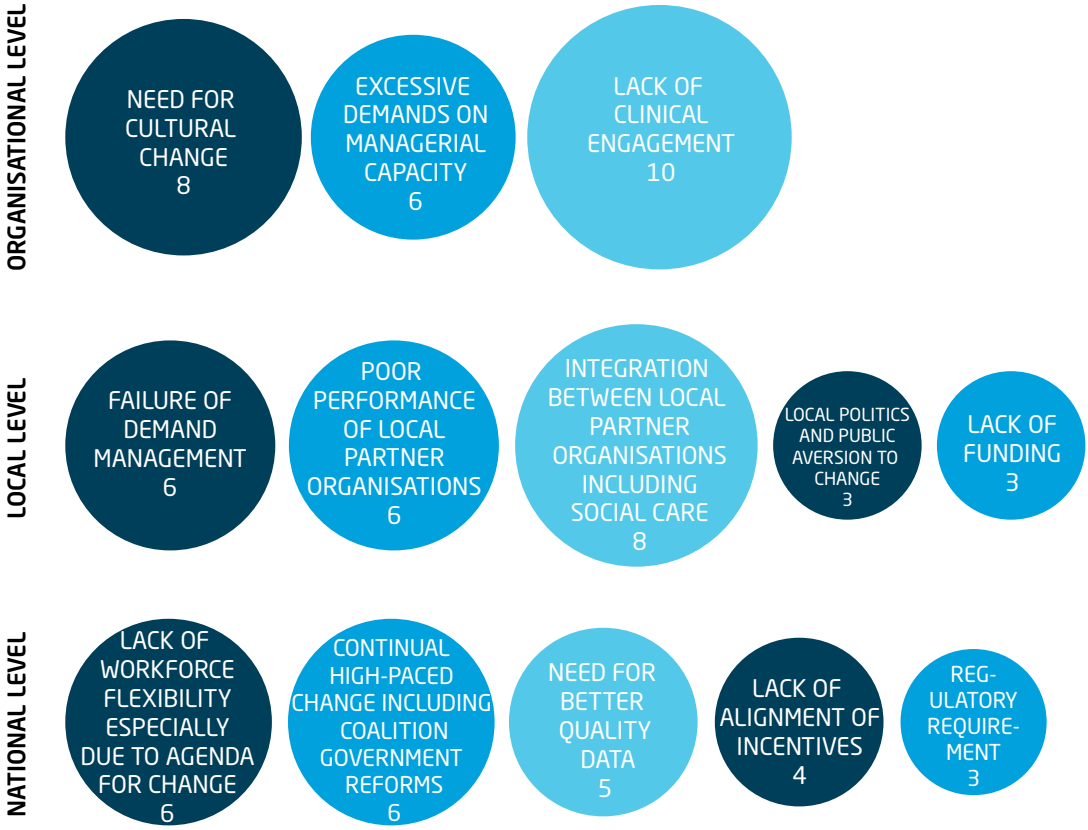
KEY BARRIERS TO PRODUCTIVITY IMPROVEMENTS

In order to gain a better understanding of the main factors that can hamper NHS organisations from making productivity improvements, we asked the finance directors what they see as the top three barriers to achieving improvements in productivity in their organisation. Responses were grouped into three categories, those at the organisational, local and national levels.

Two of the most frequently mentioned barriers lay at the **organisational level**: lack of clinical engagement and the need for cultural change. Ten finance directors listed a lack of clinical engagement in change or reluctance to change among clinicians. This was supported in the interviews, where good clinical leadership was described as vital to improving productivity (see Interview 1). Those who saw the need for cultural change as a key barrier cited fear of change, failure to see the need for change and a lack of imagination and innovation.

Barriers relating to **local issues** had the most mentions overall. One of the most common was a lack of integrated working between different organisations. Related to this were failure of demand management schemes and poor performance of local partners. Many of the acute sector finance directors described a situation where demand was growing and local commissioners were not achieving plans to control it, making reductions in acute capacity difficult to make or to sustain. Other themes included: constraints arising from local politics and public aversion to change, making reconfiguration difficult and lack of funding, in particular with reference to partner organisations holding back spending.

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



'The thing that will deliver for us is the pathways work. We're trying to work with our acute partners, looking at physical and mental health issues for one individual rather than boxing people up in different disease groups. And we're already working with GPs to look at how we move people currently in the secondary care system back into primary care. If we don't do it through those pathway changes, we're going to be into some very difficult choices around what services are provided to whom and where.'

Mental health trust
INTERVIEW 5

INTERVIEW 5
MENTAL HEALTH TRUST
Productivity target: 6.0 per cent

Pressure from local PCTs has determined the mental health trust's high productivity target. PCTs acknowledge that this means that in some areas the trust will undertake less activity and provide a reduced service.

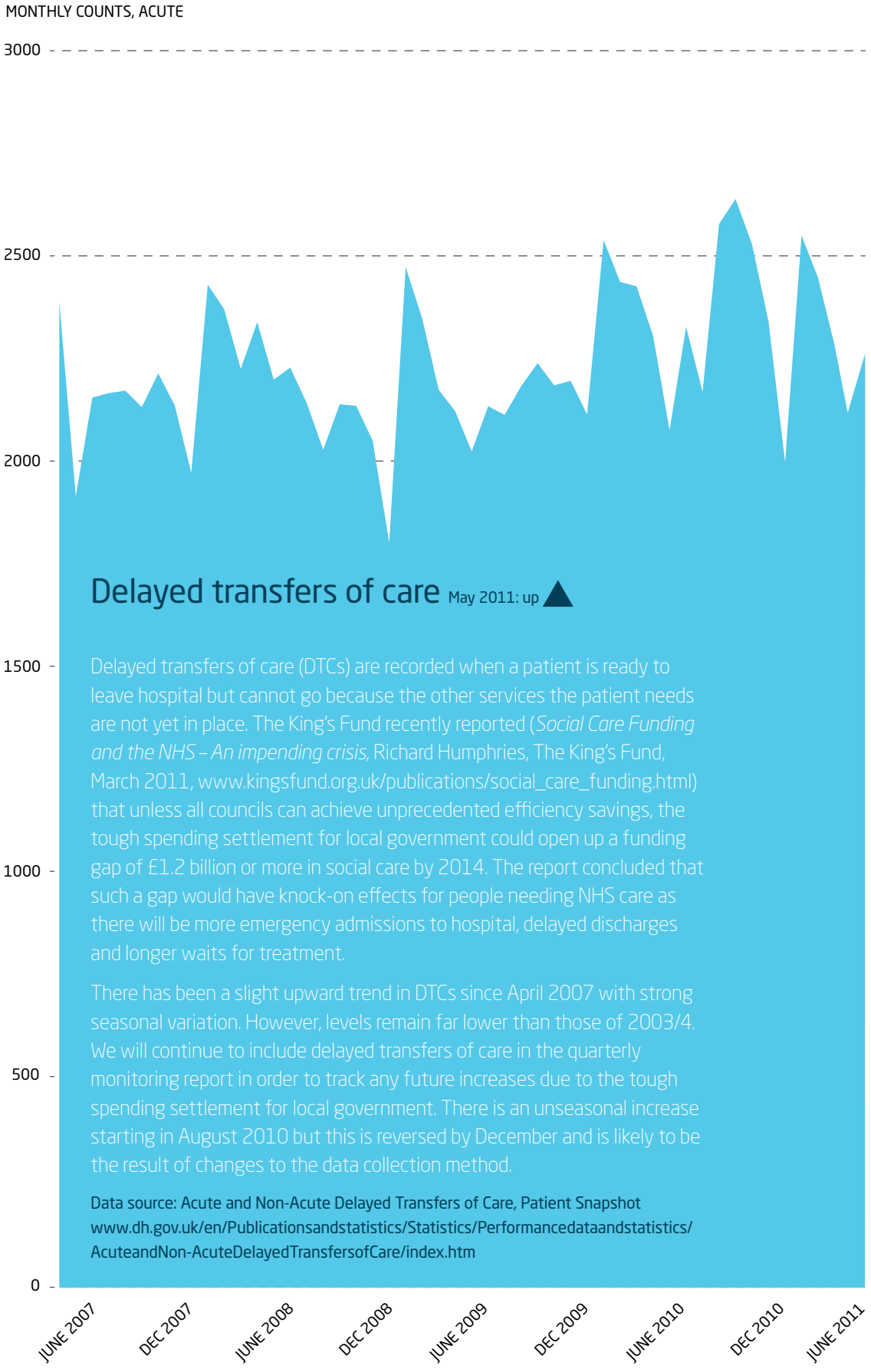
The finance director aims to meet the funding gap by working with acute and primary care partners to change patient pathways. However, he does not have the evidence to assess the likely extent of the benefits, and these might be lower than anticipated. The finance director is concerned that cuts to social care budgets may diminish the support available from this sector. Nonetheless, he remains hopeful that the necessary gains can be made using this approach.

The third group of barriers were those relating to national government policy. Lack of workforce-related flexibility and continual high-paced change, including the coalition government reforms, were the main barriers cited. Agenda for Change was specifically mentioned by four panel members as a key issue here. All of the five finance directors who mentioned a need for more data were from non-acute organisations, showing the lack of progress in this area outside of acute care. Those raising lack of alignment of incentives referred to inconsistencies between Payment by Results and the QIPP (quality, innovation, productivity and prevention) agenda, a theme that also emerged from the interviews.

Only a small number of the finance directors specifically mentioned the coalition government reforms as a barrier to productivity improvements. When asked specifically whether they thought the reforms would be of positive benefit in helping their organisation achieve improvements in productivity, most said they would not be in the short term, but in the long term they were more uncertain.

Selected NHS performance measures

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

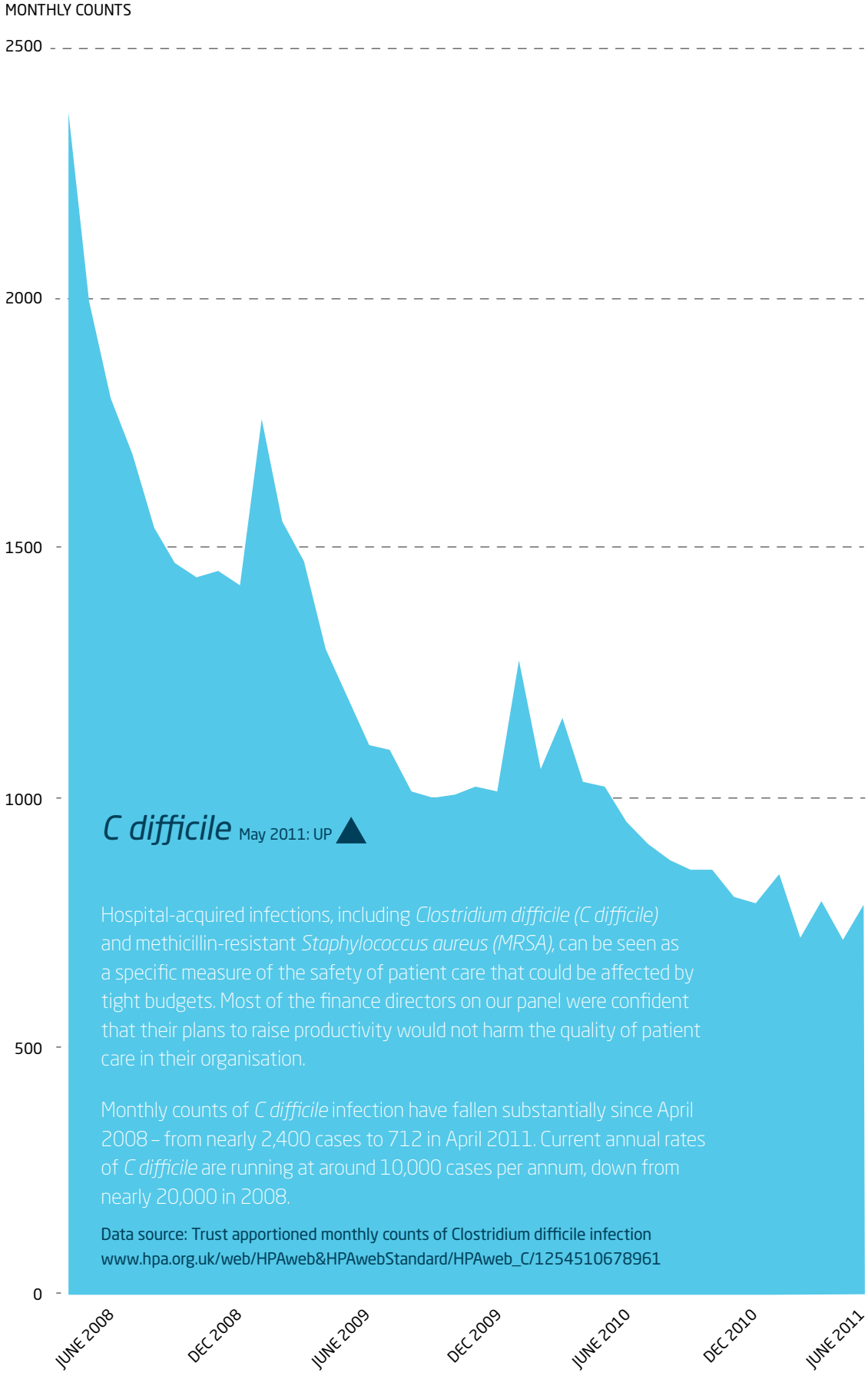


Delayed transfers of care May 2011: up ▲

Delayed transfers of care (DTCs) are recorded when a patient is ready to leave hospital but cannot go because the other services the patient needs are not yet in place. The King's Fund recently reported (*Social Care Funding and the NHS – An impending crisis*, Richard Humphries, The King's Fund, March 2011, www.kingsfund.org.uk/publications/social_care_funding.html) that unless all councils can achieve unprecedented efficiency savings, the tough spending settlement for local government could open up a funding gap of £1.2 billion or more in social care by 2014. The report concluded that such a gap would have knock-on effects for people needing NHS care as there will be more emergency admissions to hospital, delayed discharges and longer waits for treatment.

There has been a slight upward trend in DTCs since April 2007 with strong seasonal variation. However, levels remain far lower than those of 2003/4. We will continue to include delayed transfers of care in the quarterly monitoring report in order to track any future increases due to the tough spending settlement for local government. There is an unseasonal increase starting in August 2010 but this is reversed by December and is likely to be the result of changes to the data collection method.

Data source: Acute and Non-Acute Delayed Transfers of Care, Patient Snapshot
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm

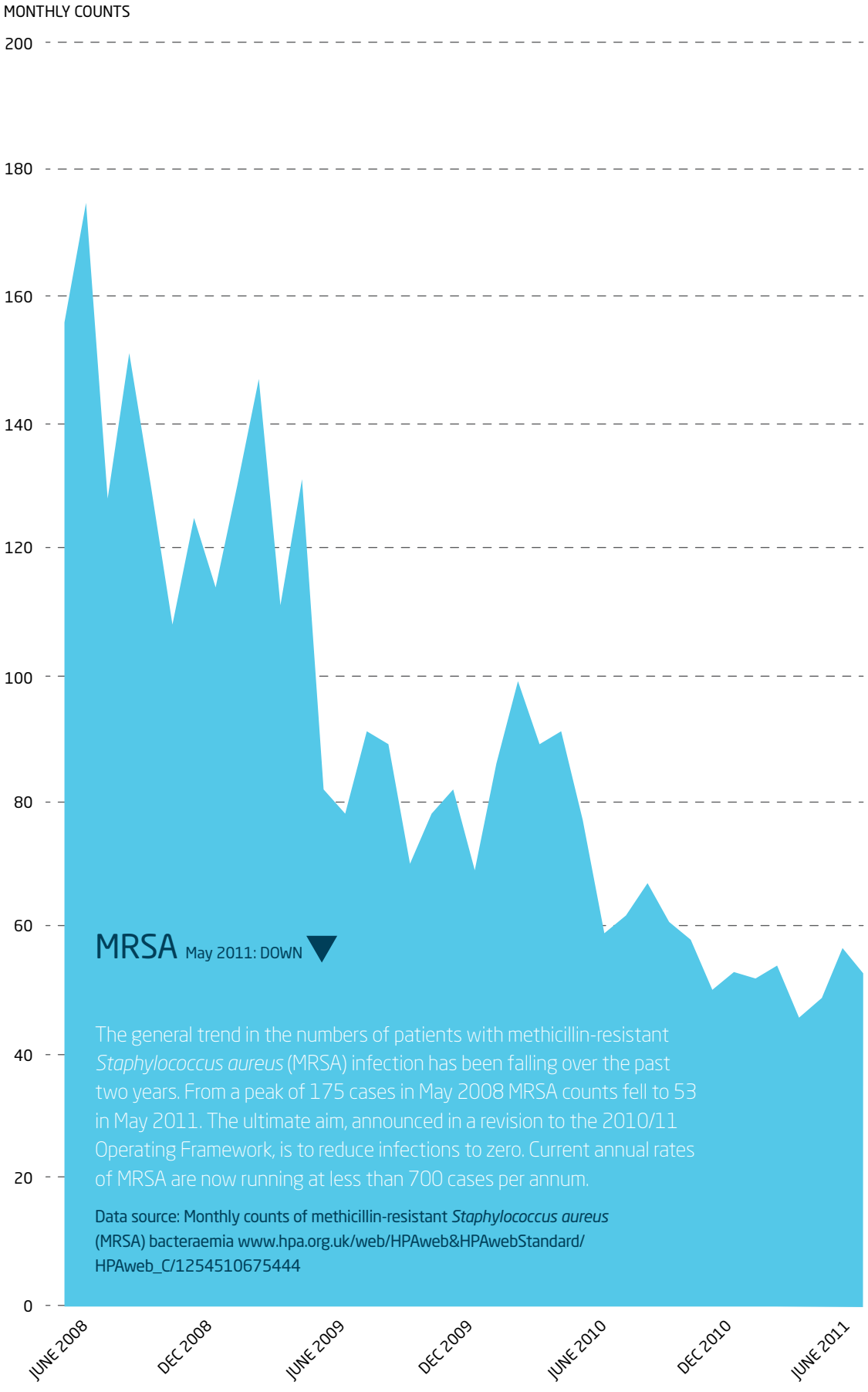


C difficile May 2011: UP ▲

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

Monthly counts of *C difficile* infection have fallen substantially since April 2008 – from nearly 2,400 cases to 712 in April 2011. Current annual rates of *C difficile* are running at around 10,000 cases per annum, down from nearly 20,000 in 2008.

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



MRSA May 2011: DOWN ▼

The general trend in the numbers of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) infection has been falling over the past two years. From a peak of 175 cases in May 2008 MRSA counts fell to 53 in May 2011. The ultimate aim, announced in a revision to the 2010/11 Operating Framework, is to reduce infections to zero. Current annual rates of MRSA are now running at less than 700 cases per annum.

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

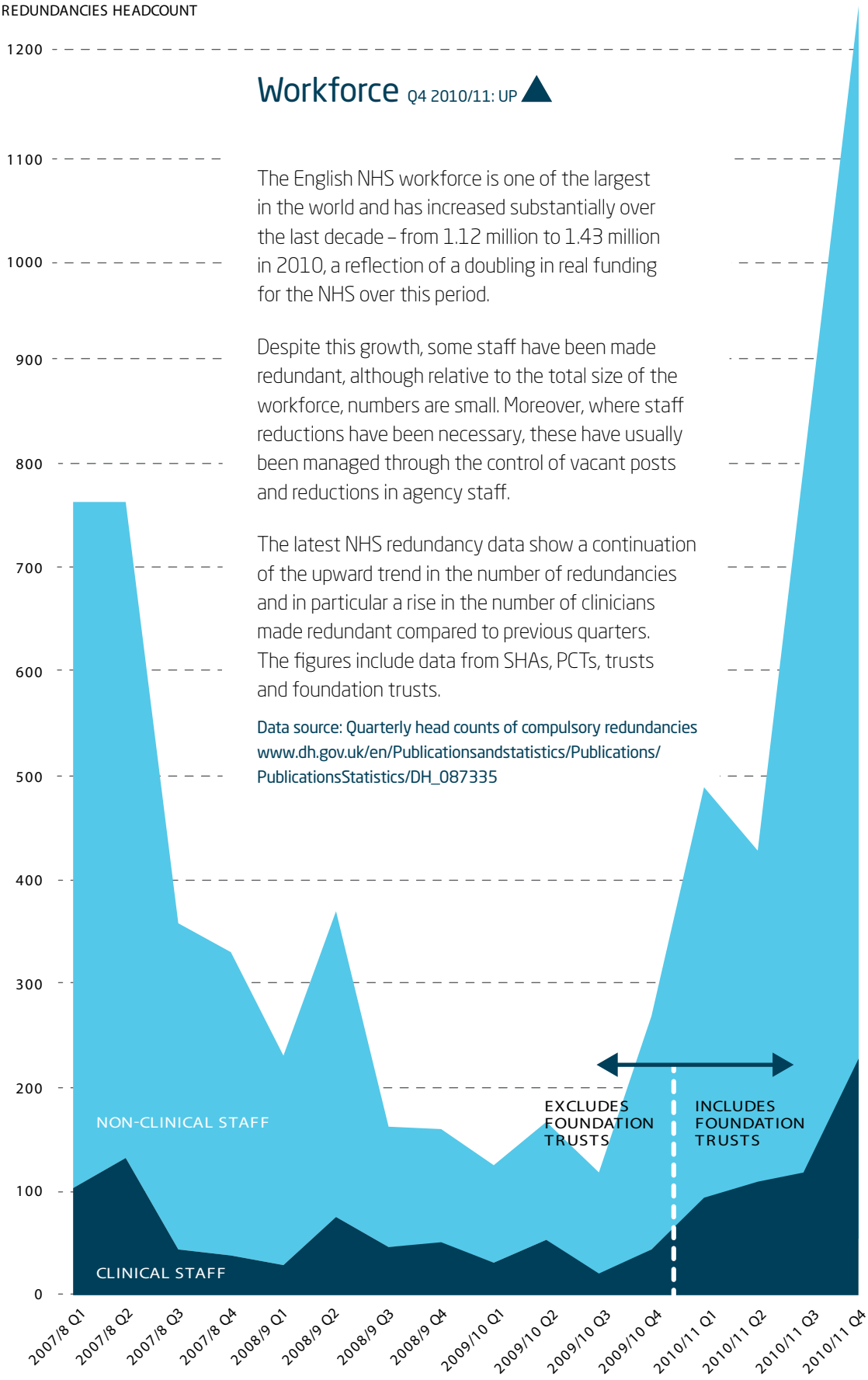
Workforce Q4 2010/11: UP ▲

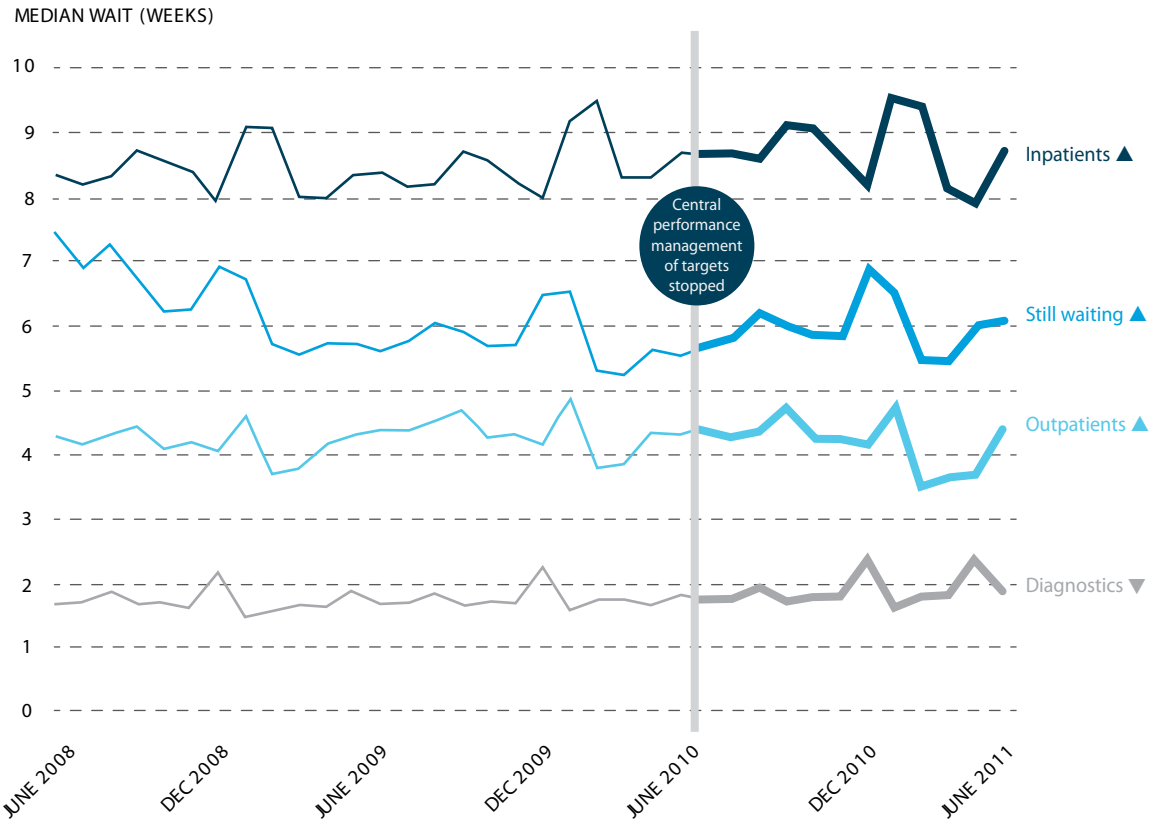
The English NHS workforce is one of the largest in the world and has increased substantially over the last decade – from 1.12 million to 1.43 million in 2010, a reflection of a doubling in real funding for the NHS over this period.

Despite this growth, some staff have been made redundant, although relative to the total size of the workforce, numbers are small. Moreover, where staff reductions have been necessary, these have usually been managed through the control of vacant posts and reductions in agency staff.

The latest NHS redundancy data show a continuation of the upward trend in the number of redundancies and in particular a rise in the number of clinicians made redundant compared to previous quarters. The figures include data from SHAs, PCTs, trusts and foundation trusts.

Data source: Quarterly head counts of compulsory redundancies www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_087335





Waiting times: Median

In May 2011, median waiting times – the maximum time spent waiting by the first half of patients on waiting lists – rose for those admitted (inpatients), those not admitted (outpatients) and those still waiting. This broadly reflects seasonal trends for this month. The figures have now returned to the same levels as June 2010, having fallen for a couple of months.

Median waiting times for diagnostics rose in April 2011 but fell back in May. The April peak was unusual for this month and was equivalent to those that have previously occurred each December. The overall trend in median waiting times for diagnostics seems to be gradually upwards though the median remains low at about two weeks.

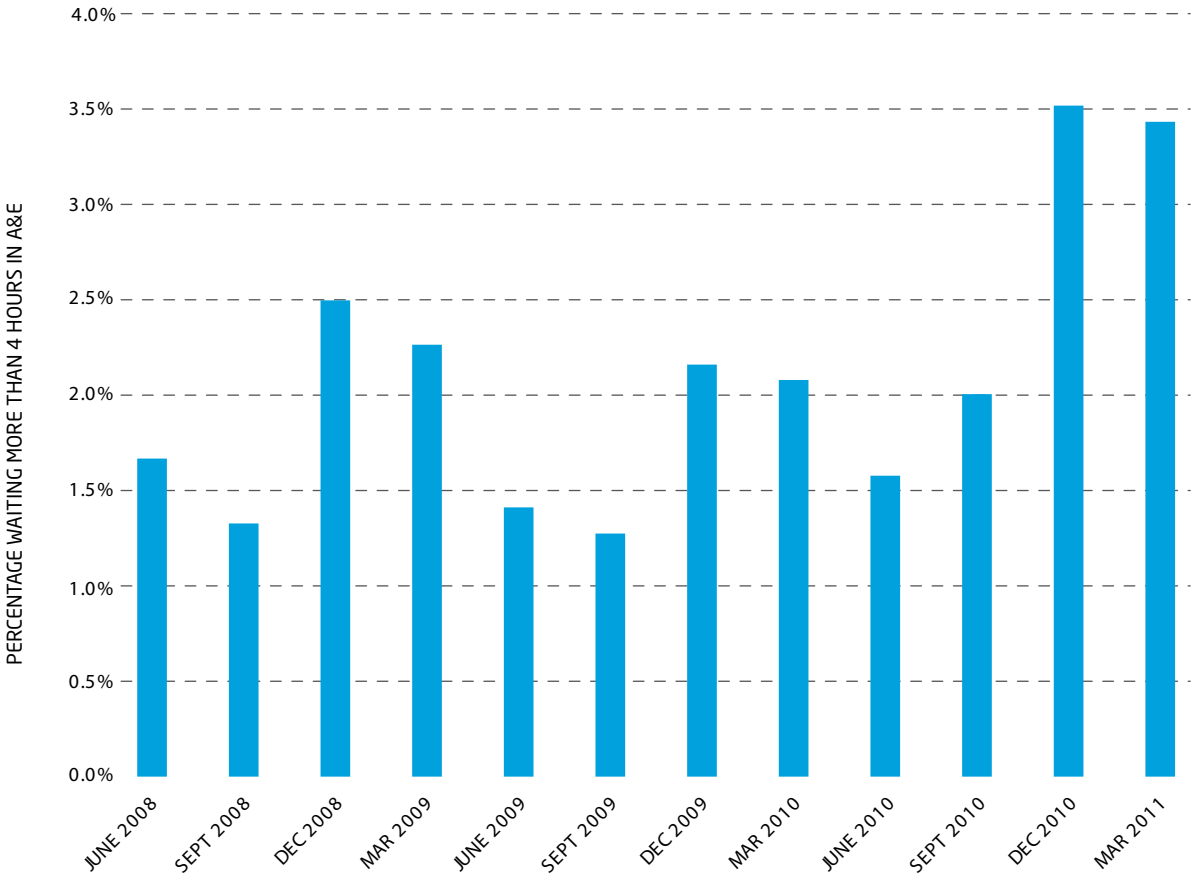
Data sources:
Referral to Treatment Waiting Times Statistics www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

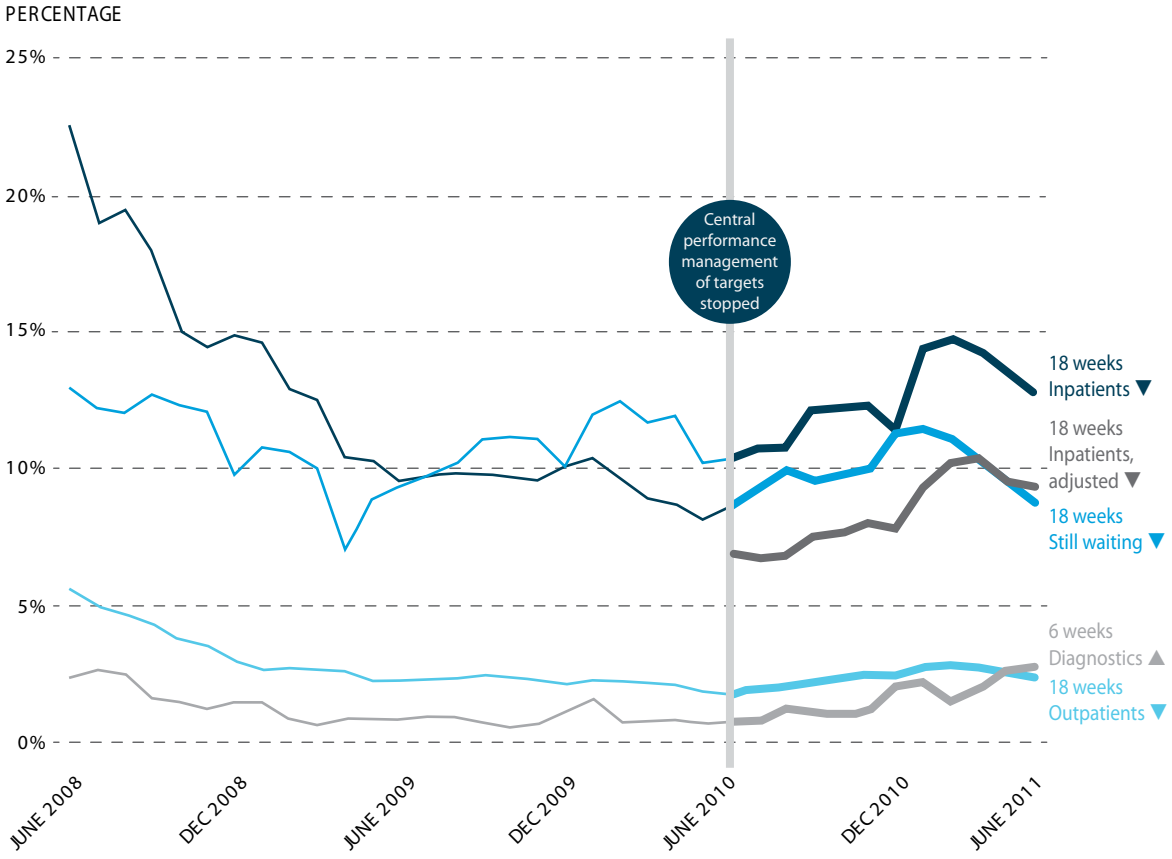
Diagnostic Waiting Times Statistics
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm

Waiting times: A&E and 18 weeks

The Department of Health has recently changed the way it manages performance in A&E. It now states that 95 per cent of patients should wait no more than 4 hours compared to the previous government's target of 98 per cent. In future a range of indicators will be used to assess performance. The latest data for four-hour A&E waits (2010/11, quarter 4) showed a slight decrease but remains high and masks considerable variation. 144 providers report less than 1 per cent waiting over four hours whereas 44 report more than 5 per cent. These 44 providers have in effect breached the new threshold.

The latest 18-week referral-to-treatment waiting times data for February to May 2011 show decreases in the percentage of patients waiting longer than 18 weeks for inpatients, outpatients and those still on waiting lists in all three months. The same is true for adjusted inpatient data where account has been taken of those patients who delay treatment through choice. This may reflect a seasonal trend; the number of patients waiting longer than 18 weeks in these categories fell in the Spring in 2008 and 2009. The percentages waiting also remain higher than in June 2010. These figures mean the operational standard was met – just – using the adjusted figures.





In contrast, the trend for the proportion waiting more than six weeks for diagnostics is upward and has risen from 0.7 per cent in May 2010 to 2.7 per cent in May 2011. This is equivalent to a rise in patients waiting more than six weeks from 3,500 in May 2010 to more than 16,000 in May 2011. However, this is still relatively low in terms of recent history – 35 per cent of patients waited more than six weeks in April 2007.

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

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

Registered charity: 1126980
www.kingsfund.org.uk