



How is the NHS performing?

Quarterly monitoring report

September 2012

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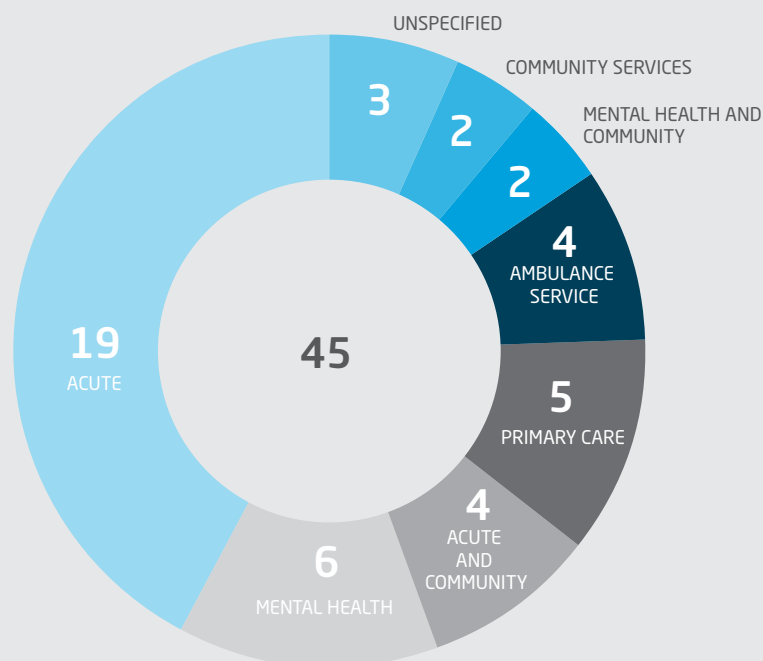
The King's Fund published its first *Quarterly Monitoring Report* in April 2011 as part of its work to track, analyse and comment on the changes and challenges the NHS is facing. This is the sixth report and aims to take stock of what is happening on the ground, 18 months into the Nicholson Challenge. It provides an update on how the NHS is coping as it continues to grapple with the £20 billion 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 finance directors on the key issues their organisations are facing.

THE FINANCE DIRECTORS' PANEL SURVEY

This quarter we carried out an online panel survey between 16 and 30 July 2012. One hundred and nineteen finance directors were contacted to take part and 45 were available to give their views.

The figure below provides a breakdown of the type of organisations represented in the survey



Overview

HEADLINES

- A majority of finance directors are confident of delivering on planned cost improvement targets of, on average, just under 5 per cent.
- Nearly all NHS organisations surveyed also felt confident of ending this year in surplus or at break even.
- However, 18 months into the current four-year £20 billion productivity challenge, a majority thought there was a very high or high risk that the NHS as a whole would not deliver on its £20 billion productivity target by 2015.
- Next year is seen by many finance directors as a potential turning point as savings and productivity gains become harder to deliver and the two-year public sector pay freeze comes to an end in April 2013. This could have negative consequences for the quality of patient services – more than 40 per cent of finance directors said that they expect patient care to worsen over the next few years.
- Despite remaining a key concern among finance directors, in broad terms and with some fluctuations over the past two years, the NHS has so far managed to maintain the historic reductions in waiting times it achieved by the middle of 2009, as well as continuing impressive reductions in health care-acquired infection rates.
- However, there is growing pressure on emergency care, with the proportion of patients waiting longer than four hours in accident and emergency (A&E) departments at its highest level for this quarter since 2004/5. In addition, there is a possible emerging upward trend, beginning in the middle of 2009/10, in the proportion of patients waiting more than four hours to be admitted to hospital via A&E (so-called ‘trolley waits’).

Revised spending and inflation figures for 2011/12 revealed that NHS spending in England fell in real terms fractionally (by 0.02 per cent) and is planned to rise by around 1.3 per cent in 2012/13. However, as in previous years, small changes in actual spending and inflation rates will almost certainly mean this figure will change. Despite some clawback of funding by the Treasury, the NHS started 2012/13 with an estimated surplus of nearly £1.6 billion in primary care trusts (PCTs), strategic health authorities (SHAs) and NHS trusts carried over from 2011/12 (Department of Health 2012b) and surpluses in foundation trusts totalling around £0.4 billion (Audit Commission 2012). The plan for this year is to continue this strategy to generate surpluses to carry over to the new NHS Commissioning Board in 2013/14 – with no PCT allowed to plan for a deficit (Department of Health 2011).

Overall, however, despite small changes at the margin, funding remains very tight, especially for sections of the NHS – such as hospital trusts – subject to tariff and other pressures.

Our latest panel survey of 45 finance directors across all types of NHS organisations reports a degree of optimism about the forecast outturn position for March 2013. The vast majority (42) forecast a surplus or breakeven position, with just three suggesting possible deficits. While this year's real reduction in tariffs of almost 2 per cent (following a real overall cut of around 1.5 per cent last year) has created extra pressure on providers to reduce costs, the national pay freeze has to a large extent attenuated cost inflation for providers.

There is a comparatively optimistic view on the key task for the NHS over the medium term – meeting productivity and cost improvement targets this year. Cost improvement targets may remain tough – averaging around 4.8 per cent for the year – but the majority (33) of our survey panel remain very or fairly confident of meeting their cost improvement programme (CIP) plans. It remains to be seen whether such optimism will be borne out in practice towards the end of the year.

It is the longer term that presents greater worries as the current pay freeze ends next April, one-off savings due to reductions in management costs start to slow and general efficiency improvements become harder to realise without more radical service change. The end of the public sector pay freeze could be particularly significant – an average increase of 1 per cent in staff pay would add around £400 to £500 million to NHS expenditure – adding substantially to financial pressures and increasing the strain on services. Asked to assess the risk of the NHS as a whole not meeting its £20 billion productivity target by 2015, 27 finance directors felt there was a very high or high risk of failure, with just 4 assessing little risk of failure.

Such pessimism is also reflected in views about the quality of local patient care services. While most thought the quality of services had stayed the same – with 14 feeling they had got better and 7 worse in the past 12 months – only 8 thought they would get better over the next few years and 19 thought they would get worse. The view that, while the NHS locally and nationally has coped well up to now, things will get much more difficult on a number of fronts next year is evident in other results from our survey: half (23) were fairly or very pessimistic about the state of their local health economy's finances over the next 12 months compared to just 11 who felt fairly optimistic. No one was very optimistic.

While there has almost certainly never been a time when the NHS has not faced one organisational challenge or other, the continuing need to generate unprecedented productivity improvements overlaid with implementation of the coalition's reforms of the service mean that many organisations will face difficult decisions over the next year. Key issues that NHS organisations are currently most concerned about include meeting various targets – particularly the 18-week referral-to-treatment waiting time target, further reductions in health care-acquired infections (already at an all-time low) and the A&E four-hour wait target. Finance directors also report concerns about rising emergency admissions (and coping with consequent financial penalties) and, for some, increases in demand generally at a time when tariff prices are being squeezed in real terms.

Progress on maintaining or improving performance across a selected range of official measures broadly looks good – although there may be some signs of pressure and continuing variation in performance at local level.

While the latest month-on-month change (June to July 2012) in methicillin-resistant *Staphylococcus aureus* (MRSA) rose by 7.7 per cent (but *Clostridium difficile* (*C difficile*) fell slightly by under 1 per cent) – the general downward trend continues, and the year-on-year changes remain impressive: a 35 per cent drop in *C difficile* and a 22 per cent drop in MRSA monthly counts.

Although waiting times were seen as a potential barometer of the financial and organisational pressures facing the NHS, in broad terms the service has so far managed to maintain the historic reductions in waiting times it achieved by the middle of 2009. Since June 2010, when the coalition government relaxed the central performance management of the 18-week referral-to-treatment waiting time targets, waiting times rose to a peak around the winter of 2010 but have since declined to levels similar to June 2010. Notably, the proportion of patients still on lists who are waiting more than 18 weeks has fallen from a peak of around 11 per cent in January 2011 to around 6 per cent in July this year.

However, while the proportion of patients waiting more than four hours from arrival in A&E to admission, transfer or discharge in the first quarter of 2012/13 (from April to June) fell by 17 per cent over the previous quarter (an expected seasonal pattern), there was a 16 per cent increase compared to the first quarter of 2011/12. Nevertheless, overall, the NHS remained within target on this waiting times measure, and the number of trusts breaching the target also fell this quarter – from 48 to 35.

However, on another A&E waiting time metric – so-called ‘trolley waits’ – from quarter 1 in 2009/10, there has been a general upward trend in the proportion of patients waiting more than four hours prior to admission to hospital via A&E: from 1.5 per cent in 2009/10 to just under 3 per cent in the last quarter. As with all waiting time figures, there are noticeable seasonal trends producing fluctuations from month to month and quarter to quarter which make detection of more general trends difficult. However, the latest quarterly trolley wait figure is the highest quarter 1 figure since 2004/5.

The impact of government commitments to cut management costs is clearly evident from routine NHS workforce statistics. Since March 2010 the number of managers has reduced by around 8,000 (to 35,555) – a drop of around 18 per cent. On the other hand, the number of consultants has risen by 10 per cent since September 2009, while the number of nurses – the largest NHS staff group – has fallen by around 5,500 (a reduction of 2 per cent) since March 2010 following an increase of around 3,600 between September 2009 and March 2010. The end of the public sector pay freeze in April will make it harder for NHS organisations to maintain current levels of clinical staff.

Despite anecdotal worries concerning changes in the number of (acute and non-acute) patients who are delayed in transferring either back home, to residential care or to other care within the NHS, and despite some fluctuations from month to month, official statistics suggest there has been a 6.2 per cent reduction over the previous year and a continuing slight decline in the six-month moving average. Indeed, over the current financial year to date (April to July) there was an average of around 3,995 patients facing delays compared with an average of 4,125 patients per day in 2011/12.

Finance Directors' Panel

I can see a way through this year with efficiency plans but they are getting more and more difficult and a stronger sense from clinicians that this is the last year where this magnitude of savings is possible.

Acute foundation trust

2013/14 is when I am expecting CIP confidence in delivery to reduce.

PCT cluster

This quarter's report is based on an online survey of 45 finance directors, 40 from provider and 5 from commissioner organisations. The panel were asked about: their financial situation; savings plans; challenging issues they are, and will be, facing this year; the state of the care they deliver; state of their local health economy; and their assessment of the ability of the NHS to meet its productivity challenge by 2015.

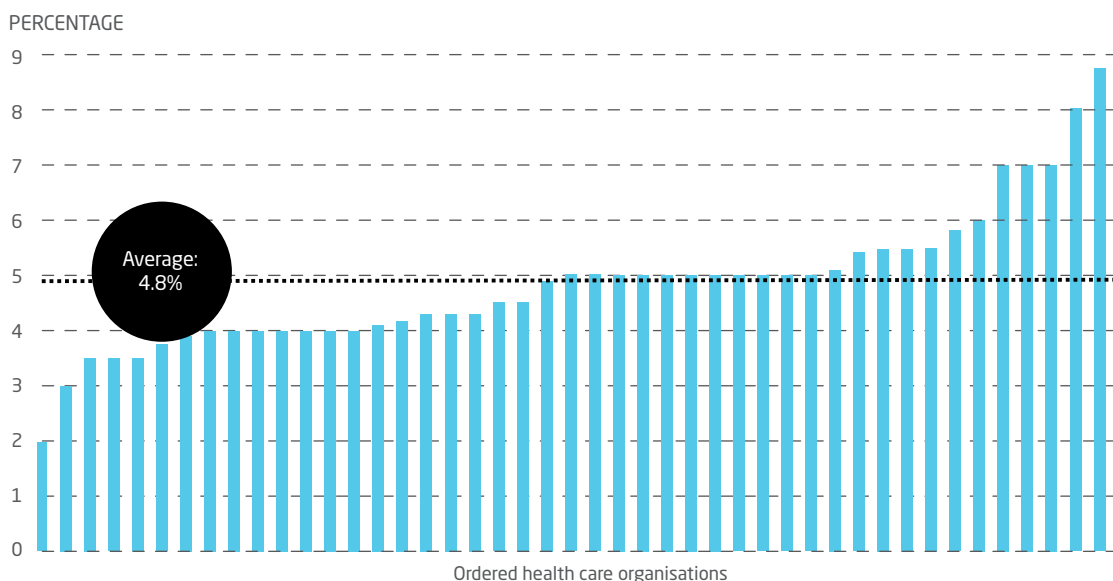
COST IMPROVEMENT PROGRAMMES AND END-OF-YEAR FINANCIAL SITUATION

2011/12 was the first full year of the £20 billion productivity challenge, and our last survey (carried out in May) indicated that our panel of finance directors aimed to achieve cost improvement programmes (CIPs) amounting to 5.2 per cent on average and actually achieved 4.7 per cent. Nationally, official figures reported savings for 2011/12 amounting to £5.8 billion (Department of Health 2012b). Now, part way into the second year of the productivity challenge, how are NHS organisations faring?

Across the whole panel, the average CIP target reported for 2012/13 was 4.8 per cent, ranging from 2 per cent to 8.7 per cent (see figure below).

The majority (26) of finance directors reported a CIP target of 4 to 5 per cent, 7 a target of less than 4 per cent, 7 a target of between 5 and 6 per cent and 5 a target of more than 6 per cent.

What is your organisation's cost improvement programme (CIP) target for 2012/13 as a percentage of turnover?

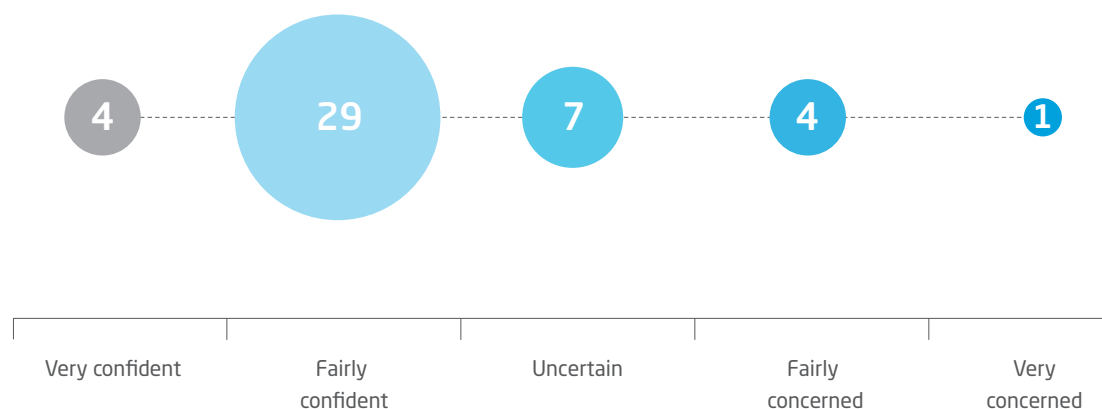


Very challenging position and at Q1 difficult to judge the whole year, but this is latest forecast.

Acute trust

Confidence in meeting these plans is high – almost three-quarters (33) were confident (fairly or very) that they would meet their target CIP. However, five finance directors were concerned that they would not achieve plans and seven were uncertain.

How confident are you of achieving your CIP target in 2012/13?



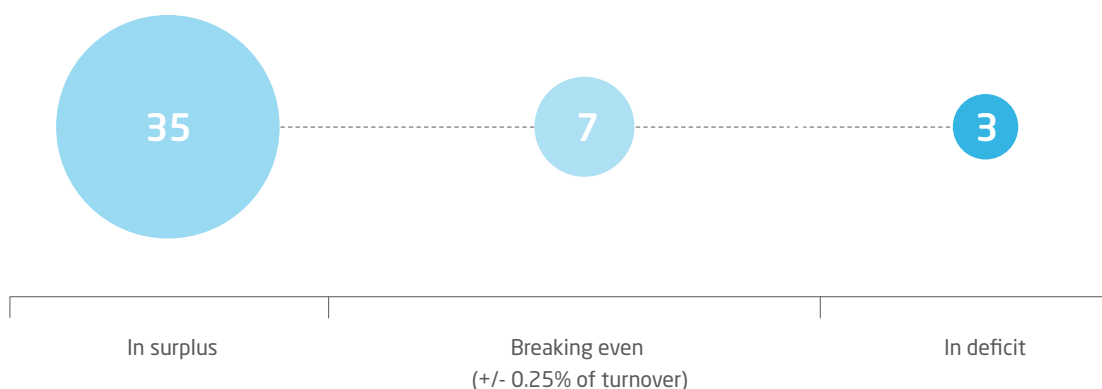
Unless we can reduce the unit cost of pay we are severely restricted in what we can achieve.

Acute foundation trust

2012/13 will be a challenging year for the NHS as it gears up to deal with significant organisational change from April 2013 while continuing to focus on delivering, maintaining and ensuring quality services to patients.

From last May's survey, only 4 out of 60 finance directors reported an end-of-year deficit – with 3 indicating these were the result of planned restructuring costs or revaluations. Part way into the new financial year prospects for achieving breakeven or better look good: over three-quarters (35) of those surveyed forecast a surplus by April 2013, 7 a breakeven position and 3 a deficit (with 1 organisation indicating that this is a planned deficit as a result of merger plans)

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



THE NHS PRODUCTIVITY CHALLENGE

*Very modest surplus
of about 1 per cent.*

Foundation trust

While the £20 billion productivity target set for the NHS for the four-year period of the 2010 Spending Review was acknowledged as an extremely challenging goal, continued problems with the economy as a whole now suggest that the NHS will face a difficult financial climate after 2015. As David Flory has noted: 'QIPP is therefore no longer a strategy for managing the NHS up to 2015; it is going to have to become a way we manage the service for the foreseeable future' (Department of Health 2012b).

*We will claim success
but there could be some
impact on service eg,
local access and likely
to be more failing, or
at risk, providers.*

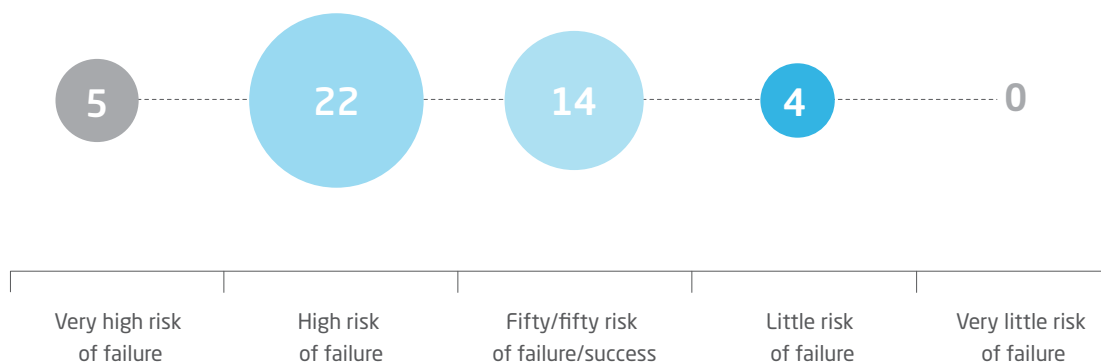
Acute trust

Quite how difficult it will be for the NHS to sustain the level of savings it achieved in 2011/12 beyond 2015 is reflected in responses to a question asked in our panel survey. Asked to estimate the risk of the NHS not achieving its £20 billion productivity target, 27 finance directors stated there was a high or very high risk of failure; 14 thought there was an even chance of success or failure, with just 4 stating there was little risk. This is in part reflected by Quality, Innovation, Productivity and Prevention (QIPP) plans, which are front-loaded, with the value of plans declining from £3.8 billion last year to £2.6 billion by 2014/15 (Health Service Journal 2012)

*It will be achieved on
paper. Too important
politically for it not to be.*
Provider

The apparent contrast with the relative confidence expressed in achieving planned savings this year is perhaps explained by the comments of one finance director, who thought that it would be next year (2013/14) when the ability to squeeze more savings out of the system will start to become much more difficult.

What is your estimate of the risk of the NHS not achieving productivity gains of the value of £20 billion by 2014/15?



THE STATE OF PATIENT CARE

Meeting cost improvement targets and ensuring financial balance are absolutely key objectives this year. 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 them.

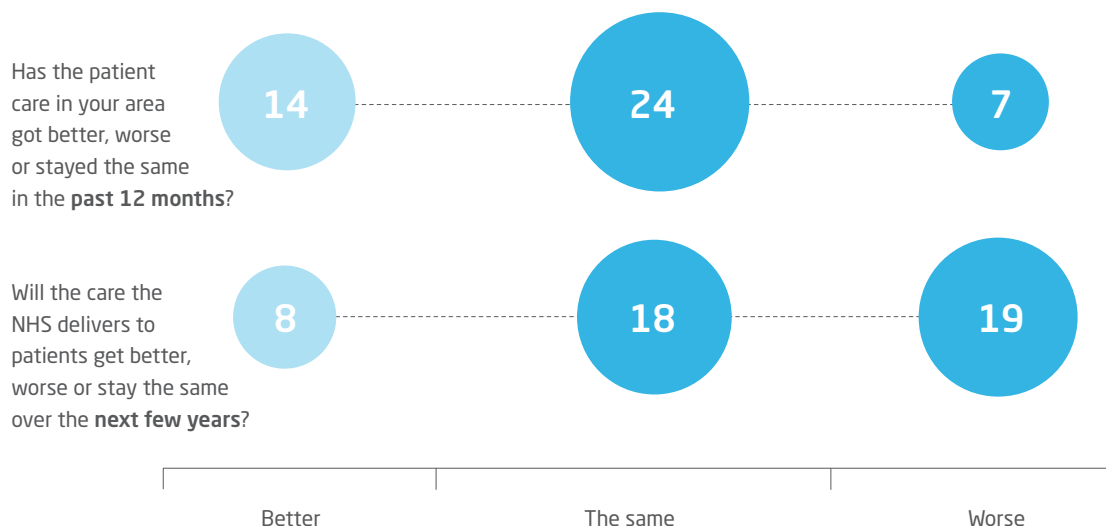
Some indications of better joined-up working. Measures of care are improving.

Acute trust

When asked about the state of patient care in their area, finance directors were generally optimistic about the past year but considerably more pessimistic about the next few years.

Thirty-eight finance directors expressed the view that in the past 12 months patient care had become better or stayed the same, with 7 stating it had got worse (see figure below).

Changes in the quality of patient care over the past year and over the next few years



Increased delayed transfers of care. Increased emergency admissions. Lengthening elective waits.

Acute foundation trust

However, views about the longer term – mirroring the lack of optimism about the ability of the NHS to meet its productivity goals by 2015 – reveal that 19 finance directors feel that patient care will get worse, and 26 that it will get better or stay the same.

These views about the future mirror similar findings from a survey of NHS staff carried out on behalf of the Department of Health conducted in winter 2011 (GfK NOP Social Research 2012). This found that 53 per cent of those surveyed thought that care would get worse over the next few years, with just 24 per cent thinking it would get better.

Key areas of care OK. More rationing of less urgent care.

Acute foundation trust

Additional comments from finance directors in our survey suggest a number of reasons for pessimism about the future ranging from a feeling that something has to give under continuing financial pressures, to concerns

that if necessary transformations (not marginal changes) to services are not planned but rather forced on the NHS as it struggles to cope with a tough financial future, such change may not necessarily be the right change.

ORGANISATIONAL CHALLENGES

The next 12 months should be OK. It's the longer term effect of year-on-year real efficiency that is of greater concern.

Community trust

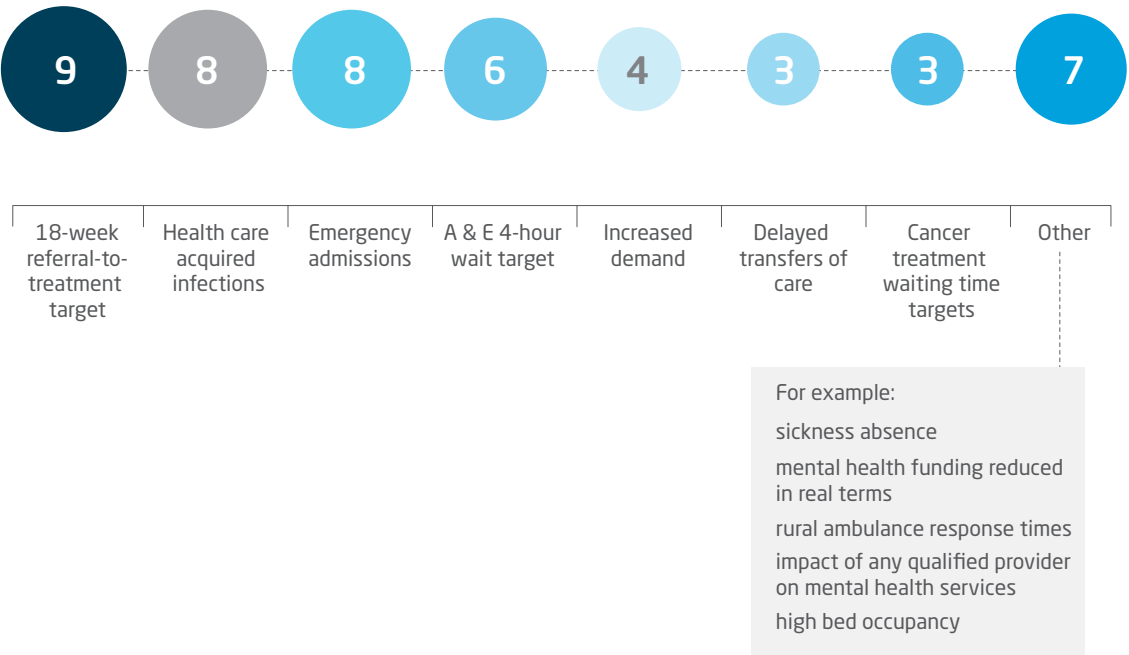
There has probably never been a time in the history of the NHS when NHS organisations have *not* faced one organisational challenge or another. But clearly, the scale of the current system reform, overlaid on an unprecedentedly parsimonious financial settlement and the associated and equally unprecedented productivity target add up to a particularly challenging set of circumstances.

The system will cope with its current resources but demand is increasing and the arrival of CCGs is not indicating joined up thinking, with a void in the system management role.

Acute foundation trust

To understand how this environment was affecting NHS organisations our survey asked finance directors to state just one aspect of their organisation's performance that was giving them most concern at the moment. The top three concerns were the 18-week referral-to-treatment target, the health care-acquired infection target and a number of issues concerning emergency admissions – largely related to increases in admissions and associated financial penalties whereby hospitals are not reimbursed for emergency readmissions (with some exemptions) within 30 days of discharge and the marginal rate tariff of 30 per cent of full reimbursement on admissions exceeding a threshold.

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



* Only one choice solicited. However, some additional issues included from comments made by respondents so total number of responses adds up to more than 45.

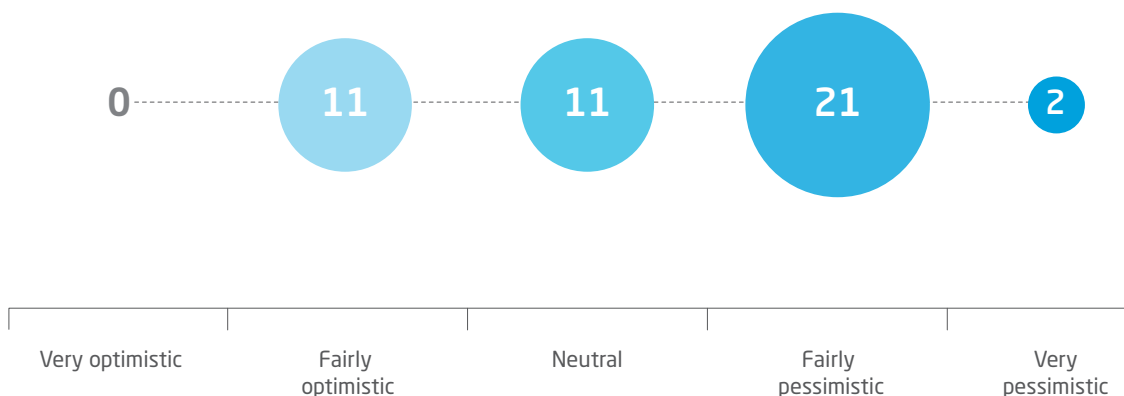
THE FINANCIAL STATE OF LOCAL HEALTH ECONOMIES

Will be very difficult to deliver the required investment in quality and safety at the same time as diverting funds to support the transition to the new commissioning organisations.

Cluster PCT

When asked about how they felt in general about the financial state of their local health economy – not just their own organisation – over the next 12 months just over half (23) were fairly or very pessimistic. This is a similar proportion from our previous panel survey in May. Eleven respondents stated that they were fairly optimistic and a further 11 that they were neither optimistic nor pessimistic.

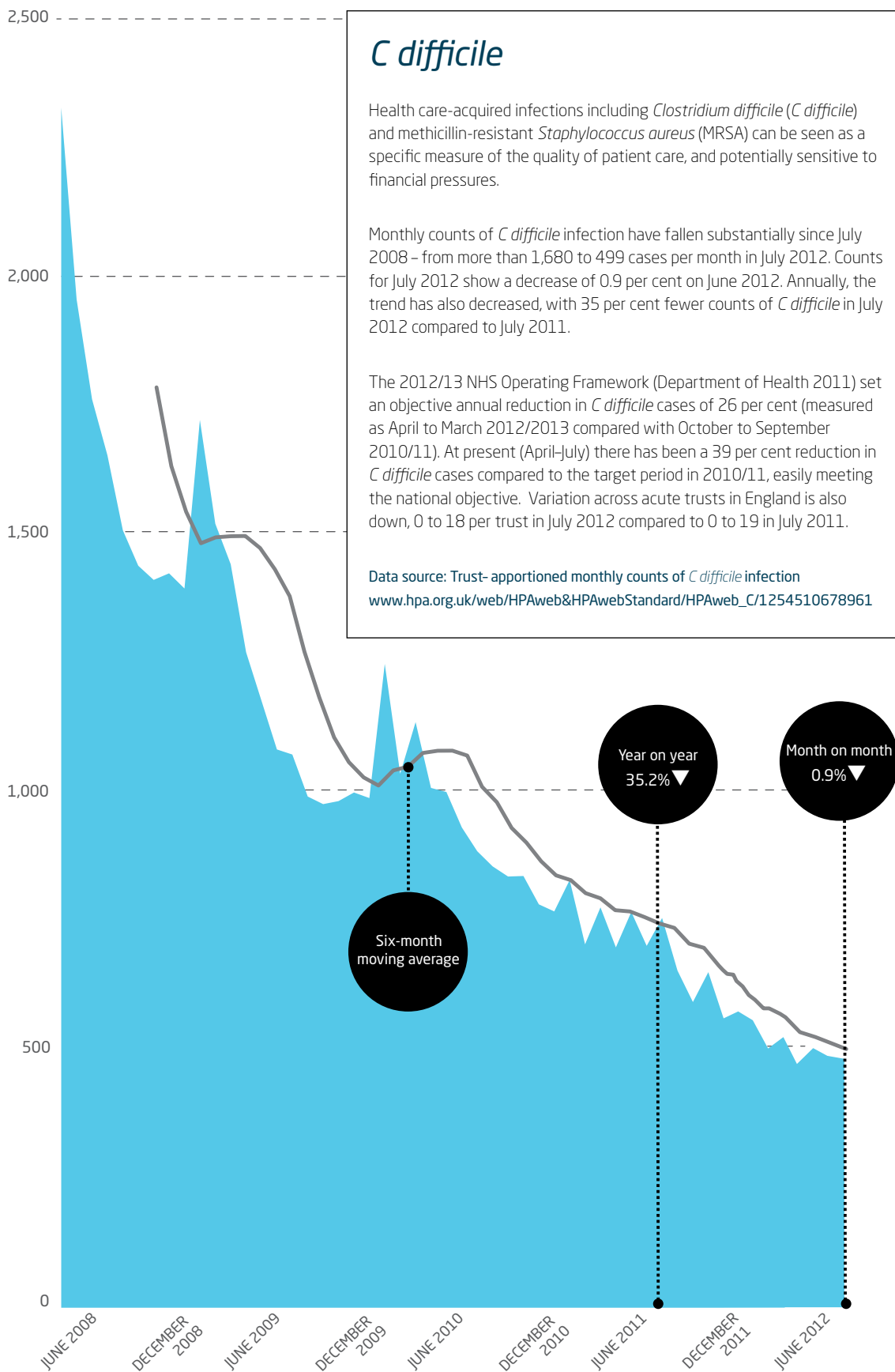
Overall, what do you feel about the financial state of the whole health economy in your area over the next 12 months?



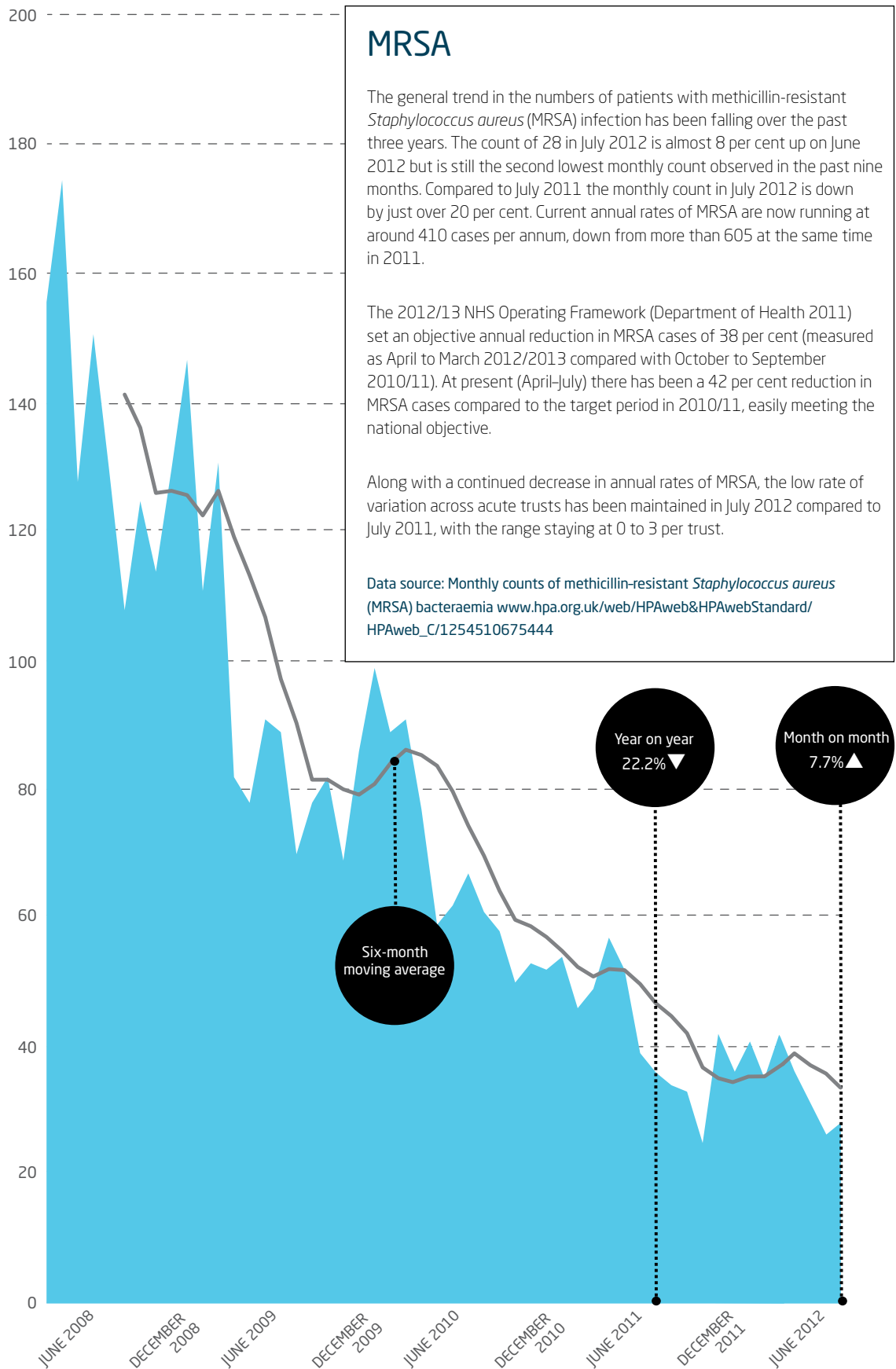
SELECTED NHS PERFORMANCE MEASURES

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.

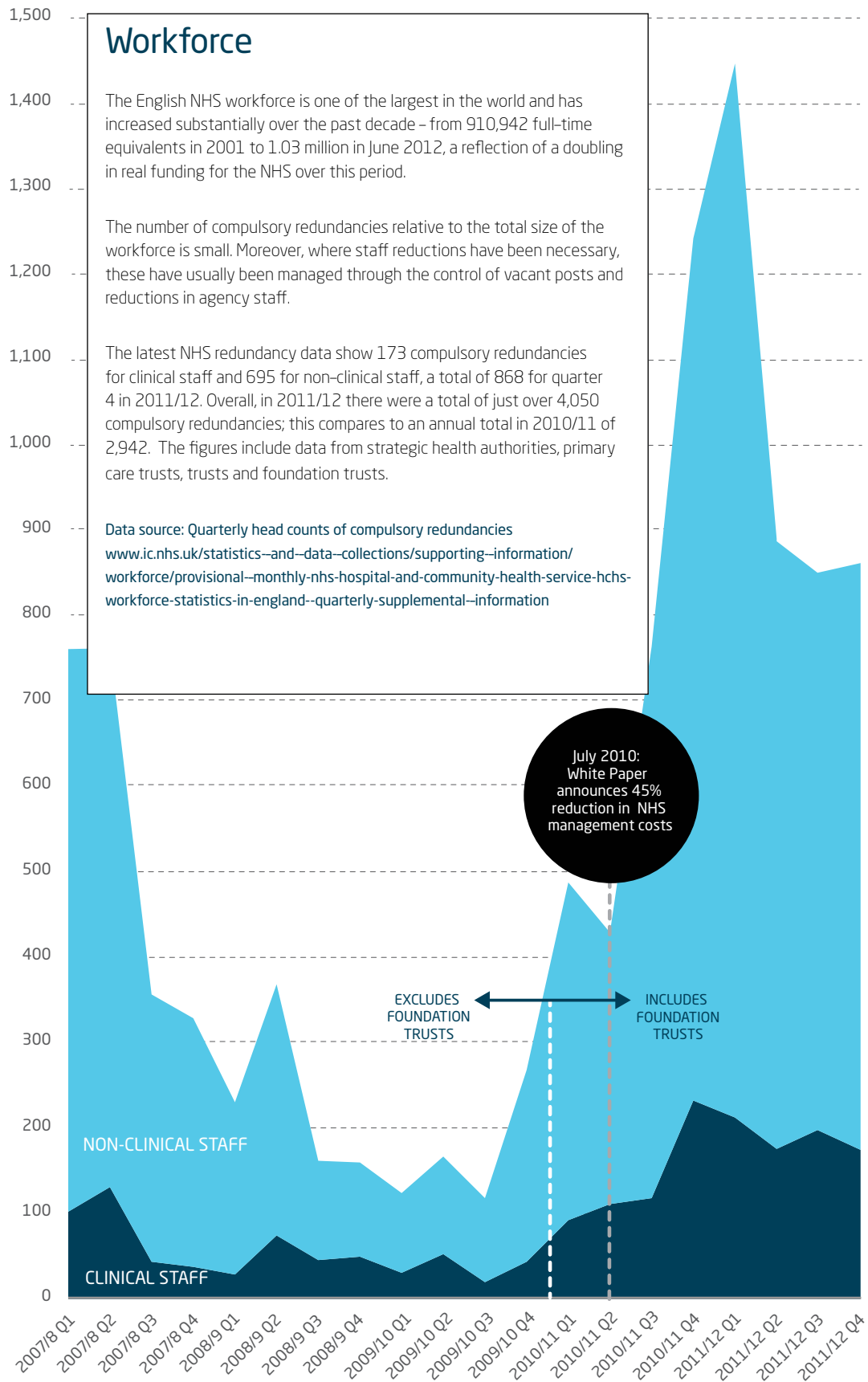
MONTHLY COUNTS



MONTHLY COUNTS



REDUNDANCIES HEADCOUNT



Workforce: Staff numbers

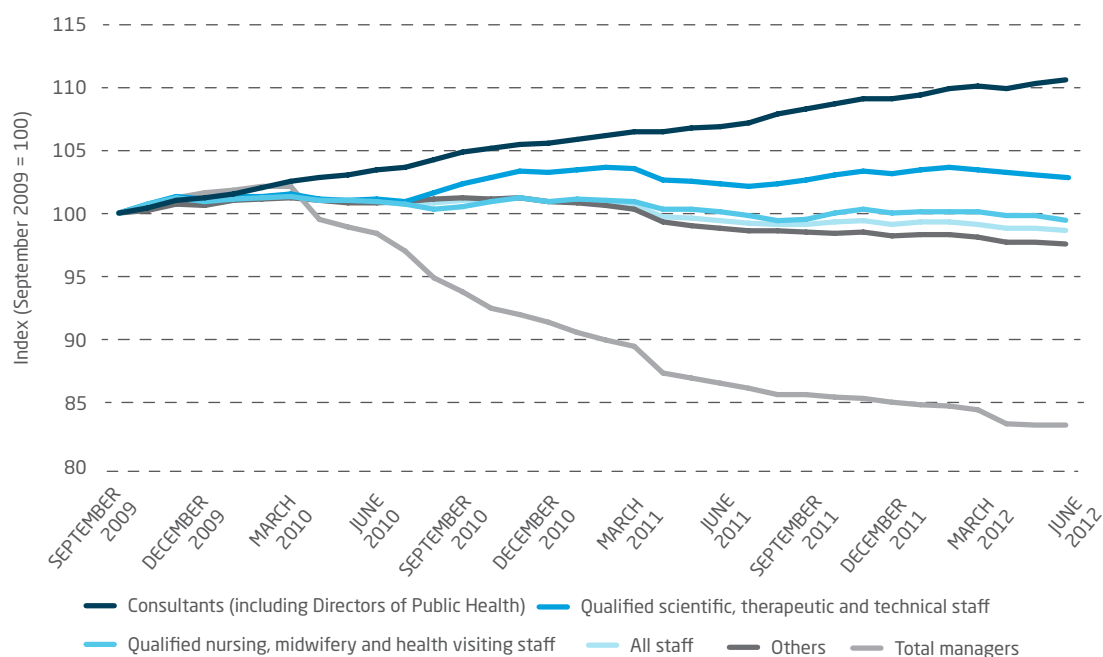
The trend in employment for all staff groups in the NHS increased by around 1.4 per cent between September 2009 and March 2010 but has since fallen by 2.8 percentage points – a reduction of 29,223 full-time posts. Changes have varied for different NHS staff groups.

Following an increase of around 1.3 per cent between September 2009 and March 2010, the number of qualified nurses, midwives and health visitors has fallen back to a fraction under the September 2009 level – a reduction of 5,509 compared to March 2010.

However, the number of consultant staff has risen continuously since September 2009 – from 34,156 to 37,693 in June 2012, a 10.4 per cent rise. The number of scientific, therapeutic and technical staff has also increased by 3 per cent since September 2009.

The impact of the decision in the coalition's White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010) to reduce management costs by more than 45 per cent over four years are clearly evident from the trends in the number of managers (both senior managers and managers). Since March 2010 there has been a decrease in managers of around 18 per cent – from 43,608 to 35,555.

Index change in NHS full-time equivalent staff: September 2009 – June 2012



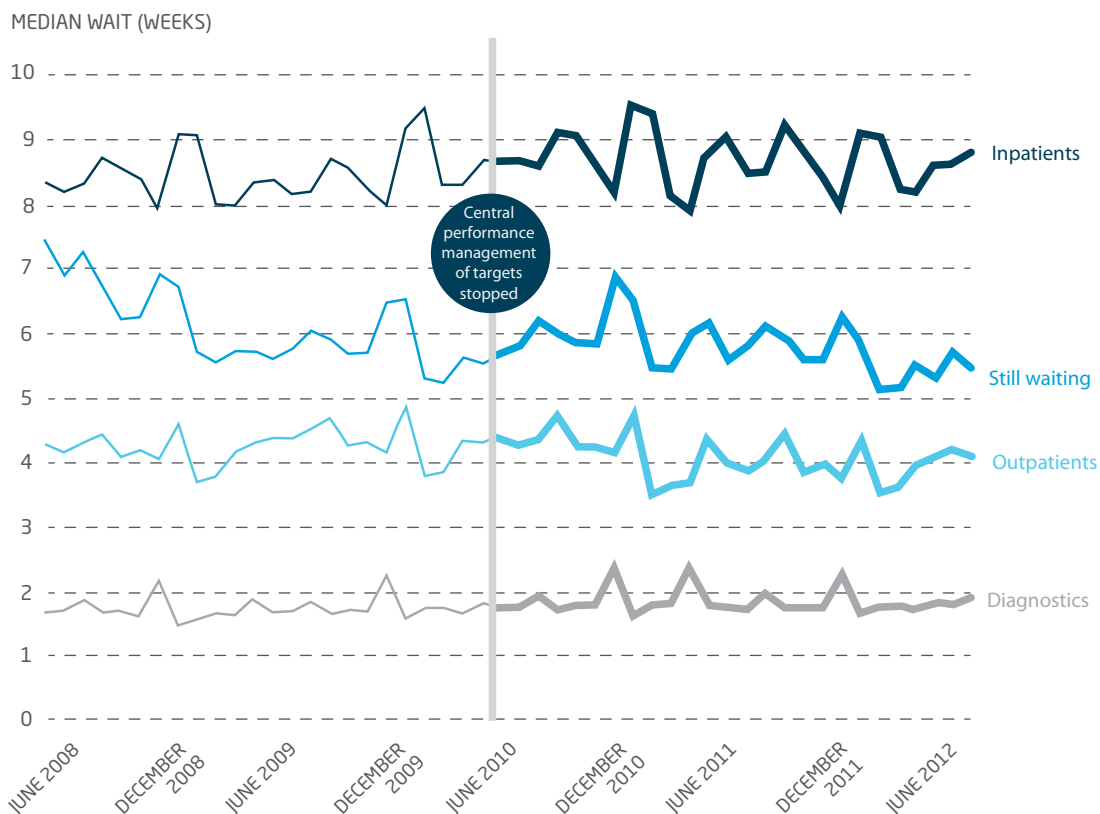
Data source: www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/monthly-nhs-hospital-and-community-health-service-hchs-workforce-statistics-in-england--may-2012-provisional-statistics

Waiting times: Median

Compared to June 2012, median waiting times increased in July for inpatients and diagnostics and decreased for outpatients and those still waiting. For diagnostics and outpatients, this is in line with seasonal trends, while the fall in those still waiting follows two years in which it increased at this time of year. The median waiting time for inpatients appears to have its own two-year cycle (one year up, one year down) and this trend has also been maintained.

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

Median wait (weeks), inpatients, still waiting, outpatients, diagnostics



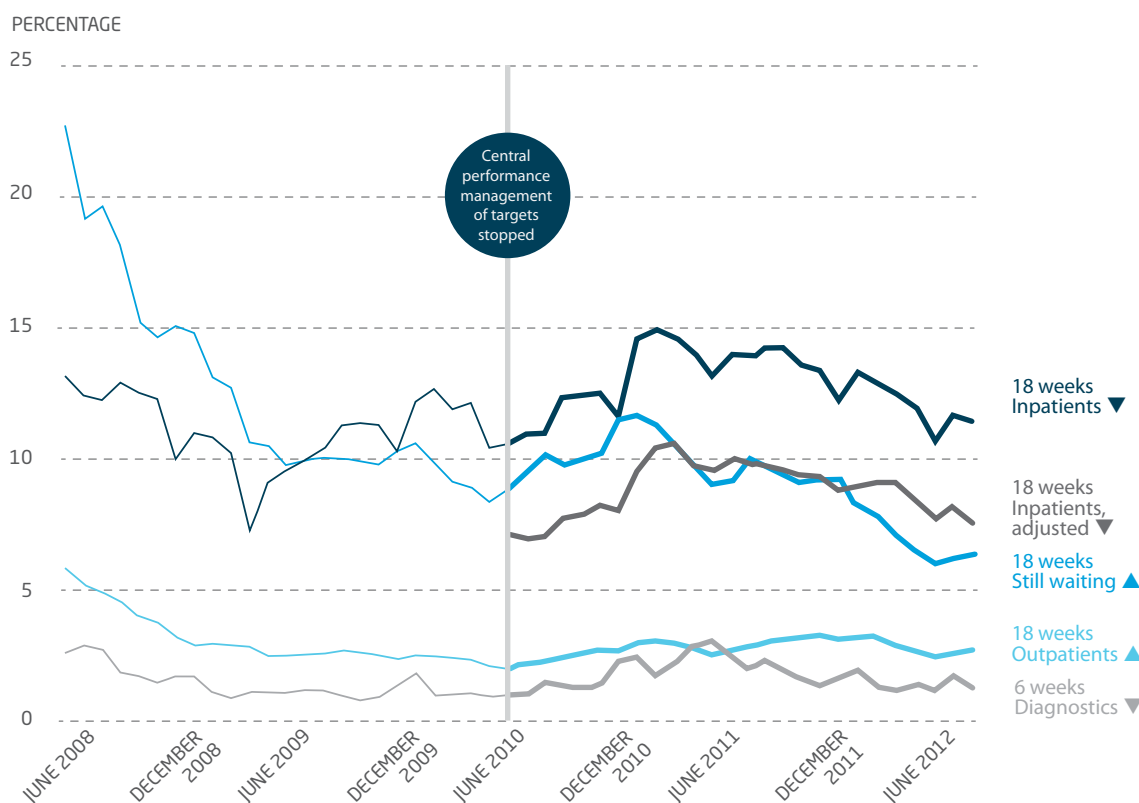
Data sources: Referral-to-treatment waiting times statistics <http://transparency.dh.gov.uk/2012/06/29/rtt-data-2012-13/>
Diagnostic waiting times statistics
<http://transparency.dh.gov.uk/2012/07/03/monthly-diagnostics-data-2012-13/>

Waiting times: Target waits

Since March 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 2012a)) have increased for diagnostics and reduced for all other waiting lists. Despite the increase in diagnostics, which breached its 1 per cent target in June 2012 (at 1.26 per cent) before reducing again in July 2012, all waiting times continue to be within their operational standards.

Since June 2010, when the coalition government relaxed the central performance management of waiting time targets, there has been a notable reduction in the proportion of patients still waiting, while all other waiting lists have remained at a similar level – though with some month-to-month and seasonal variations over this period.

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



Data sources: Referral-to-treatment waiting times statistics <http://transparency.dh.gov.uk/2012/06/29/rtt-data-2012-13/>
Diagnostic waiting times statistics
<http://transparency.dh.gov.uk/2012/07/03/monthly-diagnostics-data-2012-13/>

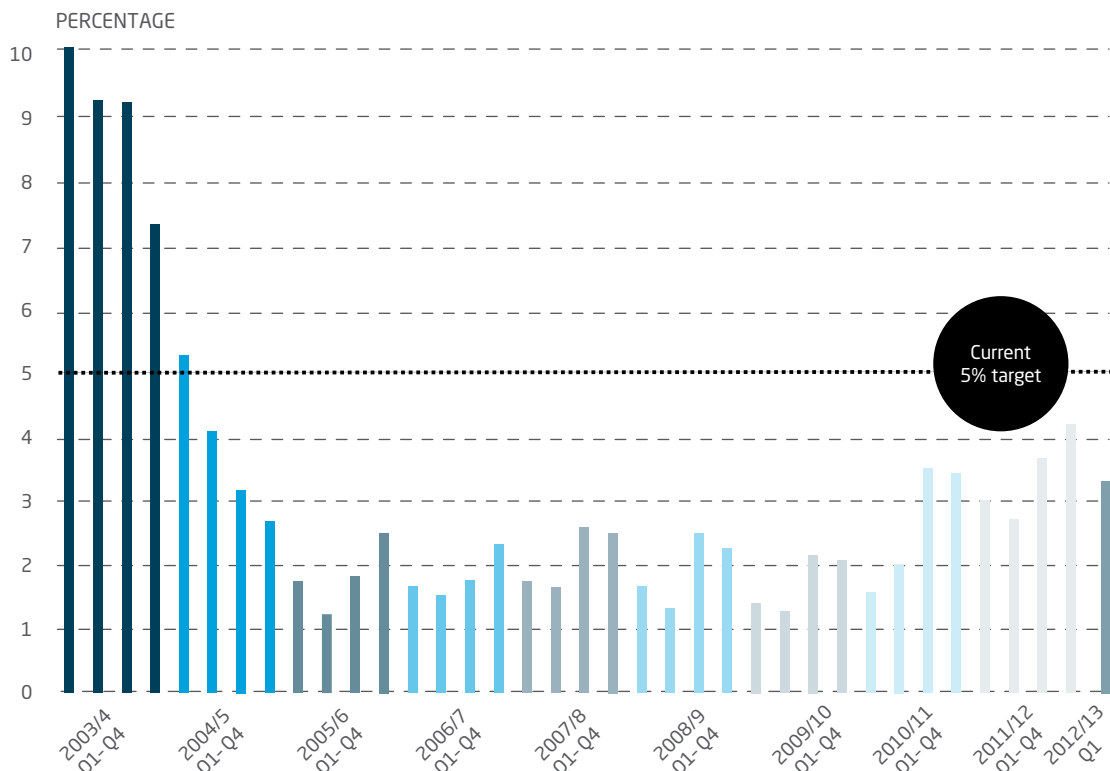
Waiting times: A&E

The latest data for four-hour A&E waits (quarter 1, June 2012) shows a decrease in the proportion of patients waiting longer than four hours in A&E compared to quarter 4 2011/12. This is in line with previous seasonal patterns. At 3.4 per cent this is also within the 5 per cent target set out in the 2012/13 NHS Operating Framework (Department of Health 2011); however, compared with previous quarter 1 figures, this is the highest proportion since 2004/5.

In total 188,594 patients waited more than four hours in A&E in quarter 1 of 2012/13 – a decrease of 17 per cent over the previous quarter but a 16 per cent increase over quarter 1 2011/12.

National figures tend to mask variations between hospitals. At an organisational level, 35 trusts (14 per cent) reported breaches in the proportion of patients waiting longer than the four-hour target. This was lower than the number of organisations reporting breaches in quarter 4 2011/12 (48), but the highest number in quarter 1 breaches since 2004/5.

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

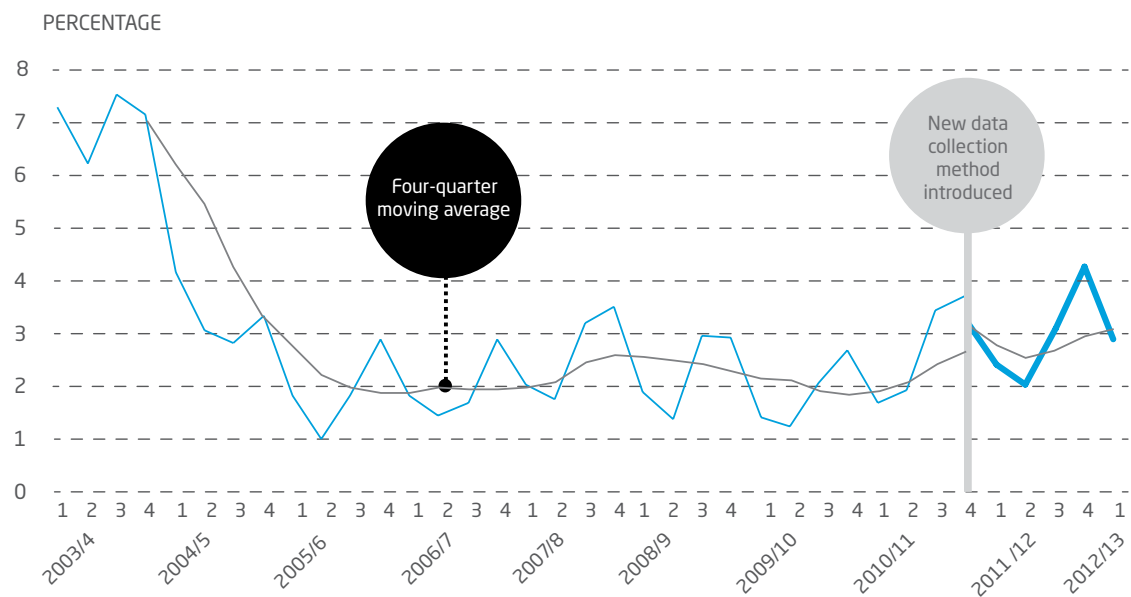


Data source: Weekly A&E SitReps 2012-13

<http://transparency.dh.gov.uk/2012/06/14/weekly-ae-sitreps-2012-13/>

While most patients who attend accident and emergency 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 the first quarter of 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 1 figures to show a decrease over the previous quarter. However, from quarter 1 in 2009/10, there is the emergence of a possible upward trend; the proportion of patients waiting more than four hours for admission has risen from 1.5 per cent in 2009/10 to just under 3 per cent in the latest quarter. 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.

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



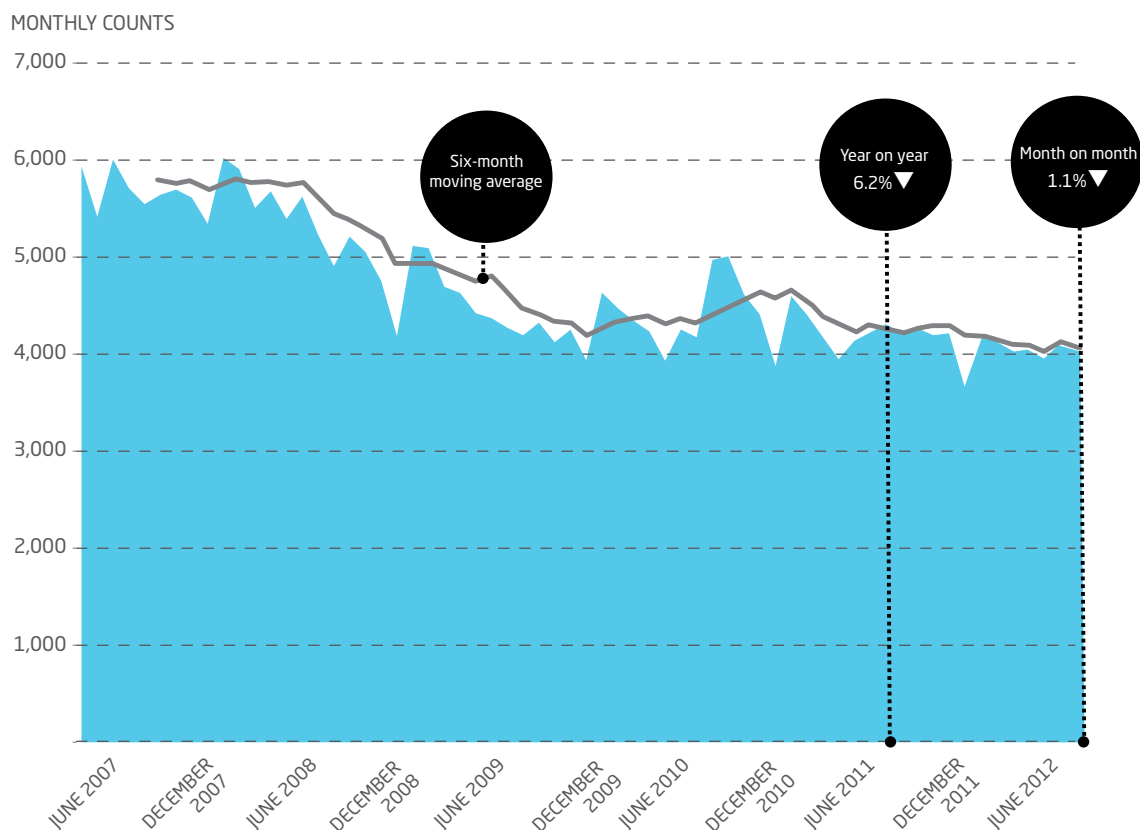
Data source: Emergency admissions through accident and emergency
<http://transparency.dh.gov.uk/2012/07/03/monthly-diagnostics-data-2012-13/>
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/AccidentandEmergency/DH_087977

Delayed transfers of care

Delayed transfers of care (DTCs) are recorded when a patient is ready to leave hospital – for transfer home or to another form of care – but cannot do so 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 provide.

The most recent data shows that the total number of acute and non-acute DTCs for July 2012 decreased on the previous month by 1.1 per cent, following similar seasonal trends for this month. Compared to July 2011, the number of DTCs decreased by 6.2 per cent. The six-month moving average continues to show a steady decline; indeed, in the previous year there were around 4,125 patients per day facing a delay in any one month while, so far, in 2012/13 this has reduced to approximately 3,995.

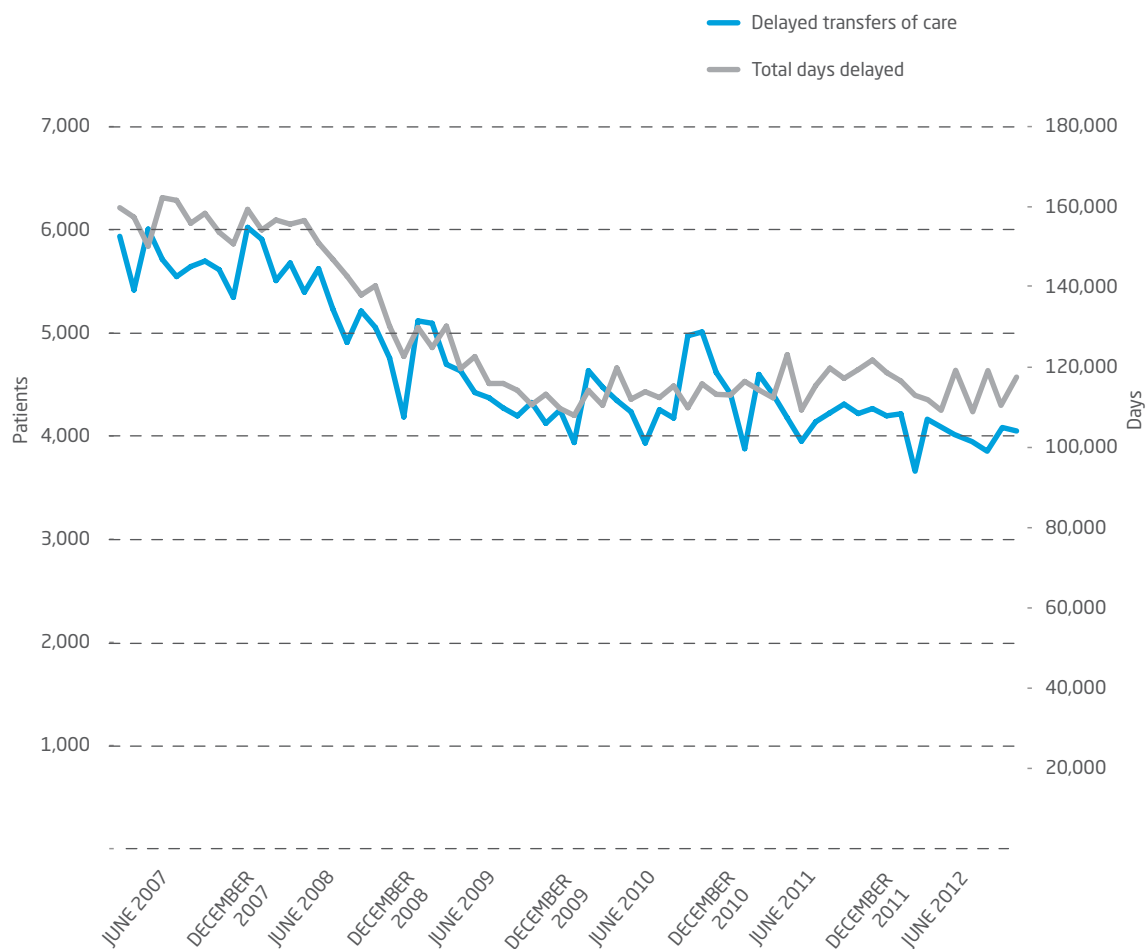
Delayed discharges: Monthly counts of patients



Data source: Acute and non-acute delayed transfers of care, patient snapshot
<http://transparency.dh.gov.uk/2012/07/03/monthly-diagnostics-data-2012-13/>

Another way of viewing delayed discharges is by the number of bed days accounted for by patients whose transfer is delayed; although the count of patients can remain stable, bed days may change depending on how long each patient is actually delayed. The figure below shows the number of days associated with delayed discharges as well as the number of patients delayed. The latest figures since the beginning of 2012/13 reveal large degrees of monthly variation but remain at a similar level to the end of 2011/12.

Delayed discharges: Patients and days delayed



Data source: Acute and non-acute delayed transfers of care, patient snapshot
<http://transparency.dh.gov.uk/2012/07/11/delayed-transfers-of-care-2012-13/>

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