The King's Fund

Ideas that change health care

How is the NHS performing?

Quarterly monitoring report

January 2012

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The NHS is now nine months into the first year of one of the toughest four-year funding settlements it has received in its history.

As part of its work looking at the pressures being faced by the NHS, The King's Fund published its first *Quarterly Monitoring Report* in April 2011. This is the fourth report, and it aims to provide a real-time update on how the NHS is coping as it tackles the evolving reform agenda while grappling with the challenges of making improvements in productivity.

The quarterly monitoring report combines publicly available data on selected NHS performance measures with views from a panel of finance directors on key issues their organisations are facing.

The performance measures being tracked in this report are important to both the public and patients. They provide an indication of the impact of the current climate as finance directors work towards a 'liberated' NHS.

PANEL OF FINANCE DIRECTORS JANUARY 2012

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

Fifty-three finance directors were invited to join the panel; 23 were available to give their views. These were collected via an internet survey between 9 and 16 December 2011.

Ten respondents were from acute trusts, six from mental health trusts, five from PCTs and one from a community trust. One respondent did not give any details about their organisation.

Overview

As the Department of Health reported just before Christmas, while the NHS as a whole was, by September 2011 (halfway through the financial year), reporting a net surplus of around £1.2 billion, there are variations locally and some slightly poorer performance in quarter 2 compared with quarter 1. Nearly 25 per cent (19) of NHS trusts in quarter 2 had their financial performance rated as 'challenged', 'underperforming' or 'under review' compared with around 15 per cent (13) in quarter 1 (Department of Health 2011b).

While our panel survey of finance directors conducted in December 2011 suggests reasonable optimism concerning their end-of-year financial position, there is more concern and uncertainty about the general financial position of their local health economy over the next 12 months.

On arguably the key task for the NHS over the medium term – meeting productivity and cost improvement targets this year – our panel survey also suggests a degree of confidence. Nationally, the Department reports quality, innovation, productivity and prevention (QIPP) savings midway through the year of around £2.5 billion – leaving around 60 per cent (£3.4 billion) to be achieved in the second six months (Department of Health 2011b).

For the coming financial year – 2012/13 – most efficiency targets are similar to this year – averaging around 5 to 6 per cent. For our finance directors' panel, these targets remain a key challenge as do maintaining the quality of services and achieving key waiting times targets.

The performance measures tracked in this report show that, at a national level, performance is mixed: for some measures – for example, delayed transfers of care, median waiting times – broadly stable. For others – for example, rates of *Clostridium difficile* (*C difficile*) and four-hour waits in accident and emergency (A&E) – it is improving, while for other measures – for example, the proportion of patients waiting more than 18 weeks before their outpatient attendance – it has deteriorated. However, as we emphasise, care should be taken not to over-interpret particular statistics (such as month-on-month or year-on-year changes) without reference to underlying and seasonal trends.

As we set out in our last report, the NHS as a whole seems to be coping well with increased pressures.However, national figures mask significant local variation across all the performance measures detailed in this report – from hospital infection rates to waiting times and delayed transfers of care.

An area of interest in this quarter is delayed transfers of care (DTCs). A number of media stories in the past few months have raised concerns about rapid increases in the number of older people delayed in hospital. The national figures in this report do not seem to bear this out. Changes in the numbers of people delayed and time spent waiting to leave hospital do not show any consistent upward trends. However, feedback from our panel of finance directors shows that in some areas there has been a rising trend in DTCs recently. Given the importance of social care and other local authority services in facilitating many patients' timely discharge from hospital, continuing budget pressures for local authorities make this an important indicator to track over the coming year.

Finance Directors' Panel

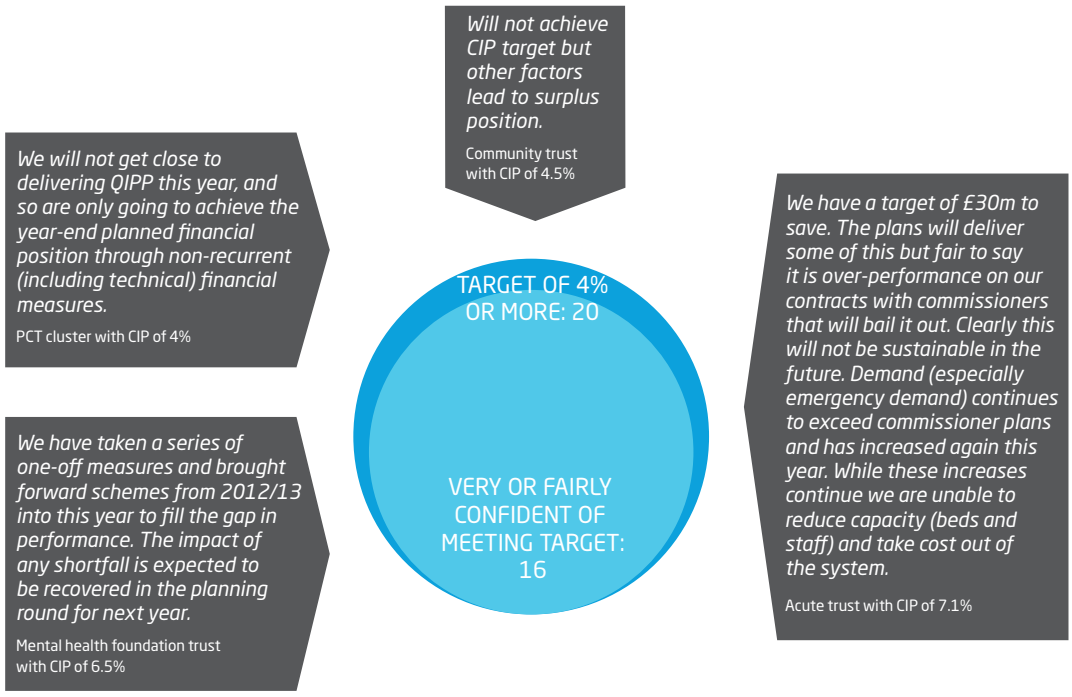
COST IMPROVEMENT PROGRAMMES AND END-OF-YEAR FINANCIAL SITUATION

As ever, the NHS is facing increasing pressures to meet expanding demands and to improve the quality of its care. Rising to the challenge to improve its services at a time when funding will grow by just enough to cover rising prices means improving productivity. The scale of the challenge is daunting. As the Department of Health has noted, by September 2011 – halfway through this financial year – 60 per cent of the estimated £5.9 billion national productivity target still remained to be met by April this year (Department of Health 2011b).

In our survey, nine months into the financial year, as in previous surveys, cost improvement targets for the majority of trusts are higher than 4 per cent, with PCT clusters reporting slightly lower targets than NHS trusts. Across the whole panel, the average CIP target for this financial year (2011/12) is about 5 per cent, ranging from 3 per cent to 7.1 per cent. Variation in the burden of the productivity challenge between PCTs and trusts in part reflect central strategies to, for example, reduce the real price of the tariff in order to incentivise hospitals to reduce costs to at least match the fall in their income from the price cut.

Setting targets is one thing, achieving them another. We asked our panel how confident they were in achieving their plans. More than half (16) were very or fairly confident that they would meet their cost improvement programme (CIP) target. Despite the scale of the challenge, only six finance directors were very or fairly concerned that they would not do so and only one was uncertain. However, three finance directors qualified their confidence as they had either incurred one-off measures, brought forward schemes set for 2012/13, or used non-recurrent costs/ incomes to meet their targets or bridge shortfalls in performance.

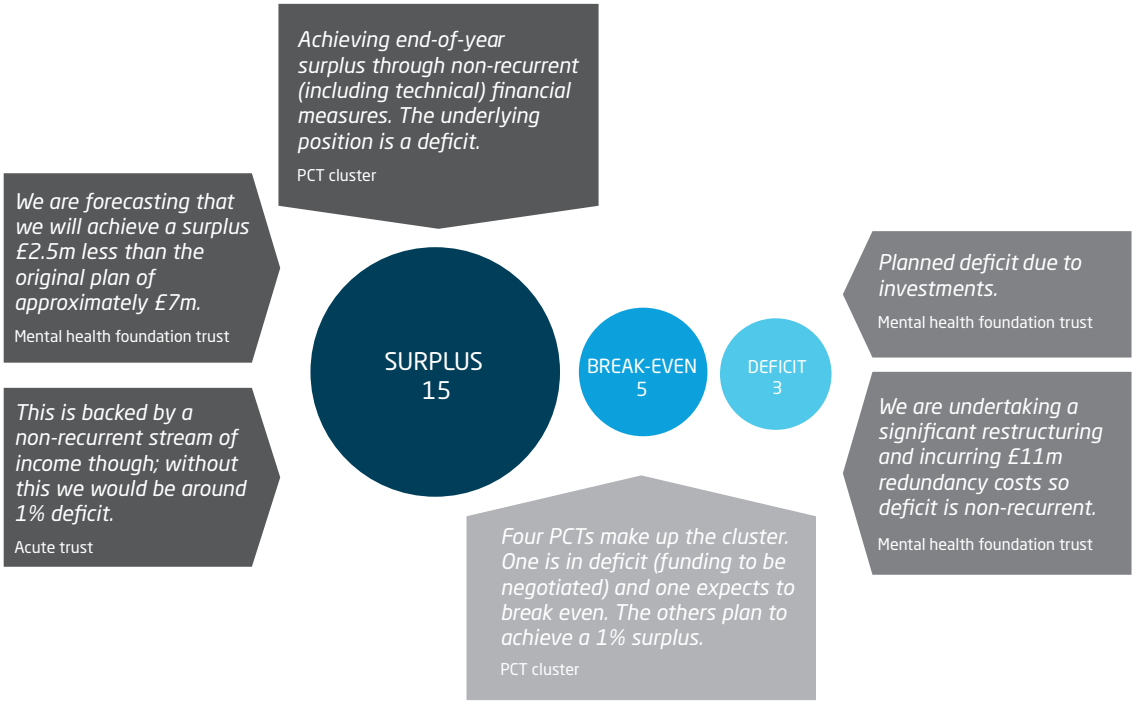
Confidence in meeting productivity targets in 2011/12



Predicting end-of-year financial outturns is not an exact science. But now – nine months into the financial year – forecasts should be clearer than they were. Over half (15) of the finance directors on our panel said that their organisation was likely to end the financial year in surplus, with five expecting to break even, and three forecasting a deficit. This optimism mirrors the responses for achieving their CIP targets for this year.

Since our survey, the Department of Health has made around £600 million available to the NHS from within the existing budget as a one-off cash injection for use on capital schemes, waiting times and 'winter pressures'. Clearly, this reflects concern centrally that some areas at least require additional help to square the need to keep finances under control without jeopardising key performance targets.

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

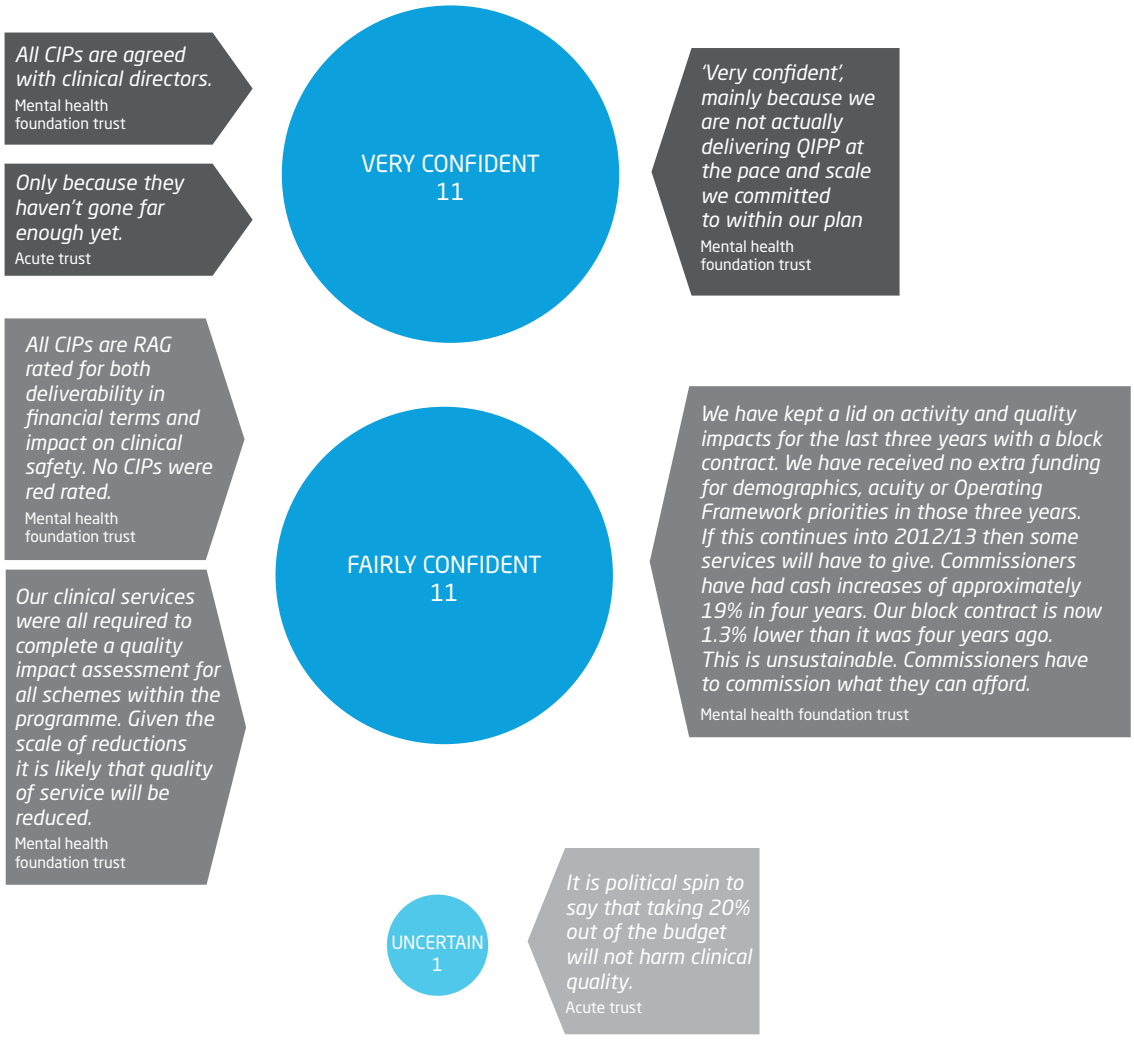


Although most of our panel were confident of meeting this year's CIP targets, for some organisations this may be a short-term win (eg, with one-off actions) leaving a longer term challenge over coming years. For the coming financial year (2012/13), 19 finance directors reported their CIP target. These show, as expected, a continuing high level of improvements being sought – between 5 and 6 per cent on average. Four directors reported a CIP target of less than 4 per cent; eight a target of 5 to 6 per cent and seven a target of more than 6 per cent.

IMPACT OF COST IMPROVEMENT PROGRAMME MEASURES ON CLINICAL QUALITY

One potentially perverse outcome of the pressure to improve value for money could be a reduction in the quality of patient care. With this in mind, we asked whether measures taken to achieve CIP targets would harm clinical quality. All but one finance director were very or fairly confident that measures being taken would not harm clinical quality. As many of the comments illustrate, one reason for this confidence is that measures taken to achieve CIP targets are 'stress tested' through, for example, risk-rating procedures and reviews by clinical directors. However, some report being confident only because of a relative failure to meet CIP or QIPP plans or stated that current plans had not yet gone far enough to risk harming clinical quality.

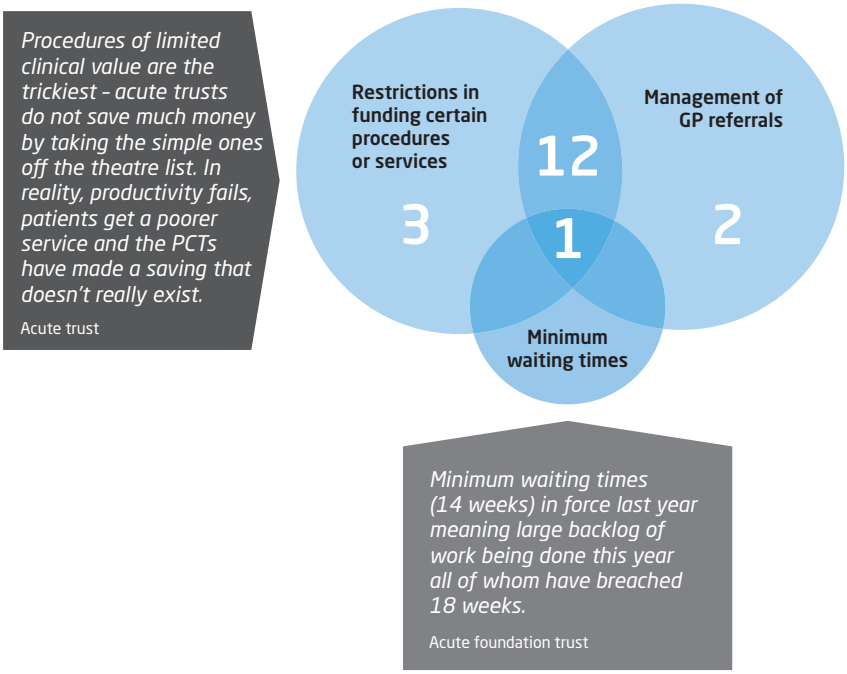
How confident are you that measures to achieve your CIP target will not harm clinical quality?



MEASURES BEING TAKEN TO MEET CIP/QIPP TARGETS

There are many ways in which NHS organisations plan to achieve their cost improvement and QIPP targets. We asked about three specific demand management tactics: restricting funding for certain procedures or services, managing GP referrals, and imposing minimum waiting times. These strategies are potentially controversial – although much depends on exactly how they are implemented. As the figure below shows, 18 organisations are managing demand through restricting funding for certain procedures or services and/or managing GP referrals to hospitals. More controversially, one organisation was also managing demand by imposing minimum waiting times. This practice has been criticised by the Co-operation and Competition Panel in one particular case (Co-operation and Competition Panel 2011) in that short-term savings (to a PCT) are likely to be outweighed by longer term costs to patients and the taxpayer.

Tactics to manage demand

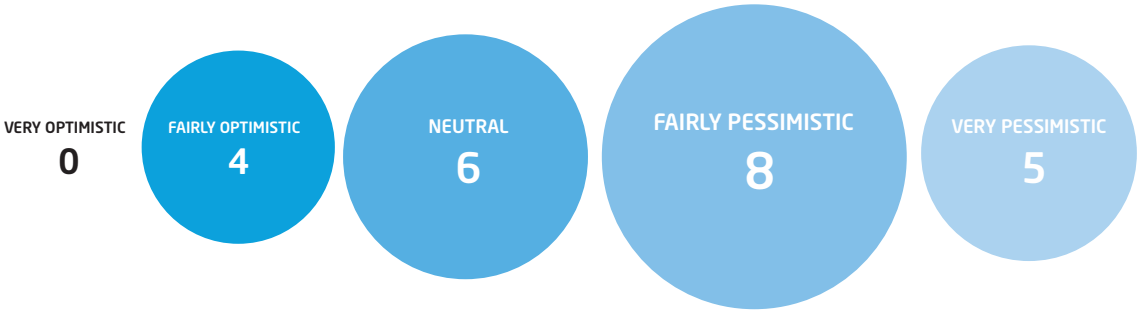


OPTIMISM ABOUT FINANCES OF LOCAL HEALTH ECONOMY

When asked how they felt in general about the financial state of their local health economy – not just of their own organisation, but of other local trusts and PCTs – over the coming year (2012/13), our panel of finance directors gave very similar, rather pessimistic, responses to last quarter's, with the majority (13) either very or fairly pessimistic.

While these results contrast somewhat with the relative confidence in achieving cost improvement targets and forecast end-of-year positions, the greater pessimism here probably reflects uncertainty about the coming financial year.

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



CHALLENGES ARISING FROM THE NHS OPERATING FRAMEWORK FOR 2012/13

The NHS Operating Framework 2012/ 13 published in November 2011 highlighted key challenges, opportunities and expectations for the NHS (Department of Health 2011a). We asked our panel what the three main challenges were arising from the Operating Framework. The table below groups actual responses from our finance directors' panel into major themes. Of note is the large number of responses concerning CIP, QIPP and the need to grapple with maintaining and improving the quality of services.

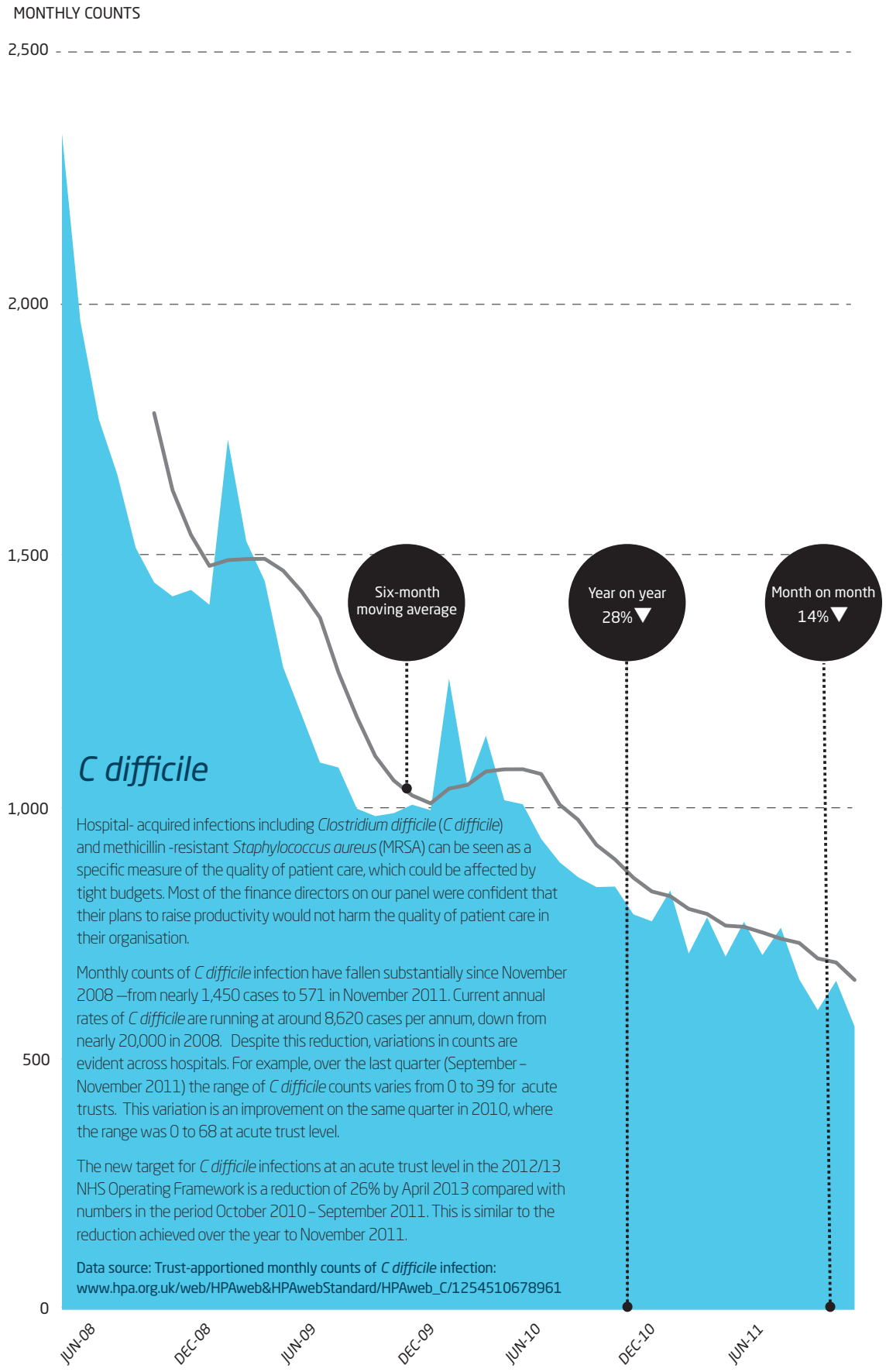
Challenges for 2012/13

CIP/QIPP/PRODUCTIVITY	• Ownership by providers of QIPP target – taking out capacity in areas of QIPP • QIPP • Reducing costs in response to QIPP activity in addition to CIP • Improving productivity/reducing costs • Hitting 5% efficiency again • Our savings challenge given 2011/12 performance • Delivery of the cost improvement and commissioner disinvestment programmes • Underlying CIP target • Managing demand for beds and clinics • Delivering CIPs • Delivering Cash Releasing Efficiency Savings (CRES) • Efficiency requirement in tariff • CIP delivery • SHA and DH realism: cannot set aside 3% of resource uncommitted (2% uncommitted headroom and 1% surplus) and expect to have a credible plan for delivery • NHS creating new cost pressures at national level • Realism by GPs and commissioning colleagues on what we can actually deliver, not what the benchmarks say we could aspire to achieving if we matched the best in case for every possible intervention and pathway • Identifying funds for investment to secure a transformation in pathways • Delivering the financial agenda without pain
QUALITY/CQUIN	• Achieving 2.5% Commissioning for Quality and Innovation (CQUIN) target given the clinical commissioning group's funding position • Meeting CQUIN goals if too tightly dictated by SHAs • Making sure additional CQUIN is achieved from PCTs • Achieving CQUIN • Maintaining and improving quality of care at the same time as delivery of financial position • Maintaining and improving quality • Maintaining quality and performance • Maintaining quality • Maintaining high-quality corporate services
TARGETS	• Maintaining waiting times/access • Referral-to-treatment-time targets • Waiting times – up this year, new target more difficult • Infection control – targets are getting ever tougher. Our MRSA target is so low that we could breach it in a bad week! • Readmissions • Readmissions • Readmissions rules remaining unchanged • Emergency threshold • Achieving 92 per cent of patients on an incomplete pathway waiting less than 18 weeks

CCG/PCT	• CCGs stepping up to deliver the QIPP targets • CCG – capacity and capability – impact of transition • The involvement of CCGs • Loss of staff due to there being no successor body to PCTs • Maintaining capacity and capability during transition in final year of PCTs • Clearing the historic PCT deficit • PCT [financial] position
TARIFF	• Negative tariff on the block contract • Unexplained tariff price reductions • Continued decrease of tariff • Mental health Payment by Results • Implementing Payment by Results for mental health in challenged health economy • Unfunded activity and activity pressures (all unfunded)
SOCIAL	• Impact of continued transfer of resources from health to social care (resource withdrawn with no apparent improvements in system) • Financial risk of service transfers to NHS Commissioning Board and local authority • Reductions of funding in social care impacting on the trust
OTHER	• Avoiding individual relationships with commissioners becoming entirely focused on transactions and fines and very short-term focused • Engagement of clinicians • Meeting foundation trust timetable • Creation of a hosted but autonomous community support unit • Acute capacity (staff count, not beds). Beds have come out but providers are using their staff capacity more efficiently, which results in same bill to commissioner, eg, day case instead of inpatient stay • Keeping mental health as a priority for the health economy • Meeting demands of CCGs (eg, for real-time information)

Selected NHS performance measures

The second part of our report gives 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 hospital-acquired infections (*C difficile* and MRSA); compulsory redundancies; waiting times for inpatients, outpatients, diagnostics, those still on lists, and accident and emergency; and delayed transfers of care.



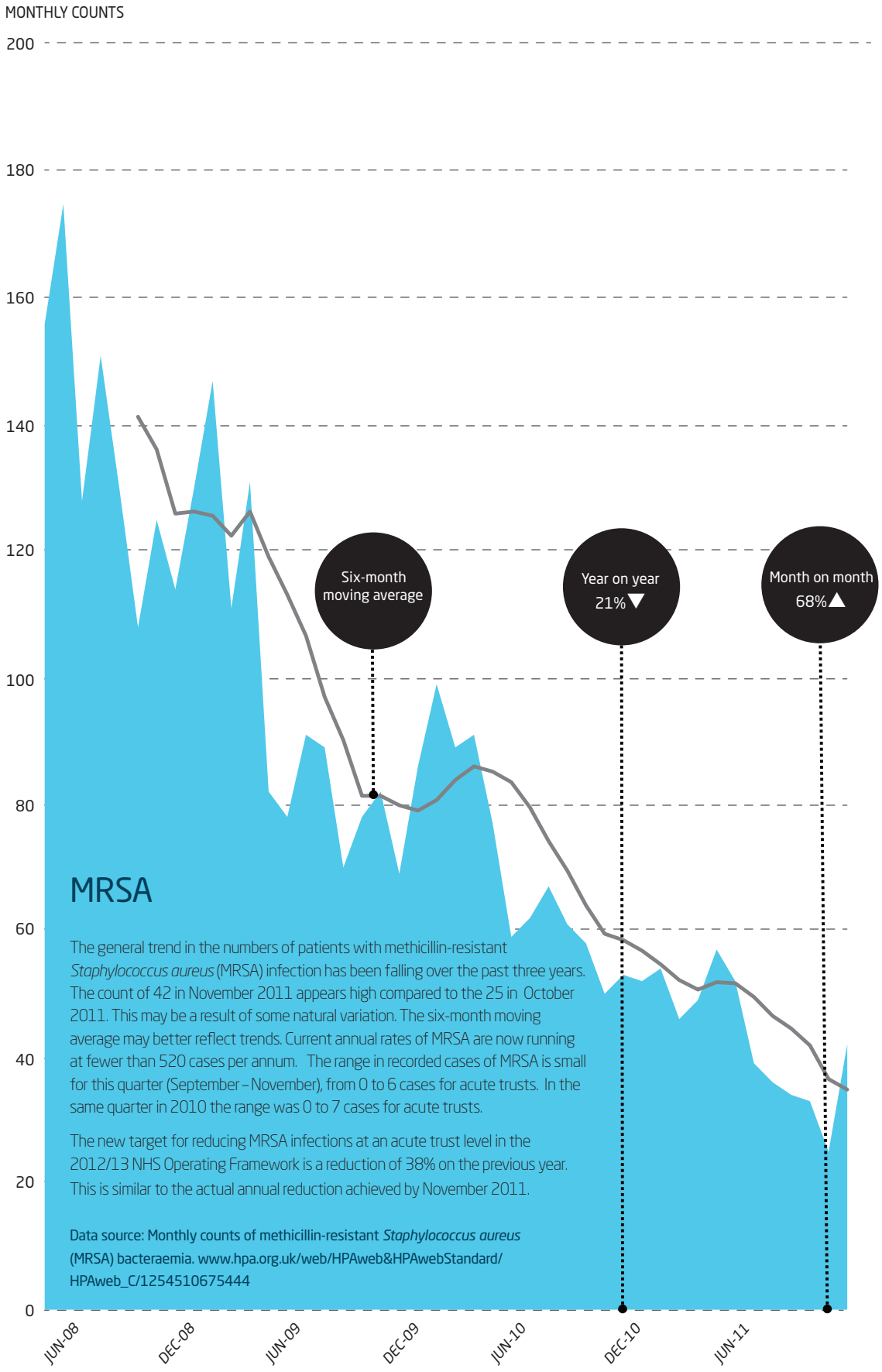
C difficile

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

Monthly counts of *C difficile* infection have fallen substantially since November 2008 —from nearly 1,450 cases to 571 in November 2011. Current annual rates of *C difficile* are running at around 8,620 cases per annum, down from nearly 20,000 in 2008. Despite this reduction, variations in counts are evident across hospitals. For example, over the last quarter (September – November 2011) the range of *C difficile* counts varies from 0 to 39 for acute trusts. This variation is an improvement on the same quarter in 2010, where the range was 0 to 68 at acute trust level.

The new target for *C difficile* infections at an acute trust level in the 2012/13 NHS Operating Framework is a reduction of 26% by April 2013 compared with numbers in the period October 2010 – September 2011. This is similar to the reduction achieved over the year to November 2011.

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 42 in November 2011 appears high compared to the 25 in October 2011. This may be a result of some natural variation. The six-month moving average may better reflect trends. Current annual rates of MRSA are now running at fewer than 520 cases per annum. The range in recorded cases of MRSA is small for this quarter (September – November), from 0 to 6 cases for acute trusts. In the same quarter in 2010 the range was 0 to 7 cases for acute trusts.

The new target for reducing MRSA infections at an acute trust level in the 2012/13 NHS Operating Framework is a reduction of 38% on the previous year. This is similar to the actual annual reduction achieved by November 2011.

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

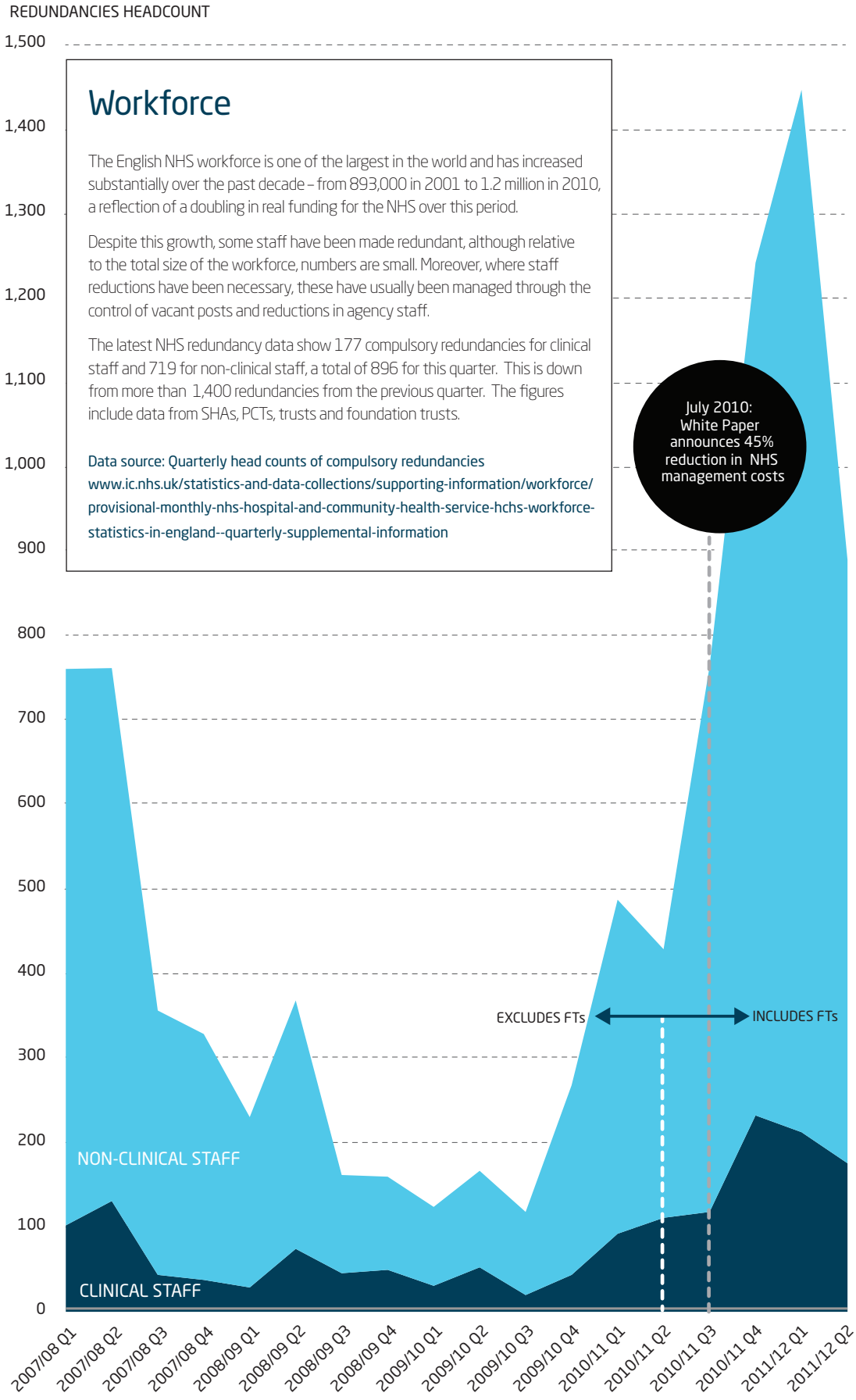
Workforce

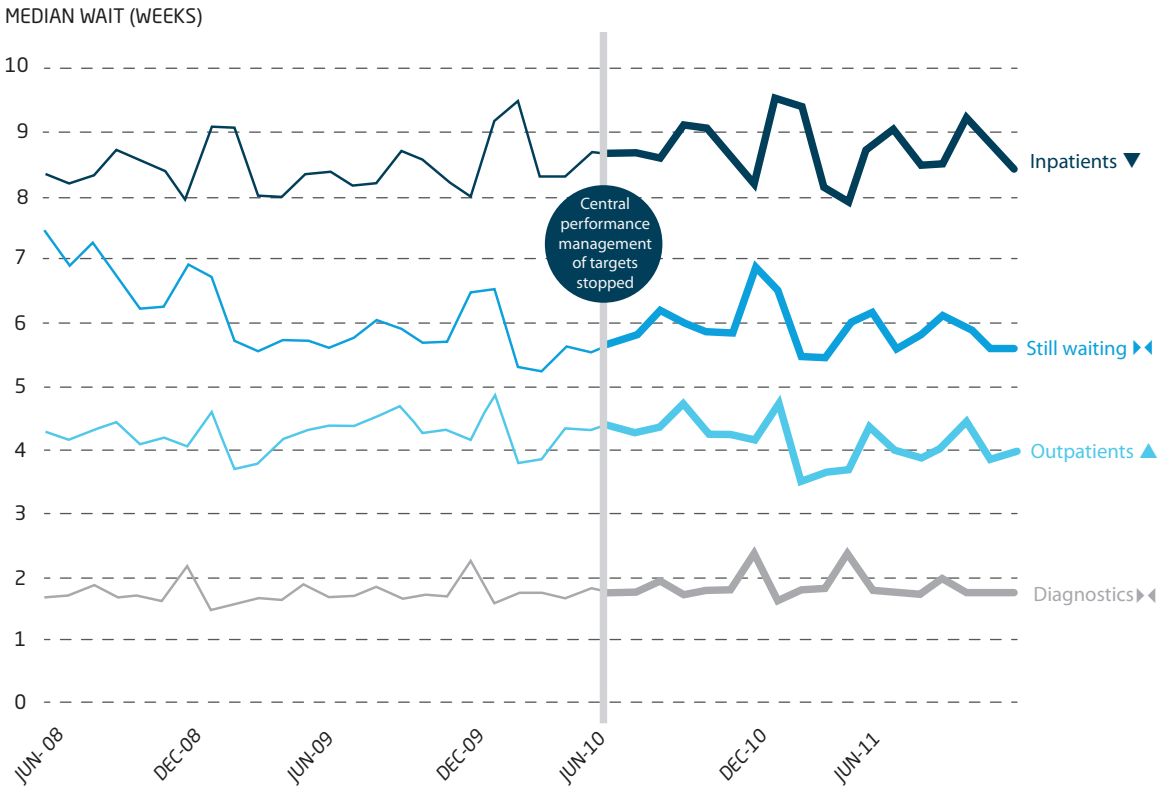
The English NHS workforce is one of the largest in the world and has increased substantially over the past decade – from 893,000 in 2001 to 1.2 million in 2010, a reflection of a doubling in real funding for the NHS over this period.

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 177 compulsory redundancies for clinical staff and 719 for non-clinical staff, a total of 896 for this quarter. This is down from more than 1,400 redundancies from the previous quarter. The figures include data from SHAs, PCTs, trusts and foundation trusts.

Data source: Quarterly head counts of compulsory redundancies
www.ic.nhs.uk/statistics-and-data-collections/supporting-information/workforce/provisional-monthly-nhs-hospital-and-community-health-service-hchs-workforce-statistics-in-england--quarterly-supplemental-information





Waiting times: Median*

In November 2011, median waiting times remained stable for diagnostics and patients still waiting to be admitted to hospital or attend outpatients, decreased slightly for patients already admitted as an inpatient, and increased slightly for those seen in outpatients. This is as expected following previous seasonal trends.

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

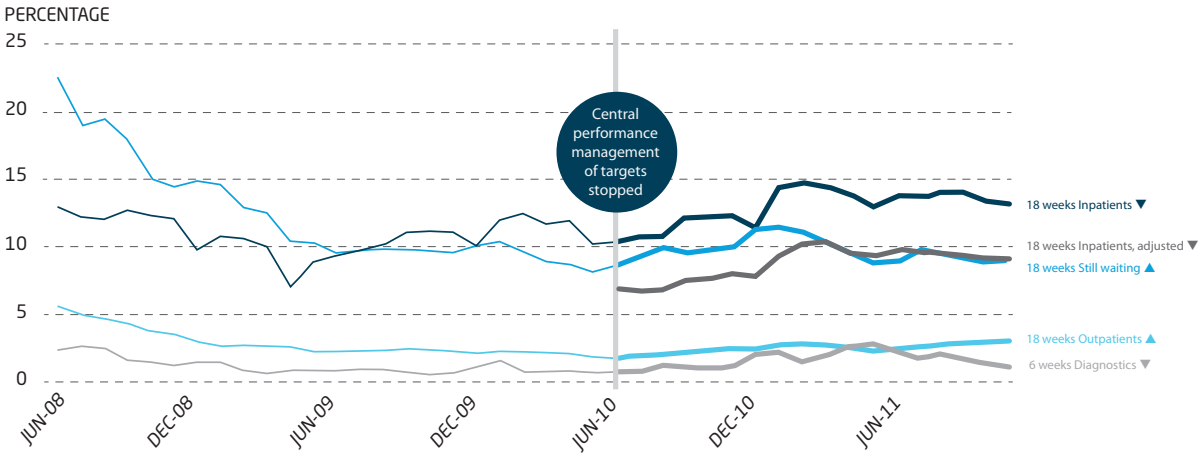
Data sources:
Referral-to-treatment waiting times statistics
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm
Diagnostic waiting times statistics
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm

Waiting times: 18 weeks

The latest 18-week referral-to-treatment waiting times data for November 2011 show increases in the percentage of patients waiting longer than 18 weeks for inpatient and outpatient treatment. Figures for those still waiting and for diagnostics fell slightly. Compared with November 2010, performance remains poorer for inpatient, outpatient and diagnostic waiting. Despite these increases, the 18-week target for inpatients (90 per cent admitted within 18 weeks – allowing for legitimate delays (the adjusted inpatient trend in figure below)) was met in November, just over 9 in 10 (90.95 per cent) of inpatients having waited less than 18 weeks. The operational standard for outpatients (95 per cent) was also met in November with more than 9 in 10 (97 per cent) of outpatients having waited less than 18 weeks.

The trend since June 2010 for the proportion of patients waiting more than six weeks for diagnostics was upward until May 2011 but has since reduced; however, the percentage waiting more than six weeks has risen from 1.07 per cent in November 2010 to 1.08 per cent in November 2011 – equivalent to a rise in the number of patients from 5,700 in November 2010 to more than 6,450 in November 2011. At 1.08 per cent the proportion of patients waiting for a diagnostic test is fractionally higher than the 2012/13 NHS Operating Framework standard of 1 per cent. However, this is still relatively low: over one third of patients waited more than 6 weeks in April 2007.

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



Data sources:
Referral-to-treatment waiting times statistics: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/PerformancedataandstatisticsReferralToTreatmentstatistics/index.htm
Diagnostic waiting times statistics: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm

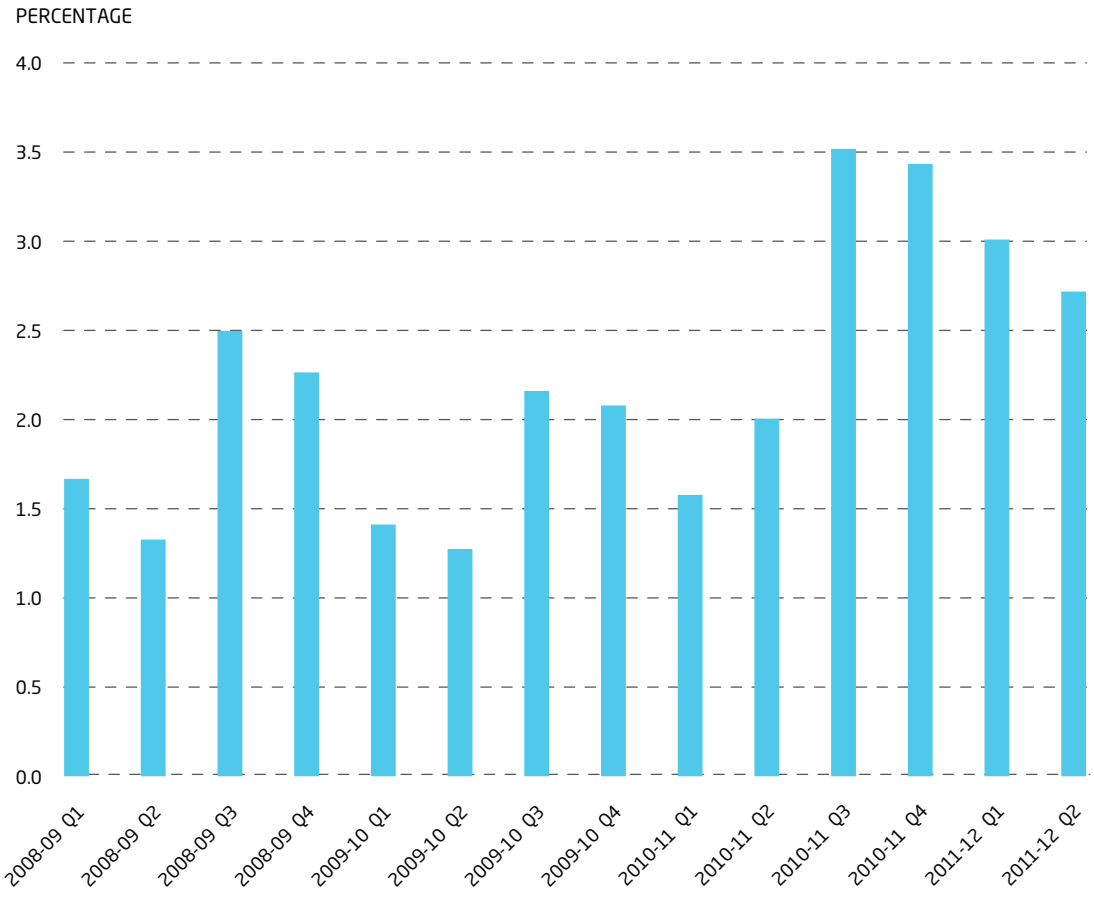
Having announced a new 18-week target for patients still waiting for hospital treatment in November 2011, the Department of Health has decided not to adopt this until 2012/13 at the earliest. The new target was proposed to reduce the number of patients still waiting for admission but who had already passed the 18-week maximum target. The aim is to ensure that no more than 8 per cent of patients on incomplete pathways should wait longer than 18 weeks. The current level of patients on an incomplete pathway in November 2011 still waiting longer than 18 weeks is 9.07 per cent – which means that the NHS is not meeting this target at present.

Waiting times: A&E

In the 2012/13 NHS Operating Framework, the Department of Health has maintained the threshold for performance management target that no more than 5 per cent of patients should wait more than four hours in A&E. Additional clinically led performance measures brought in during 2011/12 will continue in 2012/13 to be published at a local level.

The latest data for four-hour A&E waits (2011/12, quarter 2, September 2011) showed a continued decrease but remains historically high and masks considerable variation – 123 providers report less than 1 per cent waiting more than four hours whereas 18 report over 5 per cent. The latter have in effect breached the target threshold.

Percentage waiting more than 4 hours in A&E



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

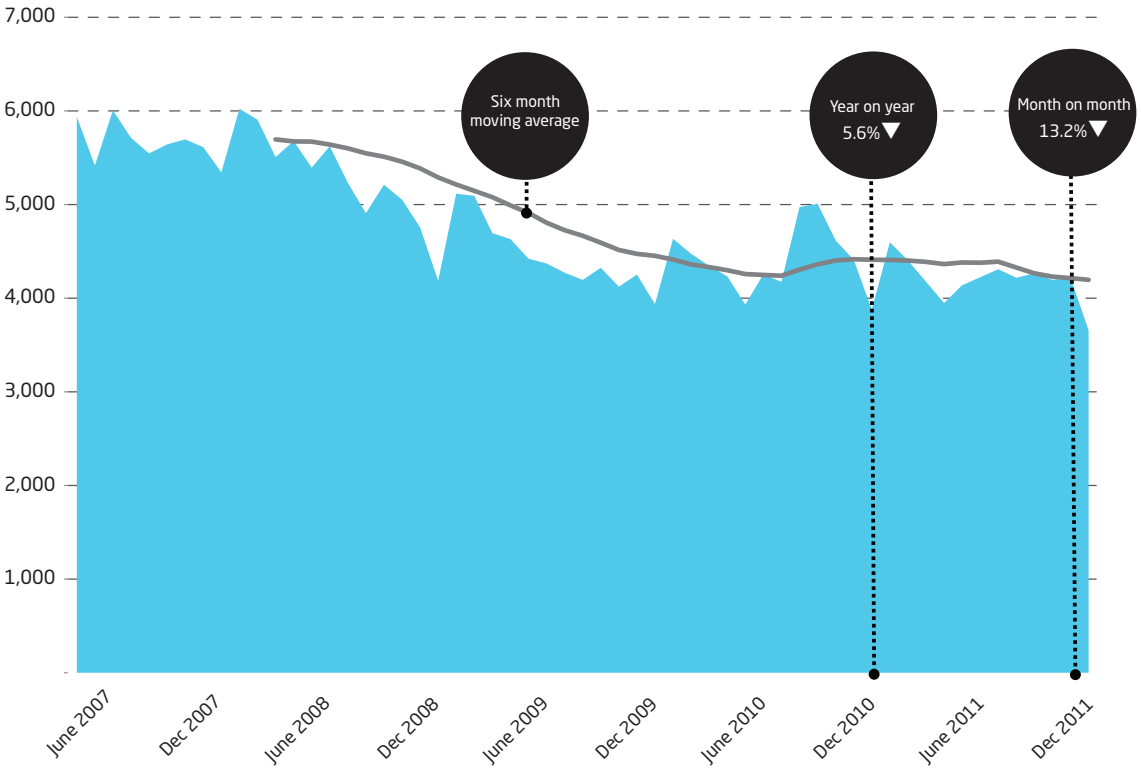
Delayed transfers of care

Delayed transfers of care (DTCs) are recorded when a patient is ready to leave hospital but cannot go because, for example, other services or family support the patient needs are not yet in place. Delays can occur across all hospital sites, regardless of the care they deliver. Previous quarterly monitoring reports have detailed DTCs only for acute care, here we also include non-acute care.

The most recent data shows the number of acute and non-acute DTCs for December 2011 decreased on the previous month by 13.2%. Compared to December 2010 the number of DTCs decreased by 5.6%. The decrease in December 2011 was expected given the strong seasonal pattern over winter, with the number of patients delayed falling over Christmas (followed in January by an increase). The figure also shows that since June 2010 the six-month moving average trend for delayed transfers has been fairly stable, with around 4,500 patients facing a delay on a given day in any one month.

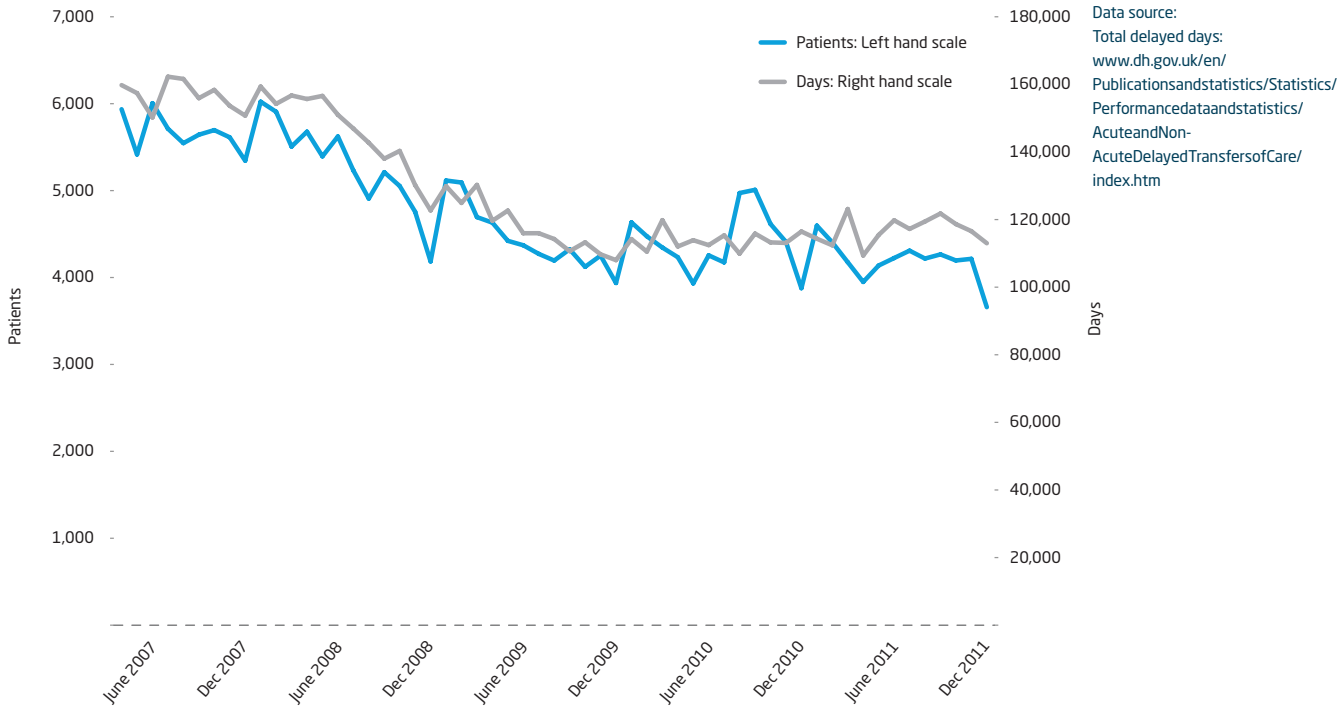
Data source:
Acute and non-acute delayed transfers of care, patient snapshot: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/PerformancedataandstatisticsAcuteandNon-AcuteDelayedTransfersofCare/index.htm

Delayed discharges: Monthly counts of patients



Another way of viewing delayed discharges is by the number of days accounted for by patients unable to leave hospital; although the count of patients can remain stable, bed days may change depending on how long each patient is actually delayed. The figure below shows the number of days associated with delayed discharges as well as the number of patients delayed. Trends are broadly similar across both measures.

Delayed discharges: Patients and days delayed



Data source:
Total delayed days: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm

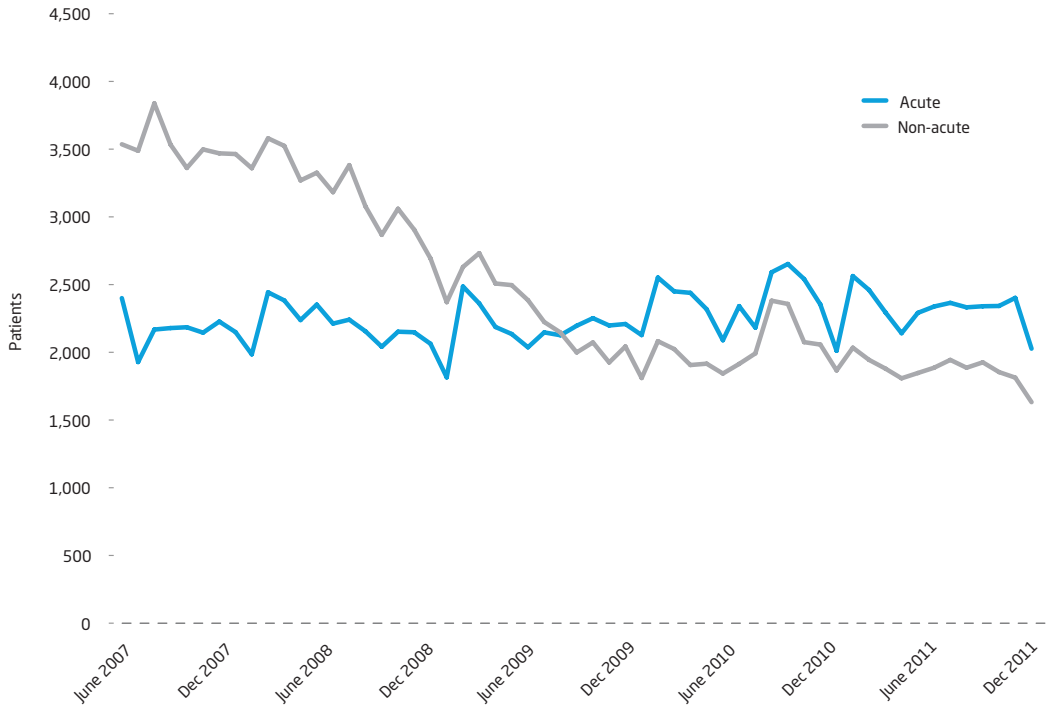
Data source:
Acute and non-acute delayed transfers of care, patient snapshot: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm

Our finance directors' panel survey provides another, more anecdotal, perspective on delayed discharges. As the figure shows, asked about recent trends in delayed discharges in their area, respondents were more or less split between reporting increases and reporting no change. A few stated that delays were decreasing.

View of recent trends for delayed transfers of care in local health economies

It is worth noting that there are differences in recent trends of delayed discharges depending on the location and stage of care for patients. Patient delays classified as 'acute' include patients who are delayed leaving acute care (eg, after an operation) and those waiting to move to another stage of care, for example, rehabilitation (possibly within the same hospital). Delays classified as 'non-acute' include patients delayed going home following, say, convalescence, or delayed moving on to another form of non-acute care. In these definitions, 'acute' should not be interpreted as either more important or more urgent than non-acute.

Acute and non-acute delayed transfers of care



Data source: Acute and non-acute delayed transfers of care, patient snapshot www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm

Overall, the general picture that emerges from these various views on delays in getting patients out of hospital is that at the national aggregate level, delays in terms of patient numbers and days remain fairly stable. As the long-term trends show, there are, of course, fluctuations from month to month and, especially around Christmas and the New Year, some seasonal trends. This suggests some caution is needed not to over-interpret particular month-to-month or year-to-year changes. But as the finance directors' panel responses show, there is also variation between areas that will depend on local circumstances – such as spending priorities of local authorities and the use to which the NHS transfer to local authorities of around £700 million in this financial year are put.

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