NHS

theyear. including thequarter.

Quarter 4 2011/12

NHS Chief Executive's annual report

2011/12

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Introduction

2011/2012 was a remarkable year for the NHS. I certainly can't remember another time in my three decades as an NHS manager when we have faced so many complex challenges on so many fronts at once. Not only was the service required to start delivering the Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings – releasing up to £20 billion to re-invest in quality – we did this against a backdrop of intense political and public debate about reform, and as we began to lay the foundations for an entirely new system of delivery, that necessitated a great deal of change and uncertainty for our staff.

In the NHS Operating Framework 2011/12, I said that our overarching goal in this period would be to build strong foundations for the new system by maintaining and improving quality, by keeping tight financial control and delivering on the quality and productivity challenge, and creating energy and momentum for transition and reform.

Despite the huge challenges we have faced in this extraordinary year, we have achieved the ambitions we set during 2011/12:

- ✓ Infection rates at their lowest since mandatory surveillance was introduced
- ✓ Lowest ever level of patients waiting more than 18 weeks for their treatment and both standards met each month
- ✓ All ambulance trusts meeting their category A8 performance measure for the first time since Call Connect was introduced
- ✓ Performance measures on A&E, cancer care, dentistry, waiting times – all met
- ✓ And all in a year where we worked smarter and more effectively, delivering £5.8 billion of QIPP savings to the system.

These achievements did not happen by accident or default: they are the result of the heroic efforts made by the 1.2 million staff who work for our patients in the NHS, and I want to take this opportunity to thank you all for keeping focused on what matters during this extraordinary time of change. I know that what motivates you – what motivates me – are the values of the NHS: the opportunity to work for a system that provides care to all on the basis

of need and need alone, regardless of ability to pay. It is our shared purpose that continues to sustain and motivate us throughout these challenging times, and this creates the conditions for the success that I set out in this annual report.

But although there is much to be proud of, there is also much more to be done to make sure that all of our patients get the very best quality care currently available in the NHS, so that our very best practice becomes standard practice, and we root out and end unacceptable practices wherever we find them. The journey to high quality care for all is a never ending one, and we must continue to learn from our failures, as well as our successes, if we are to harvest developments in knowledge and technology for the benefit of all our patients. The report on the public inquiry into Mid Staffordshire NHS Foundation Trust will be published later this year. This will provide a salutary moment for the NHS to reflect on the learning that emerges from Robert Francis's report. We must use it as a catalyst to raise our ambitions and drive further service improvement.

Because that's what we do when we are at our best: we take the resources we're granted by Parliament, the reforms and tools for delivery, and drawing on our experience and judgement deploy them to meet the current needs of patients and drive the transformation required for the future. And that's what I'm starting to see when I go round the country.

I've seen GPs starting to use the powers they have as doctors, and as members of clinical commissioning groups (CCGs) beginning to drive clinically-led commissioning, working with providers so services can be wrapped around the needs of patients. I've seen the NHS

really engage with local authorities around the new public health agenda and the creation of the health and wellbeing boards, so services can reflect the wider needs of all of our communities.

And every time I go out to a new area, or visit a particular service, I am struck, and indeed moved by, the response of our staff to the challenges they face. How despite the fact the reforms will have a direct impact on the job that they (may no longer) have, most NHS staff are simply rolling up their sleeves and asking themselves, as we always do: right, how can I use these reforms to get a better deal for patients?

We will need to maintain this level of commitment to our shared purpose, because the environment in which we work is about to get tougher, not easier. This is the year when we will need to start working out how we are going to respond to the Chancellor's Autumn Statement, which confirmed that restrictions on public spending are likely to remain in place for a long time to come. QIPP is therefore no longer a strategy for managing the NHS up to 2015, it is going to have to become the way we manage the service for the foreseeable future.

Some think now the Health and Social Care Bill has passed through Parliament that somehow, the reforms are 'done'. Well unfortunately, they couldn't be more wrong. This next year is when the reforms actually have to be implemented.

Together we need to implement the transition from the old system to the new, while doing all we can to reduce risk in the system and continue to deliver and improve upon the quality of care we provide to the one million patients the NHS treats every 36 hours. It is a daunting challenge, but this annual report demonstrates the efforts of our staff today have put in place strong foundations for our staff and patients of tomorrow.

> *"I want to take this opportunity to thank you all for keeping focused on what matters: making sure that all of our patients get the very best quality care.*

1. Quality

Our ambition

We have worked hard in recent years to put quality at the heart of the health care system, so that our shared purpose increasingly drives everything we do. The passage of the Health and Social Care Act 2012 provides a radical set of reforms aimed at creating an NHS with a relentless focus on outcomes for patients. Our ambitions for 2011/12 with regard to quality were threefold:

- To maintain the quality of care provided during a time of transition
- To ensure a tight grip on those quality issues that matter most to our patients to maintain and improve performance
- To begin to create the environment for greater devolution in 2012/13, and the conditions for a health care system designed to deliver quality outcomes.

The National Quality Board has led a major programme of work to ensure we maintain quality during transition, and this work is detailed on page 24. Below we set out the achievements the NHS has made in the areas that we know matter most to patients in terms of the quality of care that they receive.

What we have delivered

Infection control at lowest ever levels

On infection control the NHS has made significant improvements over the past year, with MRSA bloodstream infections and C. difficile infections at the lowest levels since mandatory surveillance for each was introduced. This improvement has helped make our healthcare system a safer place for patients and staff.

We have exceeded expectation for the reduction of cases of MRSA. For C. difficile infections, progress has also been good. The vast majority of acute trusts have delivered their trust attributable objectives, but less progress has been made in tackling community-onset cases. We should continue to focus on bringing down the number of cases in this area.

These reductions show what can be achieved with a continued focus on patient safety and reducing avoidable healthcare associated infections. Our collective and local commitment to achieving these goals is paying dividends and is reflected in the year-on-year reductions in MRSA and C. difficile rates.

Case study – a more productive and innovative NHS

Implementation of the Productive Series

The productive ward programme supports ward leaders and nursing teams with structured methods designed to improve the ward environment, systems and processes. Over 70 percent of NHS acute trusts are implementing the programme with the assistance of the Productive Care QIPP national workstream, led by Lynn Callard, at the NHS Institute.

Evidence shows that implementing the programme helps nurses to spend an extra 500,000 hours with patients in one year (Nursing Management Journal vol.15 no.5 July 2009). The equivalent level of service improvement without the programme would cost an estimated £7.5 million a year.

In South Staffordshire and Shropshire Healthcare NHS Foundation Trust, the programme delivered:

- A drop in medicine rounds from 3.5 hours to 40 minutes
- Time spent on direct care rose from 12 percent to 32 percent on the older persons' assessment ward.

Figure 1: MRSA bacteraemia: quarterly totals between April 2007 and March 2012

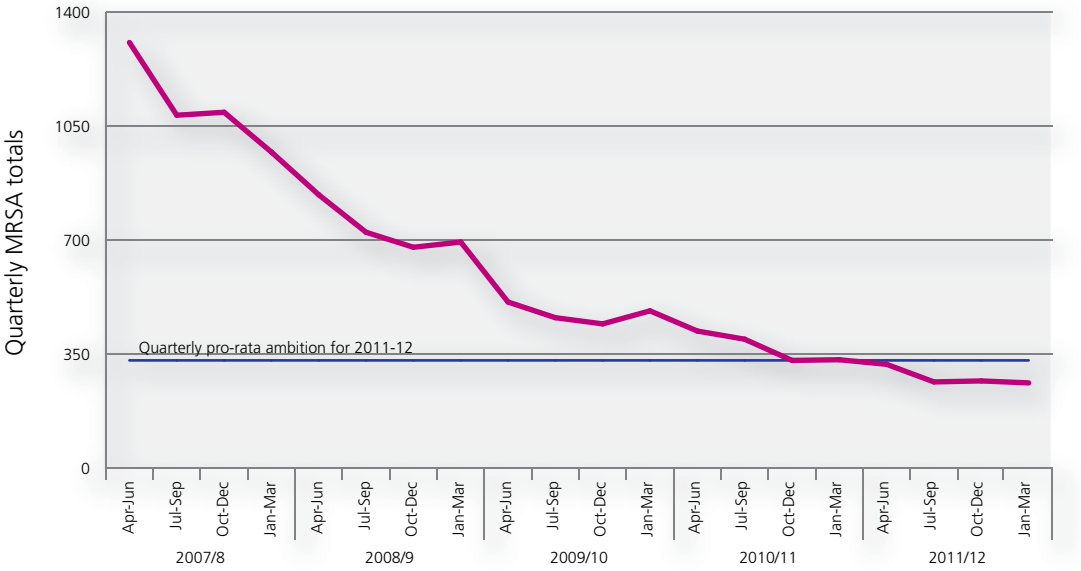
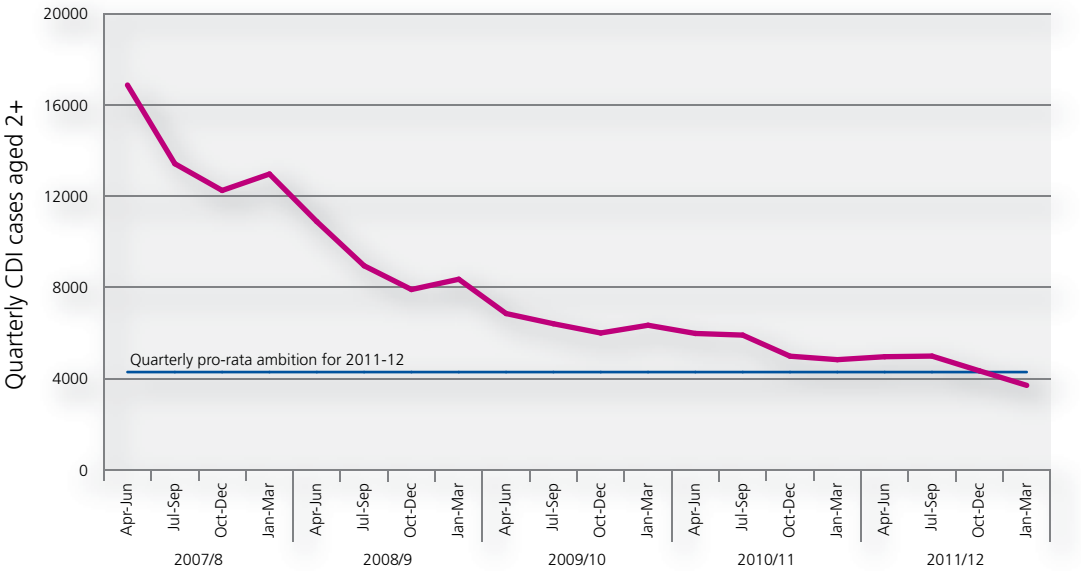


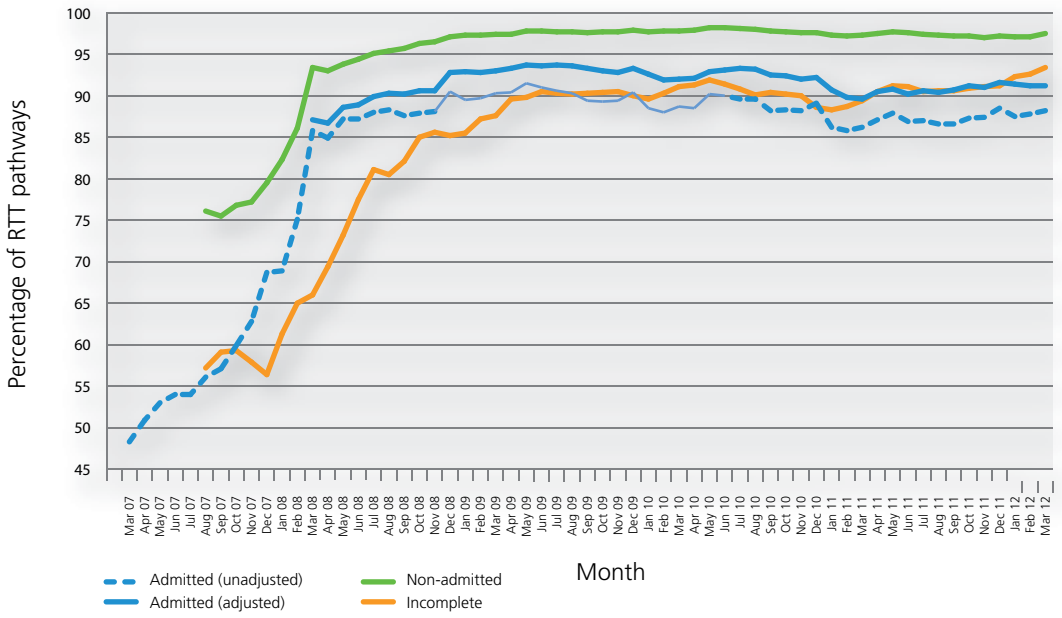
Figure 2: C.difficile cases aged two or more: quarterly totals between April 2007 and March 2012



Waiting times remain low

Access to services continues to be maintained and waiting times remained low and stable in 2011/12. Over 90 percent of admitted and 95 percent of non-admitted patients started treatment within 18 weeks of referral. By the end of 2011/12, the number of patients waiting longer than 18 weeks who have yet to start treatment was also down to its lowest ever level. For 2012/13, the new requirement set out in the NHS Operating Framework, that 92 percent of patients on an incomplete pathway should wait no longer than 18 weeks, and a focus on those waiting the longest, will make sure we keep our attention on treating our patients as quickly as possible. It is pleasing to see that the 92 percent standard has already been met for the last quarter of 2011/12, an excellent starting position for the coming year.

Figure 3: Percentage of referral to treatment pathways within 18 weeks



More people seeing an NHS dentist

Access to NHS dentistry continues to grow quarter-on-quarter. The latest figures show that 1.12 million more patients have been seen by an NHS dentist since May 2010. The total number of patients seen, 29.6 million, continues to rise and over half the population has seen an NHS dentist within the past two years.

We are determined to increase access to NHS dentistry even further. We invested an extra £28 million earlier this year through strategic health authorities (SHAs) to expand local dental services in ways that best meet their patients' needs.

Ambulance service responding well

All ambulance trusts met the Category A8[1] performance measure for the first year since Call Connect was introduced in 2008 and the service has continued to meet the A19[2] measure. This demonstrates how the NHS continues to be there for people when they need it most urgently.

Clinical quality indicators were introduced for the ambulance service from April 2011 to measure the quality of care delivered for all ambulance calls. Data is collected for system indicators and clinical outcomes of patients who receive care from NHS ambulance services. There is evidence of some variation in outcomes for various conditions around the country. Commissioners should use this information to hold their local NHS to account and to secure improvements to services for patients.

A&E performance standards met

A&E performance continues to exceed the national operational standard of 95 percent, with 96.6 percent of patients spending less than four hours in A&E.

The A&E clinical quality indicators[3] were introduced in April 2011 to replace the four hour waiting time standard, putting in place a basket of performance measures that balance timeliness of care with other indicators of quality, including clinical outcomes and patient experience. Clinicians told us that focusing solely on time spent in A&E distorted clinical decision making. That is why we introduced a range of indicators to measure the quality of care people received in A&E, as well as how much time they spend there.

These indicators will continue to be in place during 2012/13 for local use. The NHS will still need to perform against these measures, and commissioners will hold their local NHS to account and take action to ensure A&E services improve for their patients. In judging performance nationally, the Department of Health will continue to use the operational standard of 95 percent of patients being seen within four hours.

Fighting cancer

Key cancer standards have been achieved across all eight performance measures,[4] which is a fantastic achievement. On top of this, we have continued work to help increase the number of cases of cancer that are detected at an early stage, ensuring we do not get complacent in our fight against the disease. The NHS Bowel Cancer Screening Programme is currently being extended to men and women aged 70 to their 75th birthday. We also want to expand the NHS Breast Screening Programme so more women benefit and we save even more lives. The programme is currently being extended to women aged 47 to 49 and 71 to 73.

In February 2012, the Department published for the first time quarterly statistics on waiting times for cancer treatment, broken down by tumour type. This data will assist clinicians and managers to monitor the impact of different clinical pathways, including those for prostate cancer, the overall trust performance and to support patient choice and improved accountability.

1 Category A calls resulting in an emergency response arriving within eight minutes

2 Category A calls resulting in an ambulance arriving at the scene within 19 minutes

3 Refer to *the quarter*, pg 16

4 Refer to *the quarter*, pg 19

Eliminating mixed sex accommodation

The compulsory reporting of breaches of mixed sex accommodation guidance has galvanised action within the NHS, resulting in a fall of over 96 percent in just 16 months. More patients than ever are now being treated with the dignity and respect they deserve.

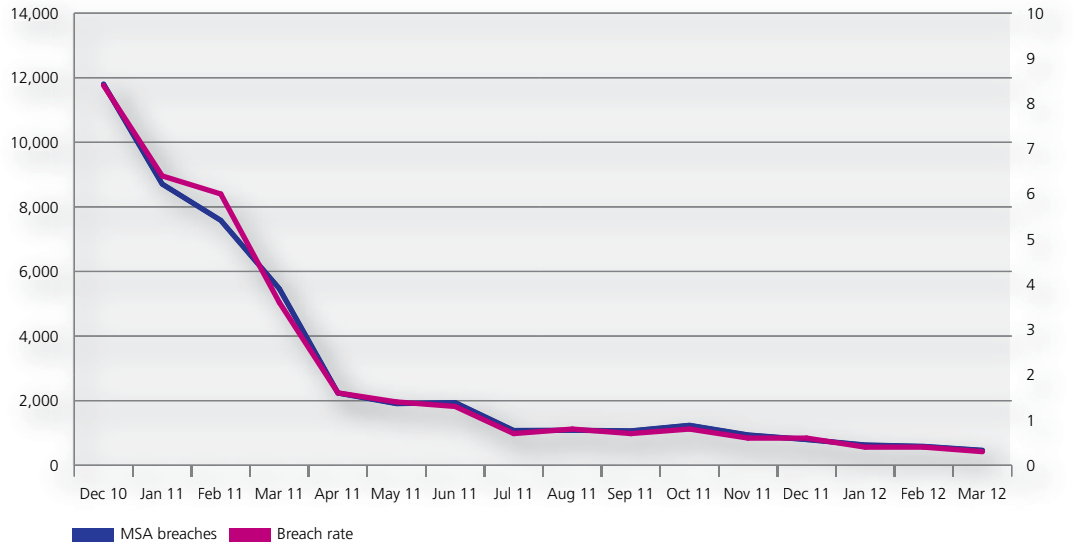
A dramatic fall in breaches (both absolute number and rates) in the final quarter of 2010/11 has been followed by a steady decline during 2011/12, and single sex accommodation is now the norm for almost all patients. This is borne out by the Care Quality Commission's (CQC) inpatient survey, showing that around nine in ten patients are in single sex sleeping accommodation. This is an excellent achievement, and goes to show how quickly we can achieve such significant turnarounds in performance when the whole system works together toward a common goal.

However, while mixed sex sleeping accommodation figures have improved enormously, there are still reports via local

monitoring and the CQC of patients who are required to use mixed toilet and bathroom facilities. We must go further in our efforts to eliminate this. All hospitals should look at their local performance management arrangements to make sure this issue is being appropriately and effectively tackled.

In January 2012, the Prime Minister announced a new system of patient-led hospital inspections, which will replace the current Patient Environment Action Team assessments from April 2013. These inspections will include attention to privacy and dignity, helping us all to keep our focus on the importance of this issue.

Figure 4: Mixed sex accommodation total breaches and breach rate for England



Improving stroke care

The latest data shows the NHS is changing the way it works to build on the progress made in stroke services, so that we can continue to improve quality and outcomes for patients. As a result, stroke patients are getting faster and better treatment than ever before.

Over 80 percent of stroke patients are now spending 90 percent or more of their hospital stay in a stroke unit, and over 70 percent of transient ischaemic attack (TIA) cases with a higher risk of minor stroke are now treated within 24 hours – both significant improvements since 2009. This trend is welcome, but there is still variation between areas.

Across the country, teams are looking to transform and reshape services to better meet the needs of their patients. In Camden, the Reach Early Discharge Service has demonstrated significant improvements in care and patient experience and has made savings in excess of £200,000, through a reduction in the need for non-elective bed days and ongoing social services packages of care. In Dorset, a comprehensive post-stroke psychological service, developed to support stroke survivors by optimising existing resources and services, has led to high levels of positive patient and staff experience.

Maintaining these improvements, developing new ways of working and ironing out regional variations are crucial to improving outcomes for patients.

Patient experience

NHS performance remains at a high standard, but we must remember it is not just what our data shows us, but the experience our patients have, and the outcomes we achieve for them, which is equally, if not more, important.

> *"We must ensure that all our patients have the very best experience of the NHS.*

Feedback should not just be collected; it should be actively used to guide the improvement and transformation of services.

Patient experience scores for NHS adult inpatient services were maintained in 2011/12, with the scores for outpatient services showing an improvement from 2009/10. In addition, the collection of Patient Reported Outcome Measures (PROMs) data has become further embedded in the NHS during 2011/12. The latest data have shown some improvement in the proportion of patients who felt their condition had improved following surgery.

It is encouraging to see a significant number of our patients continue to have a positive experience of NHS services. But there is always room for improvement. While aggregate scores are helpful in ensuring a range of patient experience areas are measured, we must not allow a good aggregate score to mask variations in performance in individual areas – we must ensure we tackle these so that all our patients have the very best experience of the NHS.

Case study – a more productive and innovative NHS

Integrated 24-hour children and young people's asthma service – reducing unnecessary hospital attendance

South East Essex Community Healthcare piloted a 24/7 home nursing service for children and young people with difficult to manage asthma. Through primary care investment in community staff and targeting recurrent users of A&E it has been possible to reduce their number of A&E attendances by 49 percent, hospital admissions by 30 percent, and to enable self-management of the condition. Feedback from those using the service shows very high levels of satisfaction and confidence with the service. The case for improved quality for patients is robust, but further work is required to explore whether the financial savings could be scaled up to wider implementation.

Challenges for the future

These are not just statistics: they are the hard won achievements of our staff that have benefited the millions of patients we treat every week. Nevertheless, we must not be complacent. While the figures in aggregate are good, beneath this national picture there is still too much variation, and occasions where the NHS falls short of what our patients and public rightly expect of their service. There is much more to be done to make sure all of our patients get the very best quality care currently available in the NHS, so our very best practice becomes standard practice. The public inquiry into Mid Staffordshire NHS Foundation Trust will shortly report, providing a salutary moment for the NHS to reflect on the learning that emerges. Robert Francis's report will provide a powerful catalyst to raise our ambitions and drive further service improvement.

The National Quality Board has recently published guidance to help ensure an effective handover on quality issues to the new system, and will shortly publish a report clarifying roles and responsibilities with regard to quality improvement and failure. Our shared challenge now is to make sure the new organisations, and the staff who will work in them, have the capacity, knowledge and skills to build on the hard won gains the NHS has made to date regarding the quality of care provided to patients.

Case study – a more productive and innovative NHS

Ambulance service frequent callers

Frequent callers to the ambulance service cost the NHS around £11 million per annum in Yorkshire and the Humber. The ambulance service provides PCTs with a monthly report on the top 10 frequent individual callers and care home callers. Patient identifiable information and the main complaint is included where possible.

Community teams in Kirklees have developed proactive case management and emergency care plans for frequent ambulance callers. They also piloted telemedicine to monitor vital signs for service users in frequent caller care homes. The care plans are made accessible to ambulance crews and to emergency care clinicians. Community matrons have also provided education for care home staff on dealing with clients' underlying health problems and on using alternative pathways, contributing to a reduction in care home 999 calls.

Patients experience improved quality of care, in the right place at the right time, and a more appropriate response by the urgent care system.

Since implementing the service in 2009/10, evidence shows a 70 percent reduction in A&E attendances from their client group, all of whom were very heavy users of both ambulance and A&E services. In the three month period to June 2011, the ambulance service received 26 less 999 calls than expected from residential care homes taking part in the project.

2. Innovation

Our ambition

Innovation, Health and Wealth: Accelerating Adoption and Diffusion in the NHS, published in December 2011, said that innovation must become core business for the NHS – it must. Innovation is the only way we can meet the challenges we face.

> Innovation is the only way we can meet the challenges we face.

Innovation, Health and Wealth (IHW) sets out eight key themes:

1. We should **reduce variation** in the NHS, and drive greater **compliance** with NICE guidance
2. Working with industry, we should develop and publish better innovation uptake **metrics**, and more accessible evidence and **information** about new ideas
3. We should establish a more **systematic delivery mechanism** for diffusion and collaboration within the NHS by building strong cross-boundary networks
4. We should align organisational, financial and personal **incentives and investment** to reward and encourage innovation
5. We should improve arrangements for **procurement** in the NHS to drive up quality and value, and to make the NHS a better place to do business
6. We should bring about a major shift in culture within the NHS, and **develop our people** by 'hard wiring' innovation into training and education for managers and clinicians
7. We should strengthen **leadership** in innovation at all levels of the NHS, set clearer priorities for innovation, and sharpen local accountability
8. We should identify and mandate the adoption of **high impact innovations** in the NHS.

We are not starting from scratch. Across the country, NHS staff are already developing new ways of working, coming up with great ideas and leading improvements in services. But we need to get better at sharing what we are doing well. We've done it before, such as with 18 weeks, healthcare associated infections (HCAIs) and venous thromboembolism (VTE), but we need to do it more routinely. If something is working in one part of the country, we should look to share this best practice quickly and thoroughly, so patients across the country can benefit.

What we delivered

Early successes

Six months on from *Innovation, Health and Wealth*, we have already made good progress. The IHW Implementation Board has been established, chaired by Sir Ian Carruthers, and 26 task and finish groups have been set up, led by senior NHS leaders to implement IHW. Both include representation and support from NHS providers, commissioners, industry and academia, ensuring delivery and building advocacy for innovation at every level of the NHS.

IHW committed us to implementing a number of recommendations in the early months of 2012. We have already delivered the following commitments:

- Implementation of IHW referenced in the NHS Operating Framework 2012/13
- The National Institute for Health and Clinical Excellence (NICE) compliance regime was introduced at the launch of IHW to reduce variation and drive up compliance with NICE technology appraisals
- 3millionlives launched in January 2012, aimed at improving at least three million lives over the next five years by accelerating the use of assistive technologies
- Innovation Pipeline Project launched in February 2012, designed to increase the adoption and diffusion of proven technologies in areas of high clinical need, to deliver high quality patient outcomes and efficiency gains
- Phase one of the Sunset Review of all NHS and DH-funded or sponsored innovation bodies commissioned April 2012
- International healthcare summit with UK Trade and Investment held May 2012
- Uptake programme for use of Oesophageal Doppler Monitoring (ODM) or similar fluid management monitoring technology launched May 2012
- Innovation included in CCG authorisation applicants pack published with supplementary guidance issued in May 2012

> We must continue to incentivise innovation wherever possible.

- The designation criteria for Academic Health Science Networks has been published.

Good progress has been made in other areas too. Building on our commitment in IHW to support people with dementia, the Prime Minister launched his challenge on dementia on 26 March 2012, setting out the Government's ambition to increase diagnosis rates, to raise awareness and understanding and strengthen substantially our research efforts, so we can help those living with dementia have a better quality of life. The Prime Minister set up three champion groups to lead the work on health and care, raising awareness and research and they will report back to him on progress made in September 2012.

Rewarding innovation

We must continue to incentivise innovation wherever possible. One way in which we are doing this is through the NHS Innovation Challenge Prizes, providing financial rewards for staff who are developing new and innovative ways of working to improve quality and safety for patients.

Dr Sandip Mitra, Consultant Nephrologist at the Department of Renal Medicine, and his team at Manchester Royal Infirmary were awarded £100,000 for increasing home dialysis in renal failure. They developed an innovative approach to re-designing existing dialysis provision to substantially increase the ability of patients to choose home haemodialysis. This has reduced service costs, and increased quality of life for patients. Over 15 percent of dialysis patients in Manchester now choose haemodialysis at home, compared to the current UK rate of 1 to 2 percent.

Round two of the awards was announced in March 2012.

Challenges for the future

During 2011/12 the NHS has risen to an unprecedented set of challenges. Going forward, it is clear we can no longer rely on the way we have always done things, hoping that more money, more new drugs, and more effort will simply resolve the issues we face. Now, more than ever, we need to do things differently. Innovation has to move from being a minority sport to become the core activity of the NHS; the way we do our business.

We need to raise our ambitions and apply innovation to service design, drawing on the best examples, such as stroke services and major trauma services, where innovative new models of care have achieved international recognition for the improvements they have made to patients' lives.

Our ambition must be for an NHS defined by its commitment to innovation, demonstrated both in its support for research and its success in the rapid adoption and diffusion of the best, transformative, most innovative ideas, products, services and clinical practice. We have the potential – as ever the challenge for the NHS will be to make this a reality.

Our ambition must be for an NHS defined by its commitment to innovation.

3. Productivity

Our ambition

The productivity challenge was first identified in 2009. We set out that the NHS would need to make £15 to £20 billion of efficiency savings, while maintaining or improving quality, to reinvest in front line services, to cope with future demand for healthcare in a constrained financial environment.

Because the productivity challenge was identified at an early stage, the NHS was able to plan and make early inroads in meeting it. In 2010/11, the NHS maintained a healthy financial position, while maintaining or improving quality in key areas such as waiting times, infection rates and patient experience. In addition, the Audit Commission[5] reported the NHS made £4.3 billion of productivity gains during 2010/11.

The NHS Operating Framework 2011/12 further clarified the need for up to £20 billion of efficiency savings between 2011/12 and 2014/15, for reinvestment in future demands for quality health services. We were clear that achieving these savings, while continuing to improve quality, was one of the toughest challenges the NHS has ever faced.

£5.8 billion saved: this is a superb achievement – and credit to the efforts of all staff – that we have been able to meet the end of year savings target.

Case study – a more productive and innovative NHS

The QIPP Long-Term Condition workstream

There are around 15 million people living with a long-term condition in England. These people are the main driver of cost and activity in the NHS as they account for around 70 percent of overall health and care spend. They are disproportionately higher users of health services – representing 50 percent of GP appointments, 60 percent of outpatient and A&E attendances and 70 percent of inpatient bed days.

The Long-Term Condition QIPP workstream seeks to improve clinical outcomes and experience for patients with long-term conditions in England. The workstream will focus on improving the quality and productivity of services for these patients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn slow disease progression and reduce the need for unscheduled acute admissions, by supporting people to understand and manage their own conditions.

The workstream is delivering a national support and improvement programme that is designed to facilitate and enable local health economy teams to deliver change at pace, in a measured and supported way. The workstream seeks to reduce unscheduled hospital admissions by 20 percent, reduce length of stay by 25 percent and maximise the number of people controlling their own health through the use of supported care planning and aims to replicate this performance nationally by 2013/14.

5 http://www.audit-commission.gov.uk/sitecollectiondocuments/downloads/20110808_nhsperformance.pdf

What we have delivered

Efficiency savings targets met

During 2011/12, we outlined that the NHS was forecasting savings of £5.8 billion for the year. During quarter four, the NHS achieved £1.9 billion of efficiency savings, building on the £3.9 billion reported at quarter three. This delivers a total of £5.8 billion of QIPP savings for 2011/12, consistent with the level forecast during the year and providing a firm foundation for sustained delivery in 2012/13 and beyond.

Each local health economy is currently working towards their own vision of how they can transform their local health system by 2015, so they can meet the efficiency savings targets while continuing to provide quality care to their populations.

It is a superb achievement – and credit to the efforts of all staff – that we have been able to meet the end of year savings target. This success provides a firm platform for securing sustainable change in 2012/13.

However, we must make sure this drive continues to be maintained. The pressures on the NHS, both social and financial, are very real. Retaining focus will help us build our health system for the future – one that is resilient, high-performing and sustainable.

Reduction in activity levels

It is pleasing to see there has been a modest reduction in activity levels over the last year, meaning we are starting to meet the challenge of treating patients in the most appropriate setting. GP referrals were lower than the previous year, there was low growth on first outpatient attendances, and there is a growing day case rate meaning people are spending less time in hospital, and non-elective activity has reduced. We must maintain our focus to make sure we continue to live within our means in future years.

Workforce size reduced in non-clinical areas

Over the 12 months to February 2012, the overall number of staff employed in the NHS fell by 1.5 percent. The reduction in numbers was particularly strong in non-clinical areas with the number of managers and senior managers falling by 5.7 percent over that period. SHA plans show it is likely that these trends will continue through 2012/13.

Supporting staff

While we do need to reduce the number of staff across some areas of the workforce, it is important we are also focusing our attention on the needs of those staff who remain. The Workforce QIPP Programme is supporting staff across the NHS to make sure they have the skills and help needed to deliver the highest standards of patient care focusing on quality and productivity.

During the year, the programme has concentrated on supporting the NHS in reducing both staff sickness absence, and spend on agency staff, to help improve NHS workforce efficiency and effectiveness.

Reducing sickness absence

To support the health and wellbeing of NHS staff there has been a drive to provide improved access to quality occupational health and staff support services. The underlying rate of sickness absence fell from 4.48 percent in 2009 to an average 4.08 percent over the 12 months to December 2011. The value of the staff time this releases is £170 million. An excellent example of this is University Hospital Southampton NHS Foundation Trust, which has saved £3.5 million and reduced sickness absence to 3.1 percent. The Trust has achieved this through joint work between its occupational health and HR staff – it has focused on reducing sickness absence longer than four weeks, adopted a high intensity case management approach, provided or signposted multidisciplinary treatment, advice and support and ensured liaison between HR business partners and line managers.

This commitment to staff welfare is mirrored across other trusts, including Doncaster and Bassetlaw Hospitals NHS Foundation Trust where staff can self-refer to a dedicated physiotherapy service. This is delivering real results, with 81 percent of staff who have used the service reporting it saved them taking time off work.

A package of staff health and wellbeing initiatives introduced at Yorkshire Ambulance Service has helped to create a cultural change in the organisation. This has delivered measurable improvements, including a healthier, more motivated workforce. Sickness absence levels in the Service's Emergency Operations Centre have reduced by 33 percent, saving £500,000, the equivalent of 20 full-time members of staff.

There is compelling evidence to show that improving the health and wellbeing of NHS staff helps us deliver better patient care and make significant savings. We will continue working with our partners, the Health and Work Development Unit at the Royal College of Physicians, NHS Employers and NHS Plus, building on progress made so far ensuring employers across the NHS have access to excellent occupational health services and staff are supported to live healthier lives.

Reducing spend on agency staff

Good progress has been made towards improving value for money through joint working with the Government Procurement Service on the national framework agreements for temporary staff, and encouraging wider use of e-rostering to support organisations in improving their workforce planning. At Taunton and Somerset NHS Foundation Trust, implementing consistent processes for managing temporary staff, along with the introduction of e-rostering, has enabled the Trust to reduce spend on agency staff by £2.5 million.

Strong financial position

The main reason why we are able to say the productivity challenges are being met is because of the continuing strong financial position overall. Throughout 2011/12, the Department of Health has reported in *the quarter* that the NHS was forecasting to deliver a healthy surplus for 2011/12, and, at final accounts, SHAs and PCTs are reporting an overall year end surplus of £1,583 million – which is 1.6 percent of the total NHS revenue resources (£1,498 million at Q3). This is an improvement on the surplus position forecast at the end of quarter three, and puts us in an excellent position as we move into the final year of transition to the new system. Our overall financial position will remain one of the key measures of our success with regard to QIPP as we go forward.

Challenges for the future

The savings we have made in this first year of QIPP are a real achievement. As we move forward in delivering QIPP, the importance of delivering sustainable savings will be clear and key to enabling commissioners to reinvest savings, meeting the needs of their local populations. This will show we are not only delivering improved care for patients, but keeping the NHS a sustainable public service.

Achieving up to £20 billion of efficiency gains by 2015 is requiring the whole health system to take a radical approach to make sure that we are not just maintaining and improving the quality of services, but the sustainability of the system. This is the year when we will need to start to work out how we are going to respond to the Chancellor's Autumn Statement, which confirmed that restrictions on public spending are likely to remain in place for a long time to come. QIPP is therefore no longer a strategy for managing the NHS up to 2015; it is going to have to become the way we manage the service for the foreseeable future.

4. Prevention

Our ambition

Preventing illness, rather than just treating it, has been a key focus for the NHS over the last year. We need to continue to do all we can to help people stay out of hospital and to lead as healthy a life as possible. This leads to both a healthier population, and reduced resource pressures on the NHS.

During 2011/12 our ambitions for the NHS were three-fold:

- To continue to maintain and lead on improvements to public health, creating a strong foundation for our successor bodies
- To manage the transition towards the new commissioning and governance arrangements of the NHS Commissioning Board, CCGs, local authorities and health and wellbeing boards
- To contribute to the prevention component of the QIPP challenge.

The latter two ambitions are reported elsewhere in this document, and the progress the NHS has made in improving public health during 2011/12 is set out below.

We need to continue to do all we can to help people stay out of hospital and to lead as healthy a life as possible.

What we have delivered

Reducing risk of VTE

Over 90 percent of adult patients admitted to hospital are now risk-assessed for venous thromboembolism (VTE) – a major improvement in patient safety. An estimated 25,000 patient deaths a year could be associated with VTE, and so since July 2010 patients are risk-assessed and given prophylaxis where needed. This improvement drive includes an incentive payment through the CQUIN scheme; a NICE Quality Standard; multi-professional leadership through the National Clinical Director and the '4 Professions Group', bringing together the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives and the Royal Pharmaceutical Society. Peer support is provided by the VTE Exemplar Network, which brings together centres of excellence in VTE prevention, and offers resources more widely across the NHS.

Progress has been measured through a mandatory data collection of the number and proportion of relevant patients assessed. By 31 March 2012:

- More than 17.7 million NHS patients had been screened since July 2010
- 93 percent of NHS patients in England are now being screened for a VTE
- Around 260,000 NHS patients are currently being screened every week.

In just 18 months this is a major achievement. Doctors, nurses, managers and commissioners have all worked together to implement this simple but powerful tool.

Increasing the number of health visitors

Thanks to the concerted support of the profession itself, the NHS, higher education institutions and wider partners, we are on track to meet the Government's commitment to increase the number of health visitors by 4,200 by 2015. In 2011/12, three times as many health visitors began training compared to 2010/11 and over 6,000 new health visitors will be trained before 2015. This year – the 150th anniversary of the profession – we will start to see real growth as this cohort of newly qualified health visitors begin to join the frontline.

The last year has seen progress in recruitment and retention, professional development and improved commissioning linked to public health improvement. Our programme of Early Implementer Sites is driving service transformation in a range of settings across the country, ensuring clinical delivery of the Healthy Child Programme, improved antenatal services, breast-feeding and immunisation rates, parental confidence and improved information sharing among practitioners and parents. Localities of the second wave of sites (bringing the total number to 46) will be announced soon.

> *"Doctors, nurses, managers and commissioners have all worked together to implement this simple but powerful tool.*

Continued focus on maternity services

The NHS Operating Framework 2012/13 makes clear the importance attached to choice and continuity in all aspects of maternity care, from antenatal care through to support at home. More joined up working by maternity providers can help women to make safe, informed choices from a full range of services, which are delivered within an integrated, flexible service.

To support women to make these choices, a new maternity services indicator has been introduced as part of the NHS Outcomes Framework 2012/13, to measure women and families' experiences of care throughout pregnancy, labour, birth and the postnatal period. We have also launched the NHS Information Service for Parents for parents-to-be and new parents, providing regular free emails and SMS messages, offering timely NHS advice and signposting them to other quality-assured information. Both of these steps will help make sure that we continue to provide women with excellent maternity services that focus on the best outcomes for women and their babies and women's experience of care.

Success on smoking prevention

We have seen continued success on smoking prevention. After adult smoking prevalence remained static for a number of years, smoking rates are again starting to decline. The use of local stop smoking services has seen an increase, both in terms of the number of people using them and the success of such services. Provisional figures show 804,307 people set a quit date through NHS Stop Smoking Services in 2011, an increase on the final figure for 2010.

> More joined-up working by maternity providers can help women to make safe, informed choices from a full range of services.

Challenges for the future

We already demonstrate prevention very well for some things. More people with diabetes are now being offered diabetic retinopathy screening than ever before, and to higher standards. Alongside the other UK countries, England leads the world in this area. As set out previously, we have made huge progress in VTE.

But we need to get better at prevention across the board, to make sure we achieve the best possible health outcomes for our communities. For example, the number of registered patients with diabetes has grown from 1.3 million in 2003/4 to 2.15 million in 2010/11, so we need to make sure that we continue to do all we can to help prevent diabetes. This includes rolling out the NHS health checks programme and the *Call to action on obesity*.

The new system has the potential to help us achieve all of this, with the NHS playing a key role alongside other organisations such as Public Health England. If we are successful, then the health and social care system will work much more upstream, to the benefit of both patients and tax payers.

Case study – a more productive and innovative NHS

Lincolnshire web-based activity dashboard

Lincolnshire CCGs are focusing on addressing variation and identifying best practice to share in A&E admissions, unplanned admissions, outpatients, planned admissions, prescribing and finance. This has been achieved through using a web-based activity dashboard to monitor activity against historical activity and plans.

The dashboard has been used by clinical leaders to engage individual practices in focused change and re-design of practice based systems and processes e.g. adoption of Dr First, re-design of access, prescribing resource management, and long-term condition management. To date practices have demonstrated a significant impact on the reduction of emergency admissions through specific projects and have implemented systematic and integrated working across the health system. This provides a number of benefits to patient care, such as improving access to the Frail Older Peoples Service (FOPS) through helping establish a single point of access, rapid access elderly care clinics and integrated working with social care.

5. Transition to the new

> Our staff deserve huge credit for delivering our ambitions, during a period of great personal uncertainty and change.

Our ambition

2011/12 was dominated by political and public debate about the merits of the NHS reforms as they passed through both houses of parliament. This presented an enormous challenge to our staff, who had to continue to deliver for today as well as engaging with the work to ensure effective design and delivery of tomorrow, in conditions of great organisational and personal uncertainty. Our ambitions during this period as managers were to:

- Maintain delivery of the priorities set out in the NHS Operating Framework 2011/12 by ensuring the current system continues to be resilient
- Start to create the conditions and build capacity for delivery within the new system
- Ensure a safe and effective transition from the old to the new.

Our staff deserve huge credit for delivering on all three of these ambitions, during a period of great personal uncertainty and change.

What we delivered

Ensuring resilience in the current system

Uncertainty about the future led to many changes at both organisational and individual levels, requiring prompt managerial action to ensure the resilience of the current system. During 2011/12 we agreed to:

- Cluster 151 primary care trusts (PCTs) into 51 PCT clusters
- Cluster 10 SHAs into 4 SHA clusters.

This created a degree of change both to geographical areas and to the executive and non-executive members of these statutory bodies. However, we judged this short-term disruption was necessary to ensure resilience for today and start creating the conditions for tomorrow. The process of clustering was carried out in the early part of the year, and enabled us to achieve the results set out elsewhere in this report.

Drawing on the lessons of previous transitions, we took steps to ensure that hard and soft intelligence on quality was not lost during the movement of staff, and required all statutory organisations to produce quality handover documents to the newly clustered organisations. An assurance process was led by Sir Bruce Keogh, NHS Medical Director, and the Managing Director for Quality during Transition, Ian Cumming.

Designing the NHS Commissioning Board

The Board has been in place in shadow form for several months and is leading on the development of the new commissioning system. Most of the very senior appointments have been made, and are ready to embrace the challenges and opportunities that lie ahead.

The Board will begin life as an executive non-departmental public body (ENDPB) in October 2012 when it will take on responsibility for the authorisation of CCGs. It takes on its full statutory responsibilities in April 2013. Organised into a national, regional and local structure, it will fulfil a range of NHS facing functions, including:

- Supporting continuous improvements in the quality and outcomes of NHS-funded services
- Promoting and extending public and patient involvement and choice
- Ensuring a comprehensive system of CCGs, supporting them and holding them to account, including working in partnership with local government and other organisations
- Directly commissioning primary care services, specialised NHS services, military health services, offender health services and a range of public health services
- Allocating and accounting for NHS resources
- Promoting equality and reducing inequalities in access to healthcare, in co-operation with Public Health England.

Developing clinical commissioning groups (CCGs)

Significant progress has also been made in the development of CCGs. The vast majority of aspiring CCGs have confirmed their member practices and established an effective geographic area.

These emerging CCGs are already operating under delegated authority, increasingly taking on day-to-day commissioning responsibilities on behalf of PCT clusters. 59 percent of their future commissioning budgets have already been delegated to them and we expect that figure to increase further during 2012/13.

Clinically-led commissioning is already having an impact on the ground, with numerous examples of prospective CCGs leading the way in areas central to the quality and productivity challenge; for example, improving the quality of community-based services and thereby containing pressures on emergency admissions.

We have worked closely with prospective CCGs on the design of the authorisation process. The aim of this process is simple – to support CCGs to be effective in their new roles and on a trajectory to be great clinical commissioners, but making sure they meet safe standards from the outset of this journey. Authorisation is necessary to make sure CCGs are ready to take on their very significant commissioning and financial responsibilities – but it must be a support, not a barrier, to their development.

Creating a robust provider sector

In 2011/12 the SHAs and Department of Health developed tripartite formal agreements (TFAs) that articulate and detail the issues NHS trusts face and the actions needed to become clinically and financially sustainable. All NHS trusts have completed these agreements, which has focused attention and is driving progress towards a full foundation trust (FT) provider sector.

The TFAs have made clear the very real requirement for NHS trusts to make the changes needed to achieve FT status. This is supported by the Health and Social Care Act, which makes provision to remove the NHS trust organisational form from legislation. In addition, the TFAs are addressing issues not tackled in previous attempts to deliver an all FT sector. Crucially, they also hold organisations to account against agreed plans and milestones.

TFAs have brought an unprecedented grip on the FT pipeline – we know where each organisation is on their path to FT status. Despite this grip, and the good progress made to date in the quality and efficiency of services as well as strategic developments, the flow of NHS trusts to FT status requires a further increase in pace. As the requirements to reach FT status are more difficult to achieve, this remains a key risk and 2012/13 should be the key year of delivery.

A strong FT provider sector will be complemented by a wider range of providers from across the NHS, private and voluntary sectors. To make sure that we maintain a clear focus on protecting and promoting patients' interests, the NHS Commissioning Board, Monitor and the Care Quality Commission will work together to implement a comprehensive framework for sector regulation across the healthcare sector.

Case study – a more productive and innovative NHS

Roll out of the QIPP Urgent Care Clinical Dashboard

The Urgent Care Clinical Dashboard presents 'real-time' information on local health economy unscheduled care activity including A&E attendances, emergency admissions and GP out-of-hours attendances, and where possible patient-level data related to GP practice disease registers. The information is displayed in a graphical, user-friendly way, through a web-based browser application, enabling practices to more proactively manage and coordinate the healthcare of their patients, especially for the most vulnerable patients and those with long-term conditions.

The dashboard has been developed at NHS Bolton as part of the National Clinical Dashboard pilot programme. Within the first pilot practices in Bolton, one practice reduced their A&E attendance by 16.8 percent, compared to an increase of 3.85 percent in their peer practices. A second practice reduced their non-elective admissions in targeted areas of asthma, COPD, diabetes, falls and heart failure by 20.69 percent. NHS Bolton as a whole has reduced A&E attendance by 3.14 percent and reduced non-elective admissions by 4.19 percent, against the increasing activity trend in the region.

The QIPP National Urgent and Emergency Care workstream, led by Sir John Oldham, has established 10 pioneer sites across the country with a number of GP practices in each who are currently testing an Urgent Care Clinical Dashboard based on the Bolton model. Now, seventeen sites have Urgent Care Clinical Dashboards.

Re-designing and improving services

However robust a provider sector we are able to build, there will be times when we need to go further than before to ensure that we are providing the best services for patients. We must not be afraid to look at how we can re-design services to improve quality and patient experience and provide added value for taxpayers.

Changes in the way stroke services are delivered in London is a prime example of how taking on ambitious change can reap real benefits. In response to evidence of poor performance, a Healthcare for London team developed a new model of care following extensive collaboration with stakeholders. The London Stroke Networks were responsible for implementation support and performance monitoring against the new rigid standards.

The award-winning acute care model now ensures that all patients – no matter where they live in the capital – are taken within 30 minutes to one of eight hyper acute stroke units (HASUs) in London where they receive top quality care from specialist staff.

Multiple analyses have proven the clinical and economic benefits of the London model, including a significant reduction in length of stay and an increase in thrombolysis (clot-busting drugs) where appropriate. This revolutionary acute pathway offers such high quality care immediately following a stroke that approximately 35 percent of patients are discharged home within a few days following their stay at a HASU. The 2010 Sentinel Audit found that five London HASUs were among the top seven in the country, and all London HASUs were in the top quartile of performance. 88 percent of patients have rated the care given in the first few days after their stroke as excellent or good. It is estimated that over 400 lives per year will be saved thanks to the new model.

The model has been recognised internationally as an example of excellent collaboration and reorganisation, including the HSJ award for Clinical Service Redesign (2011) and, most recently, through the BMJ Group Improving Health Awards (2012).

> *"We must not be afraid to look at how we can re-design services to improve quality and patient experience.*

The major trauma centre (MTC) at University Hospital of North Staffordshire has also shown how re-designing services can make such a big difference to the quality of care we can deliver. Major trauma is complex, requiring a number of specialities working together to deliver effective care. Over a number of years the quality of care in England for these patients had been shown to be in need of dramatic improvement, with greater regional organisation and far greater consultant level involvement in decision making.

Following the commitment in the NHS Operating Framework for England 2011/12 to ensure the implementation of regional trauma networks (RTNs) across England, all RTNs have now gone live, based around 22 MTCs.

Case study – a more productive and innovative NHS

Improved discharge coordination

In Torbay, using dedicated improvement support, the discharge process has been improved and lengths of stay reduced, freeing up staff and improving the discharge experience for patients.

When piloting on the ward over a three month period in 2009 they reduced bed days by 6.2 percent, reduced the mean length of stay by over 10 percent, released nursing time to spend on patient care and reduced referrals to the hospital social work team by 30 percent.

The principle of RTNs is to create inclusive networks with an MTC at the hub – which has all the facilities and specialties required to to treat patients with any type of injury in any combination – linked to a number of trauma units (TUs).

Their readiness varies in terms of rollout and the phasing in of services. There are necessarily bespoke models in each region, but all are based on agreed principles for systematic improvement to the delivery of major trauma care. The establishment of the RTNs across the country will make a real difference to the way we manage our major trauma patients and should be seen as an example to everyone across the system looking to improve service provision.

Where appropriate and necessary, service re-design, such as these examples, must always be on the table when we are considering how to improve our service offer for patients, and leaders across the system should embrace this challenge.

Case study – a more productive and innovative NHS

Derbyshire Community Health Services

The Improvement Leaders Capability Programme currently being run by Derbyshire Community Health Services (DCHS) is an excellent example of how staff groups from all disciplines can come together to deliver a robust and sustainable response to the QIPP challenge.

This initiative gives NHS staff across all areas of the workforce – clinical and non-clinical – the opportunity to lead service improvement and innovation while developing their confidence and skills. Over 200 members of staff have been trained to lead their own projects to improve quality and patient experience while delivering efficiency savings for the organisation. In the last three years, these projects have already generated savings of over £1.25 million.

Some of the key successes have been:

- Slashing a 100-plus waiting list to zero for children needing follow-up appointments for speech and language therapy in Derbyshire
- Maximising the booking systems to manage appointments for podiatric surgery, while meeting appropriate coding deadlines, has led to increased activity in Derbyshire freeing up an additional income of £100,000 for the service
- A review of dental sessions provided for children with special needs has enabled a £125,000 saving as well as improving the patient experience. Instead of running day-long clinics, the sessions are now all provided in the morning, meaning that children who require treatment under general anaesthetic for medical reasons no longer have to cope with the anxiety of going without food all day.

The DCHS programme of work has gained international recognition as a credible and practical approach both to staff development and to delivering outcomes that have a significant impact on quality and cost. With DCHS providing peer support, the programme is now being rolled out across other organisations including Mid Staffordshire NHS Trust and Lapland District Hospital in Finland.

NHS Constitution

As we continue through this period of transition, it is important we remain true to the principles and values enshrined in the NHS Constitution. It is a constant during a time of great change for the NHS and must be at the heart of everything we do.

We have always said the NHS Constitution is a living document, which needs to reflect what matters and is relevant to the needs of patients, the public and staff. We have taken steps over the last year to recognise this. In March 2012, following a public consultation, it was strengthened to take account of whistle blowing changes to tackle poor patient care. These changes set out the rights, pledges and responsibilities of staff to raise concerns at the earliest opportunity, to be supported by their managers and to have their claims fully investigated.

In spring 2012, the Secretary of State asked the NHS Future Forum to establish an independent working panel of experts to advise him on the impact of the NHS Constitution on patients, staff, carers and the public, and to advise him on any revisions that will strengthen and reinforce it for the future. The group, chaired by Professor Steve Field, consists of medical professionals, patient champions, staff representatives and charities, and their work is currently underway. The Secretary of State is due to publish his report on the NHS Constitution shortly, and there will be a public consultation on any changes to strengthen the NHS Constitution later this year.

The values and principles set out in the NHS Constitution must be embedded at every level of the NHS. Looking forward, the NHS Commissioning Board and CCGs will be required by law to not only have regard to it, but to also promote it. Leaders across the NHS should take a personal role to make sure this happens.

Empowering patients

Included in the NHS Constitution is the right for people to make choices about their NHS care, to be involved in decisions and to be given information to enable them to do this. Genuine shared decision-making is about being sensitive to people's preferences and aspirations for their care and treatment, giving them access to the right information and support, if they want it, to make informed decisions. This in turn should lead to better care and better outcomes for patients.

Over the last year we have taken a range of steps to help achieve this vision. We have recently published *The power of information*, our information strategy, covering health and care in England, which sets a ten-year framework for transforming information for health and care. It aims to harness information and new technologies to achieve higher quality care and improve outcomes for patients and service users.

We have also set out proposals aimed at giving patients more say through an opportunity to make shared decisions with their health and care professionals. Patients should be provided with choices at every stage of the patient pathway – in primary care, before a diagnosis, at referral to secondary care and after a diagnosis has been made.

These build on the choices we are already providing patients. By September 2012, many patients will be able to choose from any qualified provider in at least three locally selected community and mental health services, giving them the chance to be treated by the provider best placed to meet their needs. This will mean patients can choose from a range of high quality providers who meet NHS quality and safety standards and prices.

The NHS Commissioning Board will have an ongoing duty to ensure patient involvement in decisions about their care – this should be the main focus for everyone across the system.

Challenges going forward

The Health and Social Care Act 2012 has now passed into legislation, and at the time of writing, many new organisations are in the process of design and recruitment. The challenge going forward will be to make sure that all the different parts of the new system are clear about their shared purpose: delivering better outcomes for patients. This should provide the foundation for our respective roles and responsibilities, and the values and behaviours required to deliver this.

Now, more than ever before, it is vital we provide an integrated service to our local populations. For the first time, leaders of the local health and care system – with CCGs, health and wellbeing boards, local authorities, social care, public health and local HealthWatch at the core – will work together, with their communities, on a common purpose to drive improved services and outcomes.

This will require a new type of leadership. One that looks outwards to local patients and service users, and outwards across the whole local system – not upwards to Whitehall, or inwards to themselves. It will require managers, clinicians and local partners working together to deliver the outcomes that matter to people.

Case study – a more productive and innovative NHS

Redesigning care for COPD in Surrey

Chronic obstructive pulmonary disease (COPD) is the second most common cause of admission and the fifth most common cause of readmission, and one of the most expensive conditions in terms of acute care. In the South East Coast region 2008/09, 59,876 bed days were attributable to COPD with a 26.5 percent readmission rate – at a cost of £17.86 million to the NHS. Currently in this region there are over 60,000 people on the Quality Outcomes Framework registers with COPD, and at least 45,000 people undiagnosed.

ESyDoc (a partnership of GP practices in south east Surrey), has brought together Surrey and Sussex Healthcare NHS Trust, South East Coast ambulance services, out-of-hours providers, community teams and patients. They identified services which could be improved for patients and ESyDoc has placed a GP respiratory lead in their consortium to help motivate and enthuse staff.

As a result:

- In Q4 2009/10 there were 72 admissions with COPD as a primary diagnosis across the EsyDoc consortia; this was down to 62 in Q4 2010/11, equivalent to a reduction of 2.5 admissions per 1,000 COPD patients
- from 2009 to 2010 the number of bed days has been halved
- 30 day readmission rate better than South East Coast region average
- 90 day readmission rate dropped significantly. A year ago 40 percent of patients would be expected to be re-admitted within three months; this has fallen to 30 percent.

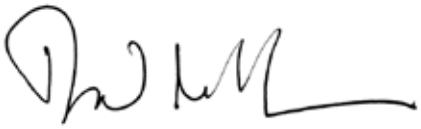
Conclusion

This year we have faced challenges on almost every level, with changes occurring at system, organisational and individual levels. Yet during this period, the NHS has been there for the one million patients who continue to need services every 36 hours. And I am proud to say, despite the extraordinary circumstances we have had to work in, we have largely achieved the ambitions and priorities set out in the NHS Operating Framework 2011/12.

These achievements are the result of the continued efforts of our staff, who have not only delivered for today, but put in place strong foundations for the new system to build upon. The next generation of leaders will face a whole new set of challenges, but their task will be made easier because of the hard work of NHS staff currently in the system, and we owe them our thanks.

Nevertheless, I am far from complacent about the future, nor am I satisfied with the level of our achievement. Like all NHS staff, I remain relentless in my ambition for our patients. I am pleased that in many places our patients get great care, but I won't be satisfied until all of our patients get great care all of the time.

This has been a turbulent year, but the reforms, combined with the need to deliver QIPP, will force us to be innovative about the services we commission and provide. Our challenge now is to respond to the pressures we face in a way that remains true to the NHS Constitution, and secures an NHS, free at the point of delivery for all, for the next generation of staff and patients.



Sir David Nicholson
NHS Chief Executive

thequarter.

Quarter 4 2011/12

An update from David Flory, Deputy NHS Chief Executive

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Introduction

The quarter provides the definitive account of how the NHS is performing at national level against the requirements and indicators set out in the NHS Operating Framework 2011/12. This edition of the quarter covers the period from January to March 2012, quarter four (Q4), the final period in the 2011/12 performance year.

In line with the previous quarters of 2011/12, this report shows the NHS has performed strongly in Q4 and is in a good position to face the challenges ahead in the final year of transition to the new system.

This quarter saw the passing of the Health and Social Care Act by Parliament, which means 2012/13 will be a unique year for the NHS. We must continue to focus on delivering and maintaining the current health system, providing high quality services for our patients, yet be ready for the new system from April 2013. This will undoubtedly be a challenging year for all who work in the service; the need to be simultaneously handling the transition process to the new system while delivering the current system to high standards will require the system to work robustly and effectively together.

Service performance

The NHS Chief Executive's annual report, the year 2011/12, sets out the key achievements the NHS has delivered during 2011/12 despite the challenges it faced and reflects on the expectations for the final year of transition.

Key performance indicators show the NHS continued to deliver the requirements set out in the NHS Operating Framework 2011/12, maintaining or improving all the key performance indicators in Q4.

- MRSA bacteraemia were 21 percent lower than during the same quarter last year and similarly C.difficile infections were 23 percent lower.
- Access to services continued to be maintained, with the NHS delivering above the NHS constitutional commitment to treatment within 18 weeks of referral for 90 percent of admitted patients and 95 percent of non-admitted services.
- The number of breaches of mixed-sex sleeping accommodation also continued to decrease to a breach rate of 0.3 per 1,000 episodes.

Gateway reference number 17758

- Key cancer standards have been achieved across all eight performance measures.
- For the first time since data was collected in this way, the A8 response standard was achieved for the first time annually.

These levels of performance have only been sustained by considerable hard work and determination from the Service. This needs to be maintained to deliver the requirements set out in the NHS Operating Framework 2012/13.

Delivering quality, innovation, productivity and prevention (QIPP)

The NHS has plans for the delivery of up to £20 billion in efficiencies over four years, required to deliver the service improvements through the QIPP programme.

In quarter one (Q1) we explained how the core themes of QIPP are vital to sustaining a high quality NHS in the future and set out the initial progress towards this ambitious goal.

During quarter two (Q2) we began to see greater involvement from emerging clinical commissioning groups (CCGs) in the ownership and delivery of QIPP in their local areas, in collaboration with existing primary care trust (PCT) clusters.

In quarter three (Q3) the NHS was broadly on track to deliver the QIPP savings, with year to date (YTD) savings of £3.9 billion. Local QIPP programmes were emerging and transformational change was demonstrating positive progress.

For Q4, the NHS has reported that £1.9 billion of QIPP savings were delivered. This builds on the savings of £3.9 billion reported at Q3, making an annual total for 2011/12 QIPP savings figure of £5.8 billion.

While the first year of QIPP delivery in 2011/12 has marked a strong start to the four-year QIPP challenge, with the NHS reporting the delivery of substantial savings, the health system faces ongoing challenges over the remainder of the QIPP period to 2014/15. As we have outlined previously, an ageing population will continue to place increased demands on a cost-constrained health system, while economic realities put pressure on the NHS to innovate at scale and pace to meet these new demands.

Quality

HCAI[1]

Performance status: improved

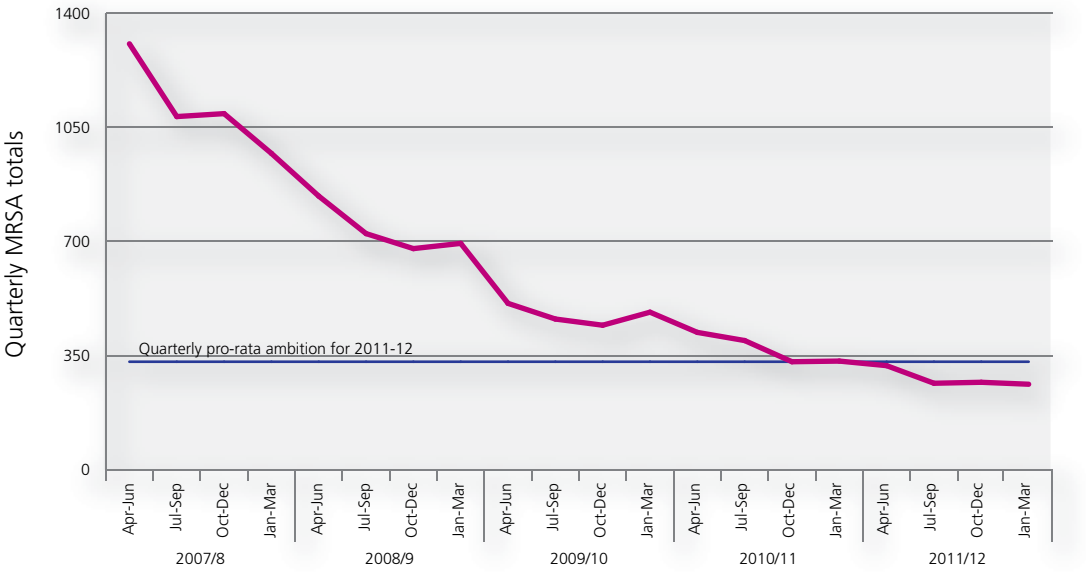
MRSA infections were 21 percent lower and C. difficile infections were 23 percent lower than the same quarter last year.

Performance on MRSA bloodstream infections and C. difficile infections continues to improve, with reductions being achieved collectively in line with the requirements set out in the NHS Operating Framework 2011/12. However, in line with previous quarters, a number of organisations need to continue to focus on infection control to make sure the levels continue to reduce and the ambitious planned reductions in 2012/13 are delivered.

MRSA

In Q4, a total of 262 MRSA bloodstream infections were reported, a 21 percent reduction on the same quarter last year.

Figure 1: MRSA bacteraemia: quarterly totals between April 2007 and March 2012



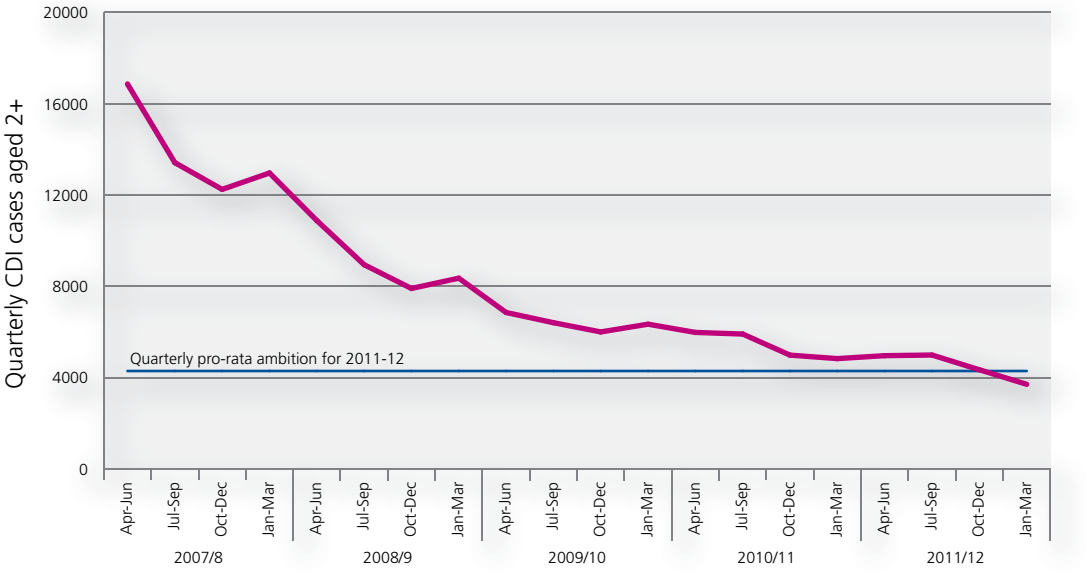
1 http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/LatestPublicationsFromMandatorySurveillanceMRSACDIAndGRE/

C. difficile

For C. difficile, 3,708 infections were reported in Q4, a 23 percent improvement on the same quarter last year.

The vast majority of acute trusts have delivered their trust attributable objectives, but less progress has been made in tackling community-onset cases and further focus will be required in 2012/13.

Figure 2: C. difficile cases aged two or more years: quarterly totals between April 2007 and March 2012



Patient experience

Eliminating mixed sex accommodation[2]

Performance status: improved

Breaches of mixed sex sleeping accommodation guidance continued to fall steadily in Q4. From April 2011, all providers of NHS-funded care have been required to declare compliance with the national definition, or face financial penalties. From this date, fines of £250 for every breach were introduced. This money is reinvested into patient care.

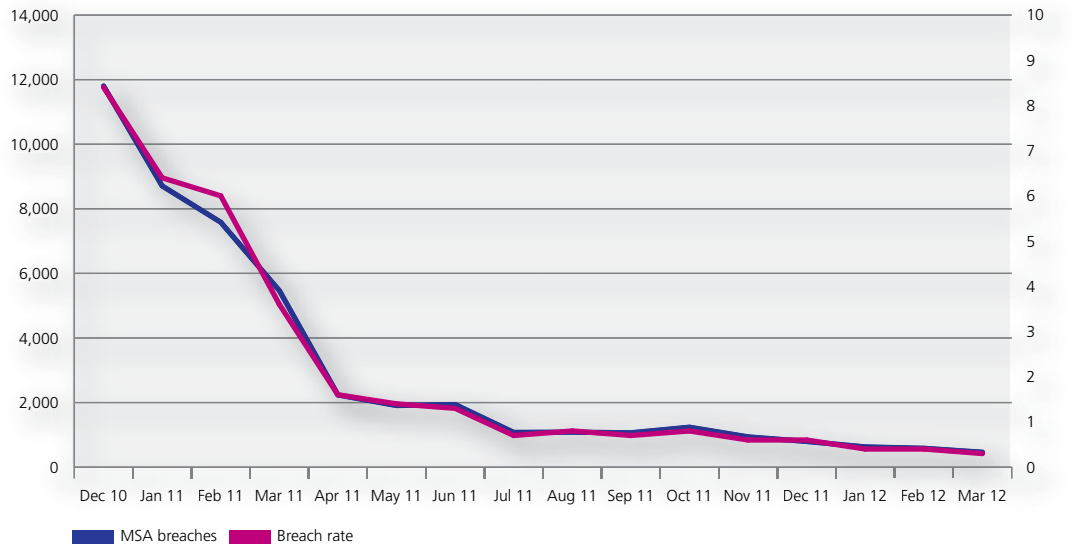
Reporting requires all breaches of sleeping accommodation to be captured for each patient affected. Figures are revised every six months, following validation with commissioners. Sixteen months of data is now available and there has been a steady reduction in the breach rate, as shown in figure 3 (Q4 figures in shaded boxes). *Asterisked figures are unrevised.

2 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/MixedSexAccommodation/DH_124391

Figure 3: Number of breaches of mixed sex accommodation

Month	MSA Breaches	Breach rate
March 2012	*461	0.3
February 2012	*583	0.4
January 2012	626	0.4
December 2011	795	0.6
November 2011	937	0.6
October 2011	1,236	0.8
September 2011	1,063	0.7
August 2011	1,083	0.8
July 2011	1,075	0.7
June 2011	1,939	1.3
May 2011	1,908	1.4
April 2011	2,236	1.6
March 2011	5,466	3.6
February 2011	8,031	6.0
January 2011	8,708	6.4
December 2010	11,802	8.4

Figure 4: Mixed sex accommodation total breaches and breach rate for England



The reporting arrangements ensure a higher degree of scrutiny and transparency of progress to eliminate mixed sex accommodation. Breaches of guidance relating to bathrooms, WCs, and day areas in mental health units are monitored and resolved locally through the usual contract arrangements. Occurrences of mixing in the best interests of the patient are monitored locally, but not reported centrally.

Overall patient experience scores[3]

Performance status: maintained

Patient experience of NHS adult inpatient services showed no change overall in 2011/12 – an overall score of 75.6 compared with the previous year of 75.7. The score for outpatient services improved from 78.8 in 2009/10 to 79.2 in 2011/12.

The overall scores are the averages of five domains of care:

- Improving access and waiting
- Safe, high quality, coordinated care
- Better information, more choice
- Building closer relationships
- A clean, comfortable, friendly environment.

On the inpatient survey, the only significant change came in the score for 'improving access and waiting', which decreased from 84.2 to 83.8. The other four domains did not change significantly.

Care Quality Commission (CQC) Adult inpatient survey[4]

Performance status: maintained

The 2011/12 Adult inpatient survey shows a clear improvement in the provision of single sex bathroom and shower areas, and patients receiving copies of letters between clinicians, but shows a small reduction in patient reported experience of their waiting times for admission to hospital.

The proportion of patients in 2011 rating their overall care as excellent was 43 percent – the same as in 2010.

The survey shows patients reporting significant improvements in:

- the provision of single sex accommodation
- the provision of single sex bathroom or shower areas
- patients receiving copies of letters between clinicians.

The survey highlighted significant declines in several areas including:

- patient reported waiting times for admission to hospital
- the quality of food in hospitals
- the provision of help for those who struggle with eating.

It is disappointing that more patients felt they had waited longer than six months for admission. This demonstrates how important it is that the NHS treats patients as quickly as possible. In fact, NHS figures show there are fewer patients than ever waiting a long time for elective treatment in the NHS.

3 http://transparency.dh.gov.uk/2012/04/24/inpatient_survey_results_2011/

4 http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2011

CQC Adult outpatient survey[5]

Performance status: improved

The 2011/12 national adult outpatient survey shows clear improvements in being seen on time for an appointment, cleanliness of wards, being treated with respect and dignity, and with receiving answers that could be understood, but shows declining standards in changing appointment dates and in explanation of the process of treatment.

The results from the 2011 adult outpatient survey were published by the CQC on 14 February 2012. The proportion of patients in 2011 rating their overall care as excellent was 44 percent, which is an increase from the score of 40 percent in 2009.

The survey also shows patients reporting significant improvements in:

- being seen on time for an appointment
- the cleanliness of wards
- being treated with respect and dignity
- various questions about doctors and in 'definitely' getting answers the patient could understand.

The survey also highlighted significant declines in several areas including respondents' saying that:

- the appointment date was changed
- the results of tests were 'definitely' explained
- what would happen during treatment was 'definitely' explained.

Commissioning for Quality and Innovation (CQUIN) national goal on patient experience

Performance status: maintained

Results from the second year show no significant change between 2010/11 and 2011/12, with seven trusts recording a significant increase and eight trusts recording a decrease.

The CQUIN national goal on patient experience was implemented for the first time in the 2010/11 financial year. The goal ('improving responsiveness to personal needs of patients') is defined by a total score, which is an average of five questions:

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

The CQUIN national goal is measured independently through the CQC national inpatient survey. Small improvements were recorded in questions three to five, but these were offset by a decrease on question two. The overall score for 2011/12 was 67.4, which was not significantly different from the score of 67.3 in 2010/11 but is significantly higher than 66.7 in 2009/10. This national goal remains in place for 2012/13.

5 http://www.cqc.org.uk/Outpatientsurvey2011

Patient Reported Outcome Measures (PROMs)[6]

Performance status: improved

The latest data, covering April 2011 – December 2011, shows an increase in the percentage of patients reporting an improvement for all four procedures. For example, 96.4 percent of patients receiving a hip replacement and 92.0 percent of patients receiving a knee replacement report an improvement, up from 95.8 percent and 91.4 percent respectively in 2010/11.

The 2010/11 data has been updated and shows a continual, although only slight, improvement in compliance. The number of patients returning pre-operative questionnaires (171,347) and the national participation rate (69.8 percent) remain broadly unchanged from the figure reported in February 2012. The national participation rate is 3.7 percentage points higher than in 2009/10. Of the 162,370 post-operative questionnaires sent out, 131,379 have been returned, implying a return rate of at least 80.9 percent. This is one percentage point higher than in 2009/10.

The data for 2011/12 (April – December) published on the 10 May 2012 also shows an improvement in outcomes compared to data for previous years in terms of the percentage of patients reporting improved health status following an intervention. The average health gain from treatment is also higher in 2011/12 than previous years for three of the four procedures. Details are given in figure 5.

Figure 5: Headline PROMs data, England

Procedure	Year*	Average health gain (EQ-5D, case-mix adjusted)	% of patients reporting improved health status**
Hip replacement	2009/10	0.411	87.2 – 95.7
	2010/11	0.405	86.8 – 95.8
	2011/12	*0.423*	*87.9 – 96.4*
Knee replacement	2009/10	0.295	77.6 – 91.4
	2010/11	0.299	77.9 – 91.5
	2011/12	*0.313*	*79.4 – 92.0*
Varicose vein	2009/10	0.094	52.4 – 83.4
	2010/11	0.094	51.5 – 82.6
	2011/12	*0.092*	*53.3 – 83.9*
Groin hernia	2009/10	0.082	49.3
	2010/11	0.085	50.6
	2011/12	*0.089*	*50.9*

* 2009/10 data finalised; 2010/11 data provisional; 2011/12 provisional data (April 11 – December 11 only) meaning scores are subject to change as more data is processed throughout the year.

** Ranges present the EQ – 5D index score and condition-specific scores. There is no condition-specific measure for groin hernia surgery.

6 http://www.hesonline.nhs.uk/Ease/ContentServer?siteID=1937&categoryID=1295

Analysis[7] of the 2010/11 data indicates a number of organisations seem to be outliers on certain procedures when compared to the national average. Figure 6 shows the organisation whose performance is statistically better than the national average; figure 7 those organisations whose outcomes are statistically below the average. Organisations in figure 7, who are negative outliers for both measures for a given procedure, are encouraged to investigate their own score to understand any underlying causes for the variation in performance.

Figure 6: List of potential statistical positive 'outlier' organisations for 2011/12 (provisional data)

Name	Procedure	Measure
East Cheshire NHS Trust	Hip replacement	Oxford hip score
Hull and East Yorkshire Hospitals NHS Trust	Varicose vein	Aberdeen varicose vein score
Leeds Teaching Hospitals NHS Trust	Knee replacement	Oxford knee score
Royal Devon and Exeter NHS Foundation Trust	Hip replacement	Oxford hip score
Scarborough and North East Yorkshire Healthcare NHS Trust	Knee replacement	Oxford knee score
South Warwickshire NHS Foundation Trust	Groin hernia	EQ – 5D index
The Horder Centre – St John's Road Sussex	Hip Replacement	EQ – 5D index
Inclusion criteria: Statistically above average scores (>3 standard deviations) for EQ – 5D index and condition specific index (Oxford hip score or Oxford knee score).		

7 The outlier methodology was published on the DH website in July 2011 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128440.

Figure 7: List of potential statistical negative 'outlier' organisations for 2011/12 (provisional data)

Name	Procedure	Measure
Barnsley Hospital NHS Foundation Trust	Hip replacement	Oxford hip score
Barts and the London NHS Trust	Varicose vein	EQ – 5D index
Basildon and Thurrock University Hospitals NHS Foundation Trust	Hip replacement	EQ – 5D index
Basildon and Thurrock University Hospitals NHS Foundation Trust	Knee replacement	EQ – 5D index
Chesterfield Royal Hospital NHS Foundation Trust	Hip replacement	Oxford hip score
Guy's and St Thomas' NHS Foundation Trust	Hip replacement	Oxford hip score
Heart of England NHS Foundation Trust	Hip replacement	Oxford hip score
Oxford University Hospitals NHS Trust	Varicose vein	Aberdeen varicose vein score
South London Healthcare NHS Trust	Knee replacement	Oxford knee score
Southport and Ormskirk Hospital NHS Trust	Hip replacement	EQ – 5D index
The Hillingdon Hospitals NHS Foundation Trust	Hip replacement	Oxford hip score and EQ – 5D index
The Princess Alexandra Hospital NHS Trust	Hip replacement	Oxford hip score
United Lincolnshire Hospitals NHS Trust	Hip replacement	Oxford hip score
Walsall Healthcare NHS Trust	Hip replacement	Oxford hip score
Whipps Cross University Hospital NHS Trust	Groin hernia	EQ – 5D index
Inclusion criteria: Statistically below average scores (>3 standard deviations) for EQ – 5D index and condition specific index (Oxford hip score or Oxford knee score).		

Referral to Treatment (RTT) consultant-led waiting times[8]

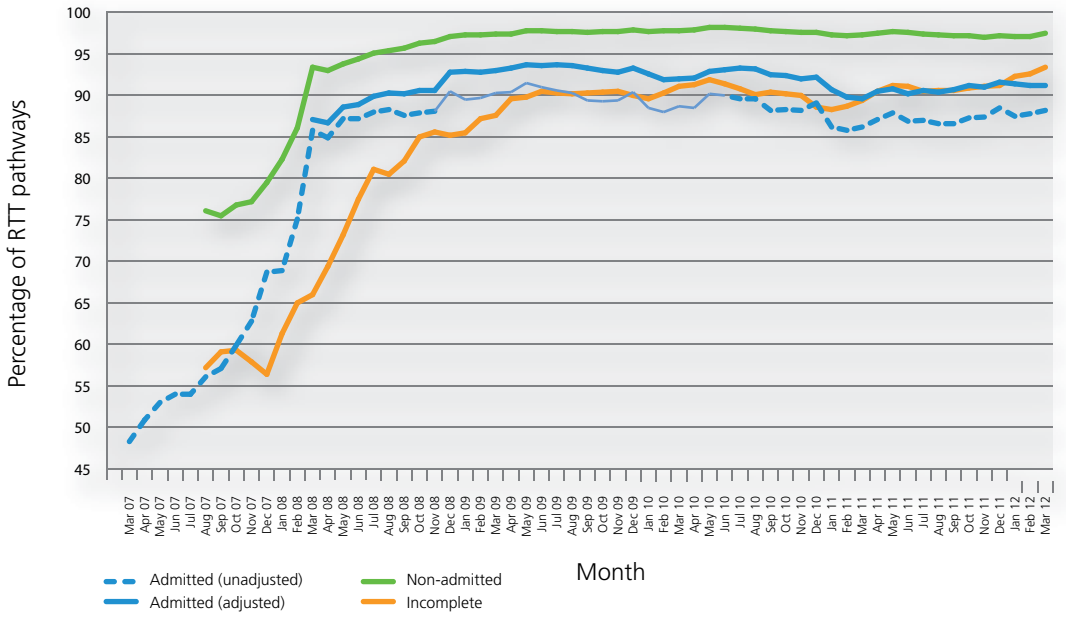
Performance status: maintained

The patient right 'to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible' remains in the NHS Constitution in England[9].

In the three months to March 2012, the NHS as a whole continued to deliver the NHS Constitution standards, that 90 percent of admitted patients and 95 percent of non-admitted patients should start their treatment within 18 weeks of referral (figure 8). In March 2012, 91.2 percent of admitted patients and 97.5 percent of non-admitted patients started treatment within 18 weeks.

Figure 8 also shows the NHS has delivered the 2012/13 operational standard that 92 per cent of patients on an incomplete pathway should have been waiting less than 18 weeks, three months early. At the end of March 2012, 93.4 percent of patients on an incomplete pathway had been waiting less than 18 weeks. The NHS continued to deliver this standard during 2012/13.

Figure 8: Percentage of RTT pathways within 18 weeks



All organisations must make sure patients receive clinically appropriate treatment in accordance with the NHS Constitution. To deliver the NHS Constitution right, and in the best interests of patients, it is good practice to publish local access policies that have been agreed with clinicians and patients and are in line with national referral to treatment rules.

Where current performance does not meet the NHS Constitution operational standards, action must be taken to make sure patients are not waiting unnecessarily to start treatment and to ensure that improvements are made as quickly as possible.

8 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

Figure 9 shows the 10 organisations reporting the best performance against the 2011/12 performance measures in March 2012.

Figure 9: Acute trusts with best performance on referral to treatment waits in March 2012

Performance thresholds	> 23 weeks	>18.3 weeks	>28 weeks	<90%	<95%	Total indicators worse than threshold
Name	95th percentile admitted pathways	95th percentile non-admitted pathways	95th percentile incomplete pathways	Adm % within 18 weeks	Non-adm % within 18 weeks	
West Suffolk NHS Foundation Trust	16.0	13.1	15.2	100.0%	100.0%	0
Chesterfield Royal Hospital NHS Foundation Trust	14.6	12.2	15.2	99.6%	100.0%	0
South Tyneside NHS Foundation Trust	17.8	12.4	17.1	98.8%	99.6%	0
Great Western Hospitals NHS Foundation Trust	17.7	15.2	16.7	98.4%	98.8%	0
The Hillingdon Hospitals NHS Foundation Trust	17.5	13.8	15.8	98.2%	99.2%	0
West Middlesex University Hospital NHS Trust	17.6	16.2	20.4	98.2%	98.1%	0
The Rotherham NHS Foundation Trust	16.9	10.7	13.5	98.0%	99.4%	0
The Christie NHS Foundation Trust	16.0	14.9	14.5	97.0%	98.4%	0
Liverpool Women's NHS Foundation Trust	16.6	16.8	23.7	96.9%	97.0%	0
Hinchingbrooke Health Care NHS Trust	17.5	10.6	14.9	96.2%	99.2%	0

Figure 10 shows the 10 organisations reporting the poorest performance across the 2011/12 performance measures in March 2012.

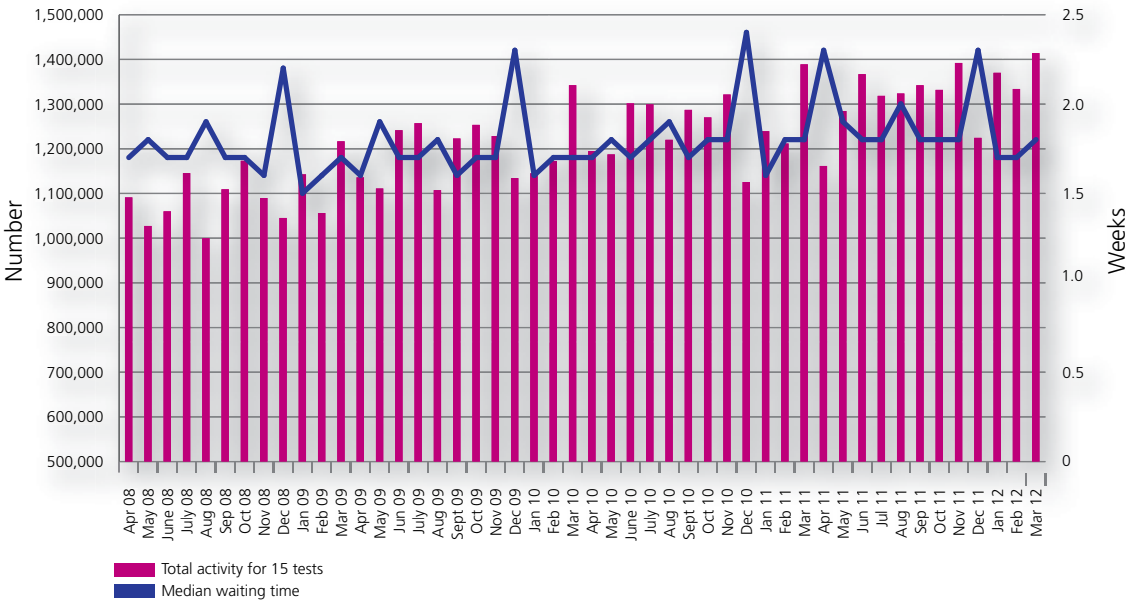
Figure 10: Acute trusts with poorest performance on referral to treatment waits in March 2012

Performance thresholds	> 23 weeks	>18.3 weeks	>28 weeks	<90%	<95%	Total indicators worse than threshold
Name	Adm 95th percentile	Non-adm 95th percentile	Incomp 95th percentile	Adm % within 18 weeks	Non-adm % within 18 weeks	
Imperial College Healthcare NHS Trust	DNR	DNR	DNR	DNR	DNR	5
Mid Staffordshire NHS Foundation Trust	31.9	23.1	27.6	75.8%	91.1%	4
East Sussex Healthcare NHS Trust	29.4	21.3	19.3	84.7%	92.4%	4
Salford Royal NHS Foundation Trust	25.4	20.2	14.1	85.4%	93.3%	4
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	41.9	15.3	40.3	59.9%	98.3%	3
Guy's and St Thomas' NHS Foundation Trust	35.9	16.4	30.3	84.9%	96.2%	3
James Paget University Hospitals NHS Foundation Trust	29.0	15.8	28.2	85.0%	99.0%	3
Royal Devon and Exeter NHS Foundation Trust	25.7	14.9	30.1	86.2%	97.7%	3
Pennine Acute Hospitals NHS Trust	26.2	16.7	29.2	86.9%	96.8%	3
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	27.6	16.6	21.1	77.7%	96.7%	2

During the three months to March 2012, the NHS has also made good progress in reducing the number of patients still waiting a long-time to start treatment. In particular, the number of patients still waiting over a year at the end of March 2012 has reduced to 5,141 (0.2 percent of total waiting list), compared to 14,355 (0.6 percent of total waiting list) at the end of March 2011. This reduction is a result of action taken by local health communities to treat patients who have been waiting a long time and action taken to validate waiting lists.

Average waiting times for the 15 key diagnostic tests have also remained low and stable in the three months to March 2012. This has been achieved during a period of increasing activity. In the three months to March 2012, total diagnostic activity increased by 7.2 percent (278,000 tests), compared to the same period in 2011 (figure 11). The annual growth in 2011/12 was 5.5 percent (822,000 tests).

Figure 11: Diagnostic waiting times: median waiting time and total activity: April 2008 to March 2012



The high percentage of patients receiving one of the 15 key diagnostic tests in less than six weeks demonstrates good progress towards the 2012/13 operational standard for diagnostic waiting times – that from April 2012 less than 1 percent of patients should be waiting six weeks or longer for a diagnostic test. The standard has been met early, in February 2012, with 0.9 percent achieved. At the end of March 2012 just 0.7 percent of patients were waiting six weeks or longer for one of the 15 key diagnostic tests.

A small number of trusts are responsible for a large proportion of the waits of six weeks or longer reported at the end of March 2012. Figure 12 shows the acute trusts with the largest numbers of waits of six weeks or longer at the end of March 2012.

Figure 12: Organisations reporting the largest number of diagnostic waits of six weeks or longer at the end of March 2012

Provider Name	Number of 6+ week waits	Total number of patients waiting for a diagnostic test	6+ week waits as a percentage of total waits
Bradford Teaching Hospitals NHS Foundation Trust	222	6,262	3.5%
Brighton and Sussex University Hospitals NHS Trust	189	5,252	3.6%
Sheffield Teaching Hospitals NHS Foundation Trust	156	6,580	2.4%
Guy's and St Thomas' NHS Foundation Trust	152	5,202	2.9%
Heart of England NHS Foundation Trust	140	10,365	1.4%
East Cheshire NHS Trust	136	1,854	7.3%
King's College Hospital NHS Foundation Trust	128	4,702	2.7%
Derby Hospitals NHS Foundation Trust	119	5,971	2.0%
Sherwood Forest Hospitals NHS Foundation Trust	118	4,826	2.4%
Mid Staffordshire NHS Foundation Trust	109	2,613	4.2%
Western Sussex Hospitals NHS Trust	104	5,231	2.0%
Norfolk and Norwich University Hospitals NHS Foundation Trust	101	6,858	1.5%
University Hospitals of Leicester NHS Trust	100	7,673	1.3%

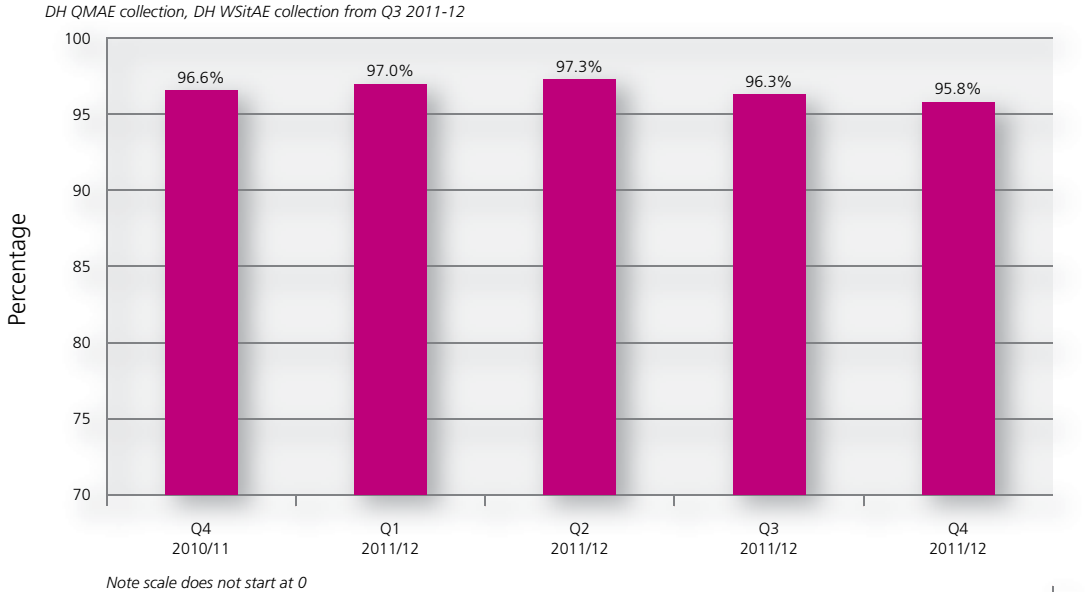
A&E[10]

Performance status: maintained

At Q4, 95.8 percent of patients spent four hours or less from arrival to admission, transfer to discharge, across all A&E types. This remains above the 95 percent standard, although slightly lower than the same period last year.

Figure 13 shows performance against the total time indicator, with quarterly monitoring A&E return (QMAE) as the data source until Q2 2011/12. Following the fundamental review of data returns consultation, QMAE ceased to be collected from January 2012. Situation (sit-rep) data, which is directly comparable, will now be the data source.

Figure 13: Percentage of patients spending four hours or less at all types of A&E by quarter, England



In April 2011, a new set of clinical quality indicators was introduced to replace the previous four-hour waiting time standard, and to measure the quality of care delivered in A&E departments in England. The new A&E clinical quality indicators use the NHS Information Centre's (NHS IC's) Hospital Episodes Statistics (HES) database; data has been published covering the period up to and including December 2011.

The new clinical quality indicators have put in place more meaningful performance measures that balance timeliness of care with other indicators of quality, including clinical outcomes and patient experience. There are eight clinical quality indicators, five of which were headline measures in the NHS Operating Framework 2011/12.

For 2011/12, the NHS was asked to focus on improving the data quality for the five indicators, as well as ensuring compliance with the total time indicator, for which the Department has good quality data available from QMAE and sit-reps.

10 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/index.htm

Ambulance[11]

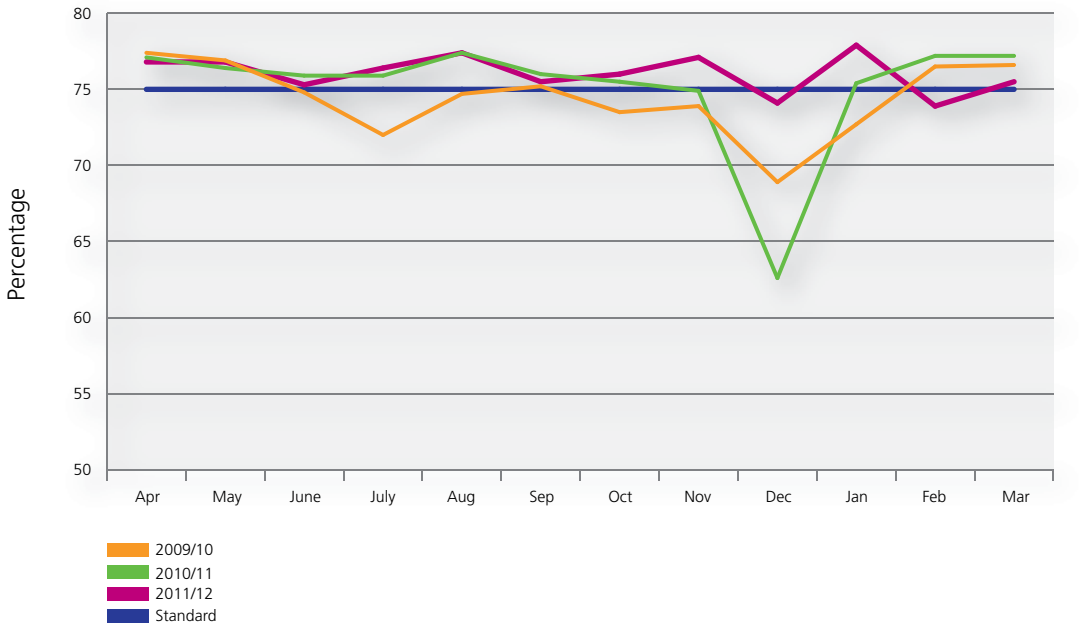
Performance status: maintained

For Q4, the proportion of Category A calls resulting in an emergency response arriving within eight minutes was 75.8 percent nationally. This standard was met annually for the first time since these records were collected. The proportion of Category A calls resulting in an ambulance arriving at the scene within 19 minutes was 96.5 percent. This compares to Q3 figures of 75.7 percent and 96.5 percent respectively. Data therefore demonstrates that fast response times for the most seriously ill patients are being maintained, as shown in the tables below.

Monthly performance data, as part of the clinical quality indicator measurements, is available in-year for Q4, and indicates that ambulance services nationally achieved against both the Category A, eight-minute response time target and the Category A, 19-minute response time target.

Ambulance data is collected and published monthly against the clinical quality indicators ('system measures'). With the exception of the nationally managed eight-minute response time target ('A8') and the 19-minute ('A19') transportation target for Category A (immediately life-threatening) calls, no thresholds have been set for these indicators.

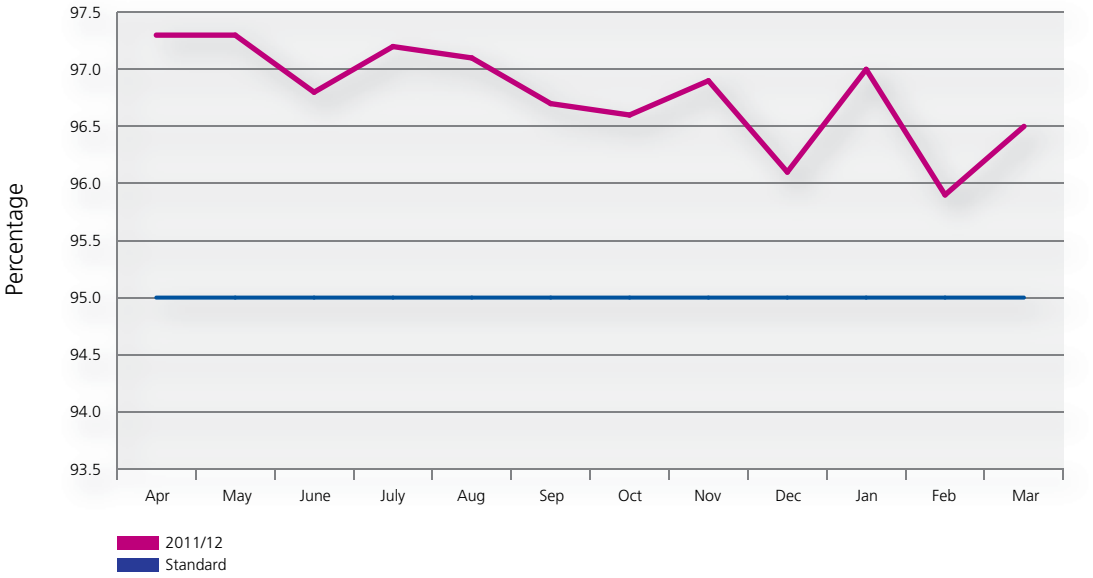
Figure 14: Percentage of Category A calls responded to within eight minutes of call being connected (England)



Prior to April 2011, data for the Category A eight minutes measure was collected weekly via the weekly sit-reps, but has been aggregated here to create a monthly time series. The weekly period covered each month will vary, either covering a period of four or five weeks.

11 http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/

Figure 15: Percentage of Category A calls responded to within 19 minutes of call being connected (England)



There were over 1,219,000 emergency journeys in Q4. The system measures for Q4 show that 1.2 percent of callers abandoned their call before the call was answered by the ambulance service, compared to 1.1 percent in Q3. The proportion of patients re-contacting the ambulance service following discharge of care by telephone increased from 12.1 percent in Q3, to 13.9 percent in Q4. The re-contact rate following discharge of care from treatment at the scene increased from 5.4 percent in Q3 to 5.6 percent in Q4. The proportion of calls closed with telephone advice was 5.6 percent in Q4, an increase from the Q3 figure of 5.4 percent. The proportion of incidents receiving a face-to-face response from ambulance services that were managed without the need for transport to A&E increased to 34.4 percent in Q4, from 34.1 percent in Q3.

Data is also being collected against the clinical outcomes of patients (reported as 'clinical outcome' measures) who receive care from NHS ambulance services. 'Clinical outcome' measures require additional reporting time to allow time for the ultimate clinical outcome to have occurred, and for data to be collected for patients who received inpatient care following transport by the ambulance service. Data for these measures run with a three-month lag on the systems indicators, as this time is required for those patients who received further care following transport by ambulance to have their outcomes resolved. Data for Q4 has not been published to date.

Cancer[12]

Performance status: maintained

The NHS has sustained performance for cancer waiting times in Q4 and continues to report achievement above the operational standards at a national level. Variation in performance at a local level has increased for some measures.

At a national level, all requirements for maximum waiting times for diagnosed and suspected cancer patients were met during the period Q4, with reported performance being above the published operational standards.

Figure 16: Performance against cancer waiting time standards

Measure	Operational standard	Q4 2011/12 Performance
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	96.3%
Maximum two-week wait for the first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	96.1%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	87.3%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	95.7%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	No operational standard has been set	93.6%
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	98.5%
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	97.3%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.7%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	98.0%

All data are taken from the Q4 2011/12 National Statistics and are provider-based (including Welsh and unknowns)

Only four providers failed to achieve the operational standard for three or more cancer waiting times requirements for Q4 (see figure 17).

12 http://transparency.dh.gov.uk/category/statistics/provider-waiting-cancer/

Figure 17: Cancer waiting times standards: identified outlier organisations

Period: Q4 2011/12 (January, February and March)
Basis: Provider-based including Welsh cross-border patients and 'unknowns'
Definitions: DSCN 20/2008
Note 1: Only providers reporting five or more cases in the period are identified in this analysis
Note 2: Only providers that failed three or more waiting times requirements in the period are identified in this analysis

Cancer waiting times standard	All cancer two week wait	All cancer one month standard	31-day standard: subsequent surgery	31-day standard: subsequent anti-cancer drug regimen	31-day standard: subsequent radiotherapy	Two month first treatment standard	62-days from screening service	Two week wait for breast symptoms	Number of standards failed
Required operational standard	**93%**	**96%**	**94%**	**98%**	**94%**	**85%**	**90%**	**93%**	
Provider	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**n**
Kingston Hospital NHS Trust	95.7%	97.2%	92.9%	100.0%		87.5%	80.0%	91.6%	3
Barts and the London NHS Trust	94.3%	95.2%	93.2%	100.0%	95.5%	73.8%	88.9%	90.7%	5
The Princess Alexandra Hospital NHS Trust	89.1%	97.9%	100.0%	100.0%		81.8%	94.8%	89.9%	3
United Lincolnshire Hospitals NHS Trust	94.9%		95.3%	97.9%	94.4%		85.7%	90.8%	3

Stroke and Transient Ischaemic Attack (TIA)

Performance status: maintained

Improving stroke care remains a priority for the NHS and latest data shows the NHS is maintaining improvements and will continue to iron out regional variations, which is crucial to improving outcomes for patients.

For Q4, 81.7 percent of stroke patients spent 90 percent or more of their hospital stay in a stroke unit. This is a slight dip in performance compared to Q3, where the corresponding figure was 82.8 percent.

There is clear evidence that care in a stroke unit improves outcomes. This has increased by over 20 percent since 2009, but there is still variation between areas and the NHS is continuing to work on this.

It is encouraging that 71.2 percent of TIA cases with a higher risk of minor stroke are treated within 24 hours. This is an increase on Q3 where the corresponding figure was 70.5 percent, and a 20 percent increase since 2009.

Maintaining this improvement is crucial to reducing the likelihood of people going on to experience a full stroke.

Dentistry

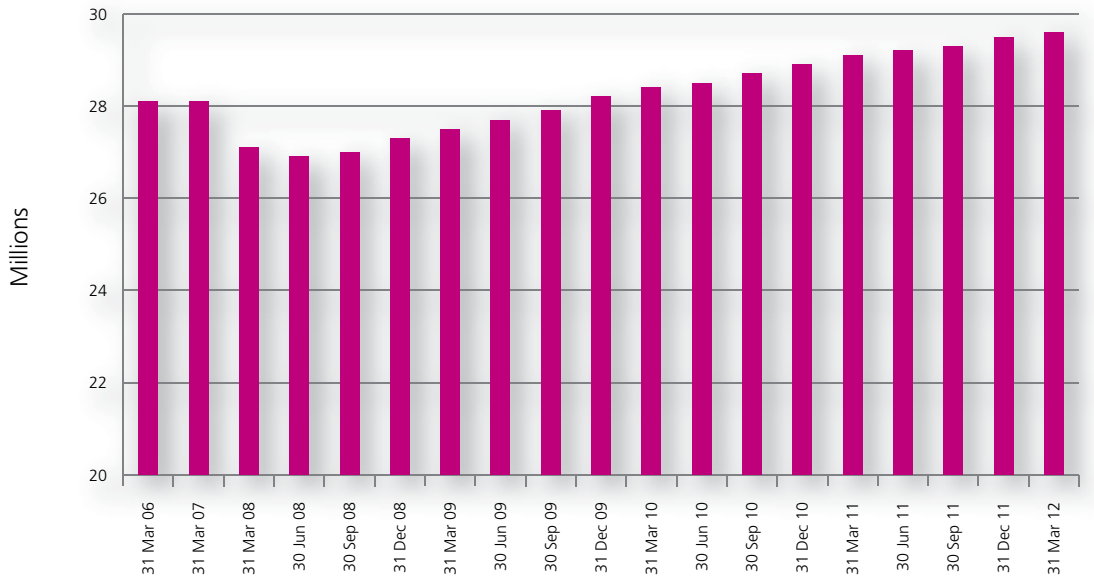
Performance status: improved

The latest data shows the number of patients accessing NHS dentistry has grown for the fifteenth consecutive quarter from 26.9 million in June 2008 to 29.6 million in March 2012. In Q4, around 113,000 more adults and around 18,000 more children have accessed NHS dental services than in Q3. The NHS Operating Framework 2011/12 required the NHS to continue to improve access to NHS dentistry, and we are continuing to see growth quarter on quarter.

The more stretching goal to increase access by a million on the level seen in May 2010 has now been met, with 1.12 million more patients seen since May 2010. An additional £28 million funding was allocated to PCTs in February 2012 to spend on increasing access in year.

In April 2011, we announced pilots to run in advance of an introduction of a new dental contract based on registration, capitation and quality, with the aim of increasing access and enabling dentists to focus on improving oral health. Elements needed to design that new contract are being piloted in 70 dental practices across England – these started on 1 September 2011 and will run until March 2013. The new contract and new commissioning system should deliver a service where dentists are encouraged and motivated to deliver high quality care, focused on improving patients' oral health.

Figure 18: Number of patients seen by an NHS dentist (millions)



Innovation

Previous versions of *the quarter* have set out progress in making sure innovation is increased across the NHS. *The year* sets out further progress against the ambitious agenda set out in December, with the publication of *Innovation, Health and Wealth: Accelerating Adoption and Diffusion in the NHS*[13].

13 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131299

Productivity

Finance

Throughout 2011/12, the Department has reported in *the quarter* that the NHS was forecasting a healthy surplus for 2011/12, and, at final accounts, strategic health authorities (SHAs) and PCTs are reporting an overall year end surplus of £1,583 million,[14] which is 1.6 percent of the total NHS revenue resources (£1,498 million at Q3).

NHS trusts (excluding foundation trusts (FTs)) are reporting an overall year end surplus of £45 million in their final accounts for 2011/12 (£30 million surplus at Q3).

Figure 19: NHS financial performance by SHA area – PCT/SHA sector

	2008/09		2009/10		2010/11		2011/12	
	£m	% Resource limit	£m	% Resource limit	£m	% Resource limit	£m	% Resource limit
North East	109	2.3	80	1.6	70	1.3	64	1.2
North West	295	2.4	185	1.4	215	1.5	267	1.9
Yorkshire and the Humber	216	2.5	185	2.0	187	1.9	189	1.8
NHS North of England	**620**	**2.4**	**450**	**1.6**	**472**	**1.6**	**520**	**1.7**
East Midlands	107	1.6	83	1.2	90	1.2	90	1.1
West Midlands	101	1.2	80	0.8	73	0.7	92	0.9
East of England	139	1.7	137	1.5	101	1.0	104	1.1
NHS Midlands and East	**347**	**1.5**	**300**	**1.2**	**264**	**1.0**	**286**	**1.0**
London	327	2.3	382	2.4	392	2.3	442	2.6
NHS London	**327**	**2.3**	**382**	**2.4**	**392**	**2.3**	**442**	**2.6**
South East Coast	62	1.0	50	0.7	65	0.9	86	1.1
South Central	44	0.8	60	0.9	67	1.0	72	1.1
South West	104	1.3	95	1.1	115	1.3	177	1.9
NHS South of England	**210**	**1.1**	**205**	**0.9**	**247**	**1.1**	**335**	**1.4**
Total	**1,504**	**1.8**	**1,337**	**1.5**	**1,375**	**1.4**	**1,583**	**1.6**

The PCT and SHA surplus from 2011/12 will be carried forward into 2012/13 and will help to make sure the NHS is in the best position as we move forward to the new landscape.

There are three PCTs reporting a gross deficit of £48 million in their 2011/12 final accounts. All three are reporting an improved position from their forecast at Q3. These are Enfield PCT (£17 million deficit, £2 million improvement over Q3), Haringey Teaching PCT (£17 million deficit, £1 million improvement over Q3) and Barnet PCT (£14 million deficit, £3 million improvement over Q3).

In addition, Croydon PCT was forecasting a deficit at Q3, but are now reporting a small surplus in their final accounts.

South London Healthcare NHS Trust (£65 million operating deficit), Barking, Havering and Redbridge Hospitals NHS Trust (£50 million operating deficit), Whipps Cross University Hospitals NHS Trust (£6 million operating deficit), and Surrey and Sussex Healthcare NHS Trust (£6 million operating deficit).

14 The position for Peterborough PCT, Oxfordshire PCT and Buckinghamshire PCT is based on their 2011/12 draft accounts.

Four NHS trusts are reporting an improved position from the forecast at Q3: Mid Yorkshire Hospitals NHS Trust (£19 million operating deficit, £1 million improvement over Q3), Epsom and St Helier University Hospitals NHS Trust (£12 million operating deficit, £2 million improvement over Q3), Imperial College Healthcare NHS Trust (£8 million operating deficit, £11 million improvement over Q3) and North West London Hospitals NHS Trust (£8 million operating deficit, £2 million improvement over Q3).

Additionally, there are two additional organisations reporting an operating deficit at final accounts. These are Mid Essex Hospital Services NHS Trust (£2 million operating deficit) and Newham University Hospital NHS Trust (£0.2 million operating deficit).

Figure 20: NHS financial performance by SHA area – Trust sector

	2008/09		2009/10		2010/11		2011/12	
	£m	% Turnover	£m	% Turnover	£m	% Turnover	£m	% Turnover
North East	17	1.9	10	3.0	3	2.9	2	3.8
North West	(15)	(0.4)	15	0.5	21	0.7	29	0.9
Yorkshire and the Humber	44	1.8	14	0.6	10	0.4	(5)	(0.2)
NHS North of England	**46**	**0.6**	**39**	**0.7**	**34**	**0.6**	**26**	**0.4**
East Midlands	22	0.8	18	0.7	2	0.1	24	0.7
West Midlands	48	1.5	53	1.6	30	0.9	33	0.8
East of England	40	1.9	30	1.4	23	0.9	12	0.5
NHS Midlands and East	**110**	**1.3**	**101**	**1.2**	**55**	**0.6**	**69**	**0.7**
London	(21)	(0.3)	(3)	(0.0)	(20)	(0.2)	(96)	(1.1)
NHS London	**(21)**	**(0.3)**	**(3)**	**(0.0)**	**(20)**	**(0.2)**	**(96)**	**(1.1)**
South East Coast	49	1.7	37	1.5	16	0.6	4	0.2
South Central	18	0.7	(7)	(0.3)	8	0.3	12	0.6
South West	33	1.4	28	1.3	28	1.3	30	1.4
NHS South of England	**100**	**1.3**	**58**	**0.8**	**52**	**0.7**	**46**	**0.7**
Total	**235**	**0.8**	**195**	**0.7**	**121**	**0.4**	**45**	**0.1**

While it is important to recognise the strong overall financial position of the service, focus will remain on the small number of organisations struggling to manage their finances.

The Department is continuing to work in conjunction with SHAs to make sure the organisations reporting an operating deficit have robust plans in place for financial recovery, while continuing to improve the quality of services to patients. As transition to the new landscape continues, it is essential to maintain a firm financial platform.

Figure 21: SHA and PCT sector surplus and (deficit) 2008/09 to 2011/12 final accounts

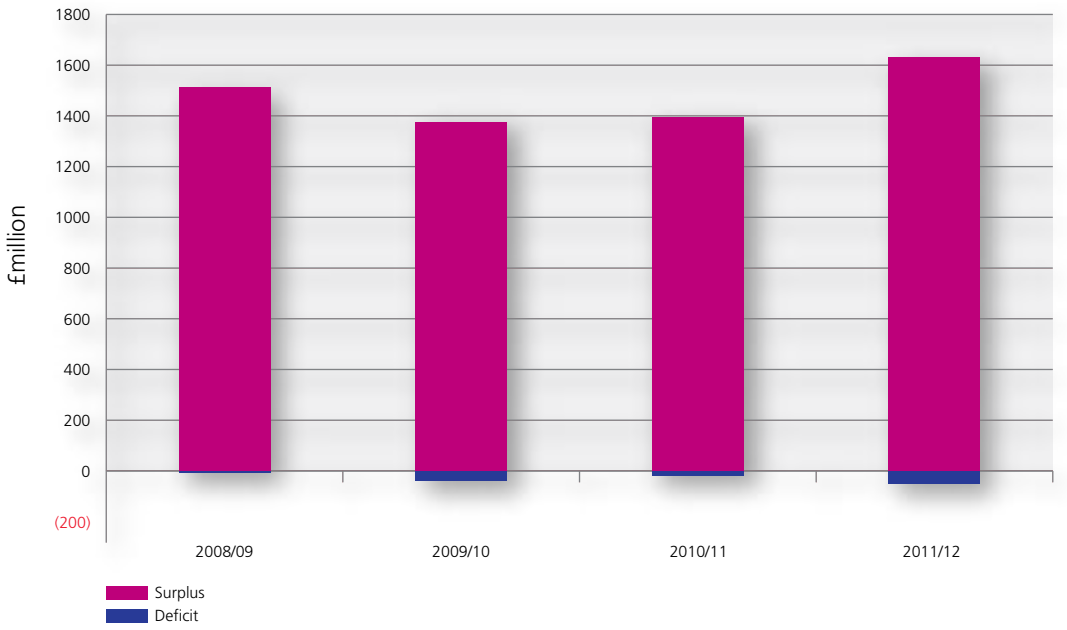
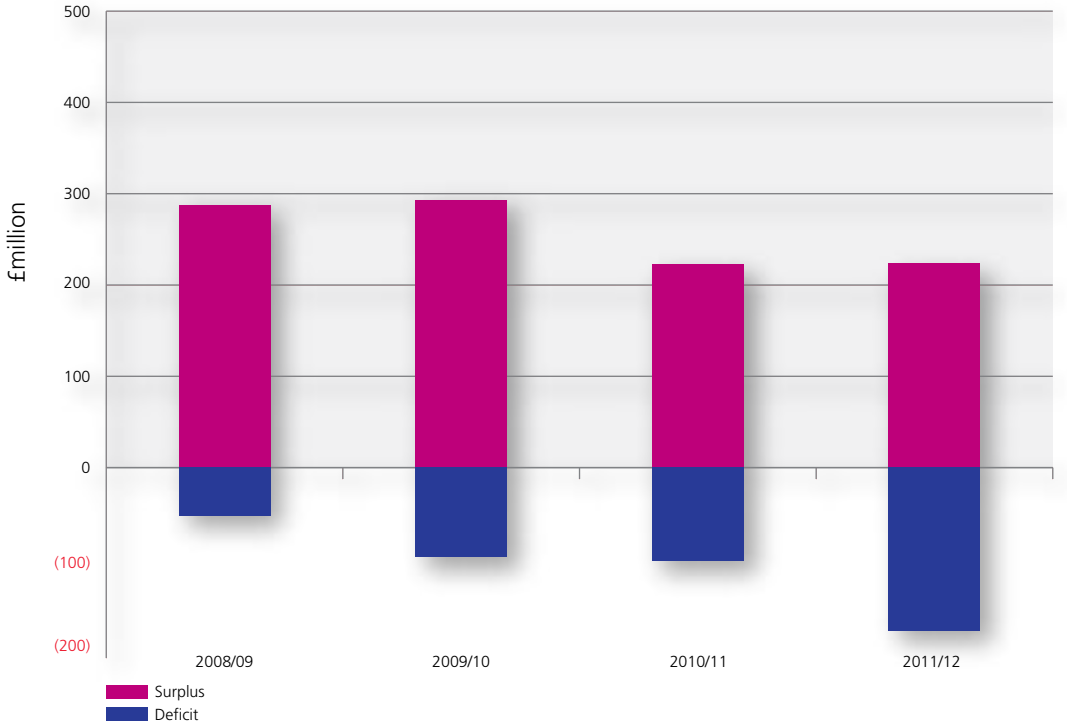


Figure 22: Trust sector surplus and (operating deficit) 2008/09 to 2011/12 final accounts



In addition to the gross operating deficit, there is a gross technical deficit of £767 million in 42 NHS trusts (ten of these organisations also have an operating deficit).

Southampton University Hospitals NHS Trust's deficit of £2 million is a technical deficit, due to part-year accounts for the first half of the year, when the Trust was still an NHS trust.

A technical deficit is a deficit arising due to one or both of the following:

a) **Impairments to fixed assets** – an impairment charge is not considered part of the organisation's operating position.

b) **The revenue cost of bringing private finance initiative (PFI) assets onto the balance sheet** – due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10 – NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI is not chargeable for overall budgeting purposes and should be reported as technical.

c) The impact of the change in accounting for donated assets and government grant reserves.

QIPP Savings

During Q4, PCTs delivered a further £1.9 billion of QIPP savings, building on the £3.9 billion achieved up to the end of Q3. Therefore, in total, PCTs reported the delivery of £5.8 billion of QIPP savings in 2011/12, consistent with the level of quality and productivity savings forecast during the year. Figure 23 identifies the categories of savings across the NHS in England by each SHA cluster.

The 2011/12 savings represent an encouraging start in meeting the QIPP challenge. It is important to build on this good progress by securing sustained delivery throughout 2012/13 and beyond.

As we have previously noted, the demands of an ageing population and increased costs owing to developments in drugs and advancing medical technologies present challenging financial conditions in a constrained economic climate. All parts of the NHS will need to take bold, long-term measures to rise to this challenge and deliver sustainable improvement in 2012/13.

Figure 23: 2011/12 NHS England QIPP savings by SHA cluster

Total 2011/12 QIPP	SHA cluster				
QIPP category	London SHA £m	Midlands & East SHA £m	North of England SHA £m	South of England SHA £m	Grand Total
Acute services	556	818	801	668	2,843
Ambulance services	8	27	23	16	74
Community services	112	122	88	141	463
Continuing healthcare	23	50	43	43	159
Mental health and learning disabilities services	133	130	101	76	440
Non-NHS healthcare (inc reablement)	37	29	50	41	157
Prescribing	214	142	229	115	700
Primary Care, Dental, Pharmacy, Opthalmic	59	126	117	115	417
Specialised commissioning	56	57	72	70	255
Other	32	122	107	46	307
Grand Total	**1,230**	**1,623**	**1,631**	**1,331**	**5,815**

Activity[15]

Overall on activity, in response to the QIPP challenge, the ambition of the NHS is to redesign pathways to make sure patients are treated in the appropriate setting. This is expected to result in a reduction in unplanned emergency admissions. A modest reduction in activity levels in 2011/12 as compared to 2010/11 is an indication that this ambition is being delivered.

Elective activity

On elective activity, the year-end position for 2011/12 shows:

- GP referrals made were 1.0 percent lower than the previous year.
- Other referrals for a first outpatient appointment were 4.6 percent higher than the previous year.
- The reduction in GP referrals made is reflected in the rate of GP referrals seen, which were 1.4 percent lower than the previous year.
- All first outpatient attendances were 0.5 percent higher than the previous year.
- Elective activity (admissions) growth was 3.6 percent, which was the same as the previous year.

The position at the end of the year is consistent with a slow down in referrals from GPs. Despite an increase in 'other referrals', elective growth for the year was the same as 2010/11, suggesting the NHS is starting to treat more people in the most appropriate setting and preventing unnecessary admission. The increase in total elective activity shown in figure 24 and the maintenance of the referral to treatment standards reflects the significant efforts made by NHS organisations to continue to maintain delivery standards in the face of demand pressures.

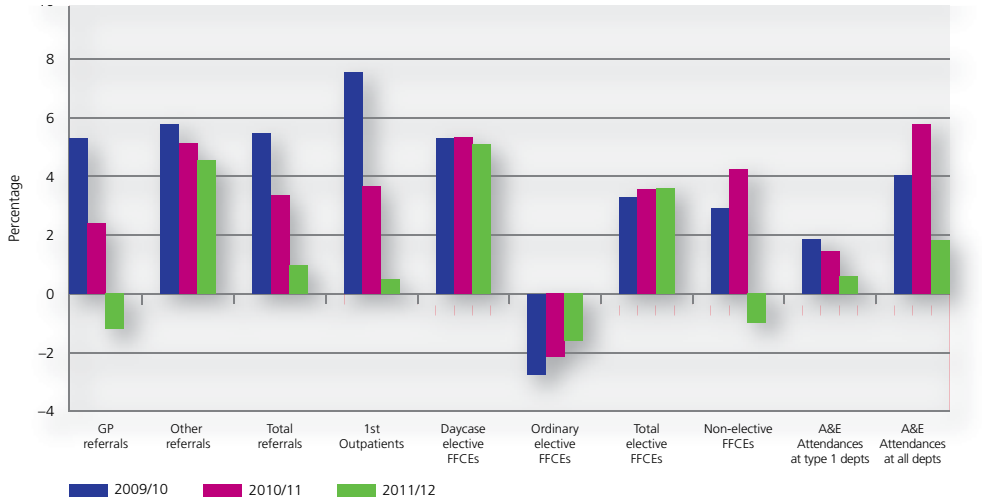
Emergency activity

On non-elective activity, the year-end position for 2011/12 shows:

- Non-elective activity (admissions) were 1.0 percent lower than the previous year.
- A&E attendances at type 1 A&E departments were slightly higher (0.6 percent) than the previous year.
- A&E attendances at all type A&E departments were 1.8 percent higher than the previous year.
- Urgent and emergency ambulance journeys per day were 1.6 percent lower than the previous year (2010/11 data were collected using weekly ambulance situation reports. 2011/12 data are collected using monthly ambulance quality report indicators. Both data sources are comparable).

Overall, non-elective activity levels are stable or lower than the previous year. This would indicate the trend of steady increases has now begun to change. In the context of a continuing increase in the demand for acute services, emergency admissions are being avoided or treated in more appropriate settings.

Figure 24: Growth in activity Indicators – England, by volume[1]



[1]A&E attendances are shown by volume per day, all other indicators are shown by absolute volume.

15 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalActivityStatistics/index.htm

Workforce[16]

Over this period, there has been a slight decrease in staff numbers published in the hospital and community health services (HCHS) workforce statistics by the NHS IC on a monthly basis. The publication mainly focuses on staff working in hospitals, PCTs and SHAs and does not fully reflect the increasing number of healthcare professionals moving into community settings, delivering care closer to patients' homes.

As part of the education and training reform programme, the Department of Health is working with workforce colleagues in the SHAs and the NHS IC to develop a process to better reflect and capture the effect of service redesign on the NHS workforce.

Figure 25 details the full time equivalent (FTE) changes in key NHS staff groups between Q3 and Q4.

Figure 25: Changes in key NHS staff groups between Q3 and Q4 2011/12

England FULL TIME EQUIVALENTS (FTE)	Q3 Nov 11	Q4 Feb 12	Q3 to Q4 change	Q3 to Q4 % change
All HCHS doctors (non locum)	99,685	99,602	–83	–0.1%
All HCHS doctors (locum)	2,073	2,036	–37	–1.8%
All HCHS doctors (incl locums)	**101,758**	**101,638**	**–120**	**–0.1%**
Qualified midwives	21,028	21,067	39	0.2%
Qualified health visitors	8,065	8,207	142	1.8%
Qualified school nurses	1,158	1,192	35	3.0%
Other qualified	278,349	277,634	–715	–0.3%
Qualified nursing, midwifery and health visiting staff	**308,600**	**308,100**	**–500**	**–0,2%**
Qualified allied health professions	63,211	63,312	101	0.2%
Qualified healthcare scientists	29,108	29,132	24	0.1%
Other qualified scientific, therapeutic & technical staff	40,262	40,550	288	0.7%
Total qualified scientific, therapeutic & technical staff	**132,581**	**132,993**	**413**	**0.3%**
Qualified ambulance staff	**18,013**	**17,999**	**–14**	**–0.1%**
Professionally qualified clinical staff	**560,951**	**560,730**	**–221**	**0.0%**
Support to clinical staff	**290,406**	**290,089**	**–317**	**–0.1%**
Central functions	96,703	96,679	–25	0.0%
Hotel, property & estates	56,512	56,232	–280	–0.5%
Total managers	36,475	36,233	–243	–0.7%
NHS infrastructure support	**189,690**	**189,143**	**–547**	**–0.3%**
Total	**1,041,048**	**1,039,963**	**–1,085**	**–0.1%**

16 http://www.ic.nhs.uk/statistics-and-data-collections/workforce

Figure 25 uses the middle data point for each quarter, i.e. November 2011 for Q3 and February 2012 for Q4. This better represents the average workforce throughout the period and is most relevant when comparing to finance, activity and other data. This revised format will continue to be used for future publications of *the quarter*.

The NHS IC has revised the published workforce statistics for November and December 2011 since the last publication of *the quarter*. Revisions are for the South Central region only and increase the FTE figures by approximately 800. The revision has been made to correct erroneous data that meant some staff were not included in the South Central figures, therefore also affecting national figures. The revision means the staff numbers reported in Q3 have changed.

Health and wellbeing

The Department is committed to supporting the NHS to improve the health and wellbeing of its staff. This is not only because we want staff to be happy and healthy, but because there is compelling evidence that a positive staff experience has a direct, positive impact on patient experience.

Moreover, promoting staff health and wellbeing can help reduce sickness absence, which costs the NHS around £1.7 billion each year and places additional pressure on colleagues.

The Department continues to work with the NHS to reduce sickness absence through tackling the main causes of ill health. Five high-impact changes have been identified that build on the NHS Health and Wellbeing Framework published in July 2011[17]:

1. Developing local, evidence-based plans
2. With strong, visible leadership
3. Supported by improved management capability
4. With access to better, local, high quality, accredited occupational health services
5. Where staff are encouraged and enabled to take more responsibility for their health

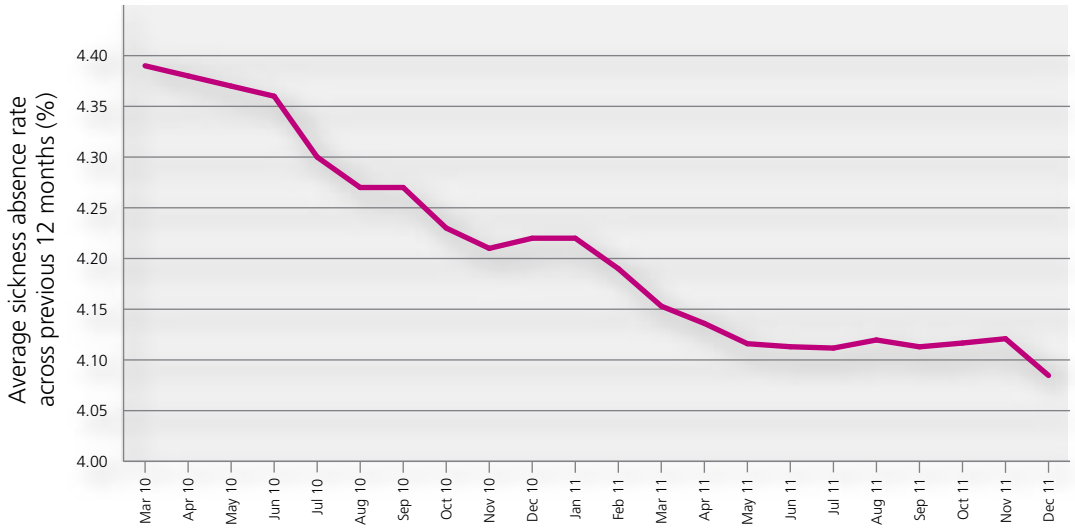
The Department is working with a variety of organisations including NHS Employers, Royal College of Physicians Health and Work Development Unit and NHS Plus to commission work to deliver these changes. Work is underway on pathfinder projects in each SHA cluster to develop local initiatives aligned to the high-impact changes.

Sickness absence

The latest report published by the NHS IC, based on data from the Electronic Staff Record (ESR), provided the results for October to December 2011. This showed that sickness absence has fallen by 0.12 percentage points compared to the same quarter in 2010, from 4.47 percent to 4.35 percent in 2011. The annual moving average sickness absence fell to 4.08 percent. Progress to date is encouraging. However, there is recognition there is more to do to reach the QIPP target of reducing sickness absence by one third. We are working with SHA cluster workforce directors, NHS Employers and the Social Partnership Forum to try to accelerate delivery to make sure we remain on track.

17 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691

Figure 26: Sickness absence – England trend: 12 month rolling annual average



Staff engagement

Evidence shows where levels of staff engagement and health and wellbeing are high, trusts are much more likely to have a better quality of patient care, better financial performance and lower sickness absence among staff.

The NHS staff survey provides the NHS with data on staff engagement each year. National NHS staff survey results published in March 2011 showed staff engagement fell marginally across NHS trusts between 2010 and 2011 to 3.61, on a scale of 1 (low) to 5 (high), compared to 3.63 the previous year. The 2011 staff survey results were published on 20 March 2012. Survey data was gathered between mid-September and mid-December 2011.

Details of how individual employers can improve staff health and wellbeing, raise engagement and reduce sickness absence are available on the NHS Employers website at www.nhsemployers.org.

NHS staff survey data is available via Picker Institute at www.nhsstaffsurveys.com.

Prevention

Health visitors

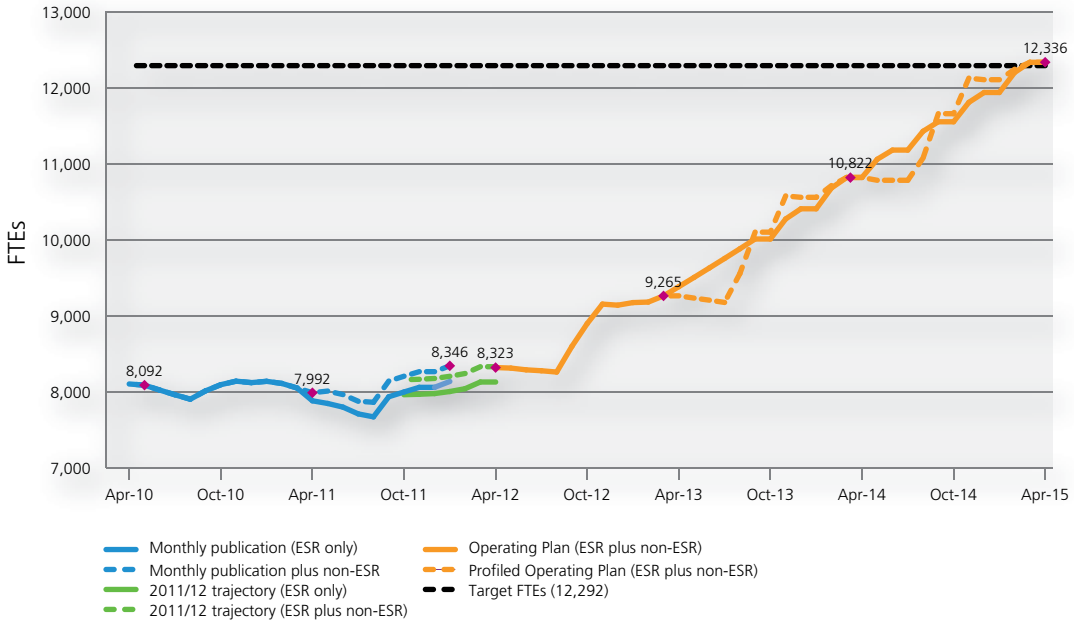
In May 2010, the Government committed to an increase in health visitors of 4,200 by April 2015, against the baseline of the time, which was 8,092. The vision is of a revitalised service, one that ensures all families in England are offered a core programme of evidence-based preventable health care, covering the breadth of the Healthy Children Programme, with additional care and support for those who need it.

The number of health visitors recorded on the ESR increased by 142 FTE between November 2011 and February 2012 and now stands at 8,207 FTE. This increase is encouraging, but a large increase in numbers is not expected until autumn 2012 when the health visiting students who entered training in autumn 2011 begin to qualify. SHA returns show there are around a further 200 FTE health visitors not recorded on the ESR (e.g. staff working in organisations such as local authorities and social enterprises).

Operating plans and trajectories for 2012/13 have now been agreed with the SHA clusters. Using these plans, the Department has produced an 'indicative' trajectory to reflect the expected change in the workforce, which is shown at figure 27. It demonstrates progress to date and the planned workforce growth over the next three years at a national level. This trajectory will be reviewed annually and we are currently working with each SHA to establish local trajectories.

The Department will be monitoring key data returns from the service, for example on numbers, training commissions and fill rates, to assess delivery against trajectory and overall performance in delivering the programme.

Figure 27: Health visitor trajectories, England



Maternity and newborn

Early access to antenatal care promotes greater choice for women and ensures women receive the right care at the right time, helping to tackle the negative impact of health inequalities from the start and beginning to improve the health and wellbeing of mother and baby.

The performance standard for the percentage of women having an assessment of their health and social care needs, risks and choices by 12 weeks and six days of pregnancy is 90 percent. The latest data indicates performance is being maintained above the standard. 94.7 percent of women who gave birth in Q4 saw a maternity healthcare professional for a health and social care needs, risks and choices assessment within 12 weeks and six days of pregnancy. The figure is comparable to Q3 when 91.5 percent of women who gave birth had an assessment within the specified time period.

Breastfeeding

Breastfeeding is good for babies and mothers and it is encouraging to see another increase in the number of women starting to breastfeed. We have set our commitment to support breastfeeding through the Healthy Child Programme. The breastfeeding initiation rate was 74.0 percent in 2011/12, a slight improvement on 2010/11 (73.7 percent). The prevalence of breastfeeding at six to eight weeks in Q4 was 46.9 percent of all infants due a six to eight weeks check, slightly higher than the figure of 45.3 percent recorded in Q4 2010/11.

Smoking[18]

The latest figures show an increase across all measures for people accessing and successfully quitting with NHS Stop Smoking Services in England, compared to the same period in previous years. The latest data covers the first three quarters (Q1/ Q2/ Q3) of 2011/12. The data is provisional and subject to the usual end-of-year revisions following validation.

552,602 people set a quit date through NHS Stop Smoking Services, an increase of 3 percent (16,780) on the final figure for same period in 2010/11 (535,822), and an increase of 7 percent (38,721).

At the four week follow-up 264,795 people had successfully quit (based on self-report), 48 percent of those setting a quit date. This is an increase of 3 percent (8,133) on the final figure for the same period in 2010/11 (256,662).

72 percent of successful quitters at the four week follow-up had their results confirmed by carbon monoxide (CO) verification. This percentage was 69 percent based on final figures for the same period in 2010/11. This demonstrates an improvement in the quality of services provided, as it is recommended that services validate their quit rates this way.

For Q3 2010/11, the increase between the provisional figures and the final figures was 4.7 percent for the number setting a quit date and 4.5 percent for the number of successful quitters (based on self-report). This suggests the final figures for 2011/12 may be higher than the provisional figures stated above.

Of the 19,048 pregnant women who set a quit date, 8,288 successfully quit at the four week follow-up (44 percent).

Total expenditure on NHS Stop Smoking Services was £62.1 million, an increase of 3 percent (£1.9 million) on the final figure for the same period in 2010/11 (£60.2 million). The cost per quitter is £235, which is the same as the final figure for the same period in 2010/11. These figures do not include expenditure on pharmacotherapies. For Q3 2010/11, there was a decrease of 1.4 percent between the provisional and final Q3 expenditure figure.

Among SHAs, NHS Yorkshire and the Humber and NHS South Central reported the highest proportion of successful quitters (53 percent), while NHS North East, NHS North West and NHS West Midlands SHA reported the lowest success rate (44 percent).

18 http://smokefree.nhs.uk/

Among PCTs, East Riding of Yorkshire PCT and Warrington PCT reported the highest proportion of successful quitters (70 percent), while Blackpool PCT reported the lowest success rate (32 percent).

Screening

VTE (venous thromboembolism) risk assessment

Of the reported 3.4 million adult patients admitted to NHS-funded acute care between January and March 2012, 92.5 percent received a VTE risk assessment on admission, an increase compared to Q3 (90.8 percent). The NHS is the only health system in the world to start such a comprehensive system of VTE monitoring and prevention at a national level. Our goal is to maintain that we risk assess 90 percent of all admitted patients, which allows for clinically justified exceptions.

Breast screening

The NHS Operating Framework 2011/12 states commissioners should make sure that all NHS breast screening services continue to take part in the age extension randomisation project, either screening women aged 47-49 or 71-73, depending on the randomisation protocol. As at the end of March 2012, 52 out of 80 local programmes (65 percent) had implemented the extension randomisation and a further nine (11 percent) were unsuitable for randomisation and were inviting only the 47-49 year-olds. 19 programmes (24 percent) are still to expand, citing lack of digital mammography, staffing shortfalls and funding as issues. The proportion of local screening programmes taking part in the age extension randomisation is slowing, and concerns remain in some areas around engagement and conversion to digital mammography.

Cervical screening test results

The NHS Operating Framework 2011/12 states that commissioners should continue to ensure that cervical screening results are received within 14 days. As recommended by the Advisory Committee on Cervical Screening (ACCS), the operational standard for achieving this has been set at 98 percent. As at the end of March 2012, 98.1 percent of women were receiving their results within 14 days.

Bowel screening

As from 23 August 2010, all 153 PCTs in England were offering bowel cancer screening to people in the 60 to 69 years age range who are registered with a GP. This completed the initial roll out of the NHS Bowel Cancer Screening Programme (BCSP) across England. As at the end of March 2012, over 13 million kits (13,253,982) had been sent out and nearly 8 million (7,885,934) returned. Over 12,000 (12,203) cancers had been detected, and over 60,000 (62,209) patients had underwent polyp removal. Men and women over the age limit can request a testing kit every two years, and nearly 170,000 (169,446) have self-referred for screening so far.

The NHS BCSP is currently being extended to men and women aged 70 to their 75th birthday. The NHS Operating Framework 2011/12 states the extensions begun in 2010/11 should continue and be maintained for 2011/12. Those centres whose end of original two-year screening round was in 2011/12 should implement the extension on completion of the original round. Those whose end of original round falls beyond 2011/12 should prepare to expand on completion of the original round. As at March 2012, 35 of the 58 local screening centres (60 percent) had implemented the extension. When the extension is fully rolled out, around 1 million more men and women will be screened each year.

The number of local bowel screening centres inviting the older age group up to their 75th birthday has slowed because of issues with endoscopy capacity. Those PCTs that began the original programme later will not begin the age extension until later in 2012/13.

Diabetic retinopathy

At Q4, 99.0 percent of patients with diabetes were offered screening for diabetic retinopathy during the previous 12 months.

More people with diabetes are now being offered screening than ever before, and to higher standards. This is in the context of

an ever increasing number of people with diabetes. Latest figures for Q4 show that 2.36 million people were offered screening and the number of people with diabetes stands at 2.58 million. When the screening programme was introduced in 2003, the number of people with diabetes stood at 1.3 million. England (alongside other UK countries) leads the world in this area – this is the first time a population-based screening programme for diabetic retinopathy has been introduced on such a large scale.

While most PCTs are offering screening to all people with diabetes, there are some that are still not offering screening to everyone with diabetes. The Department and the NHS Diabetic Eye Screening Programme is working closely with partners in the NHS and the voluntary sector to improve the standards, quality and coverage of screening programmes across the country.

Immunisation

Vaccine uptake rates for all the early childhood vaccinations, offered as part of the national immunisation programme, were higher in Q3 compared to Q2.

The largest increases in vaccine uptake were for one dose of MMR vaccine by age two (from 90.7 percent to 91.5 percent), two doses of MMR vaccine by age five (from 85.4 percent to 86.2 percent), the Hib/MenC booster by age five (from 89.3 percent to 90.0 percent) and the PCV booster by age five (from 85.4 percent to 86.9 percent).

MMR uptake in England has returned to levels not seen since 1998 when vaccination rates dipped following the publication of the discredited Wakefield research. MMR uptake (one dose by age two) exceeds 90 percent in all SHA areas except London, where it is 85.6 percent. Vaccine uptake rates are lowest in London, but the rate of improvement is greatest in this area. Therefore, the gap with the rest of England is steadily narrowing.

Reform

Choice

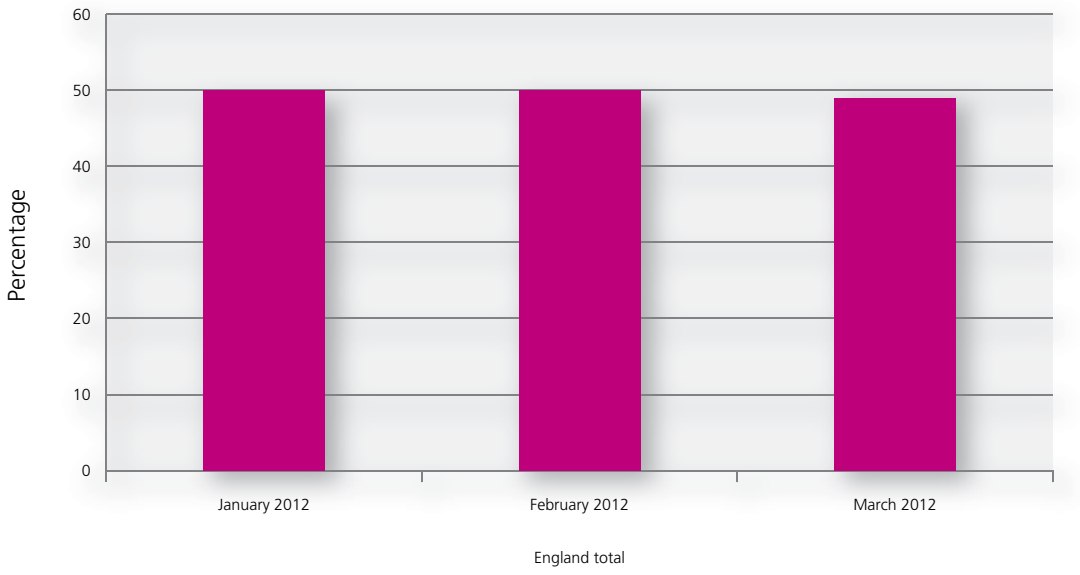
Patient choice

Indicators suggest the take-up of patient choice is slowly improving where it is offered and that the Choose and Book system is being used to a high level in most areas. Three separate Choose and Book measures are used to assess whether choice is being offered by referrers using the Choose and Book system to refer patients for first consultant outpatient services.

Proportion of GP referrals to first outpatient appointments booked using Choose and Book

Choose and Book utilisation remained relatively stable over Q4. The overall utilisation rate was 49 percent in March 2012, based on outturn GP referrals to first outpatient appointments, which was slightly lower than the February figure of 50 percent. During March 2012, 94 percent of all GP practices made some bookings through Choose and Book, but there is significant variation in level of usage between practices. Choose and Book is also used for an additional 180,000 referrals per month to other services which include allied health professionals, GPs with special interests and assessment services. This represents a steady increase in bookings through Choose and Book to services other than first outpatient services.

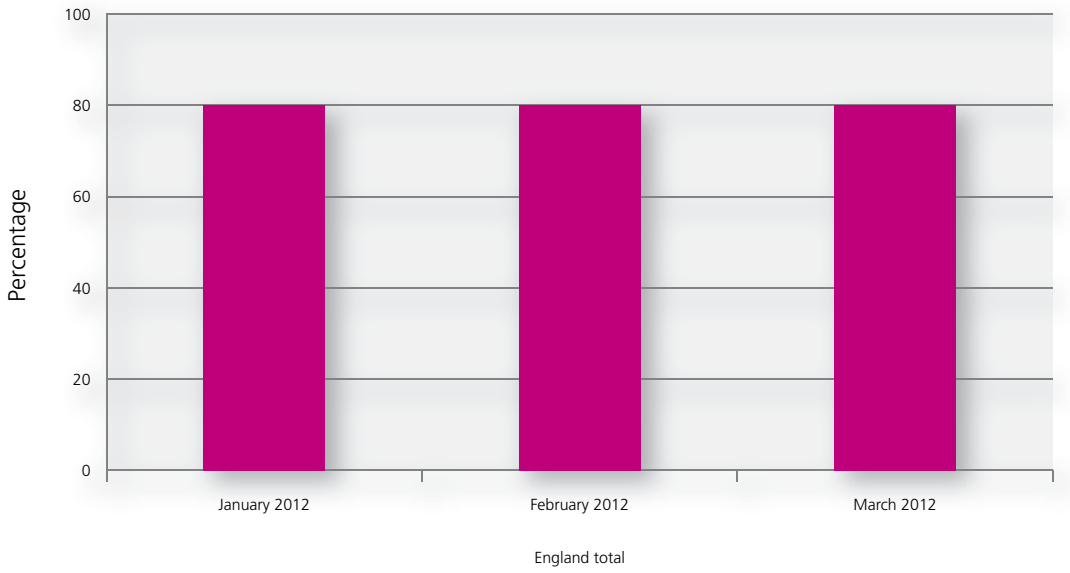
Figure 28: Proportion of GP Referrals to first outpatient appointments booked using Choose and Book



Bookings to services where named consultant-led team was available

The Department released contract guidance in October 2011, to support providers and commissioners in England when implementing choice of named consultant-led team for a first consultant-led outpatient appointment for elective care where clinically appropriate. Included within the NHS standard contracts for 2012/13 is a requirement for providers to comply with choice guidance issued by the Department. Provider organisations are continuing to add named consultants against specified Choose and Book services. Latest reports indicate the percentage of secondary care first outpatient bookings being made through Choose and Book, to services where named clinicians are available, (even if not selected), has been sustained at 80 percent at the end of Q4, after steady increases in previous months. The variation in this measure ranges from 88 percent in North West and West Midlands SHA areas to 75 percent in the London SHA area.

Figure 29: Bookings to services where national consultant-led team was available (even if not selected)

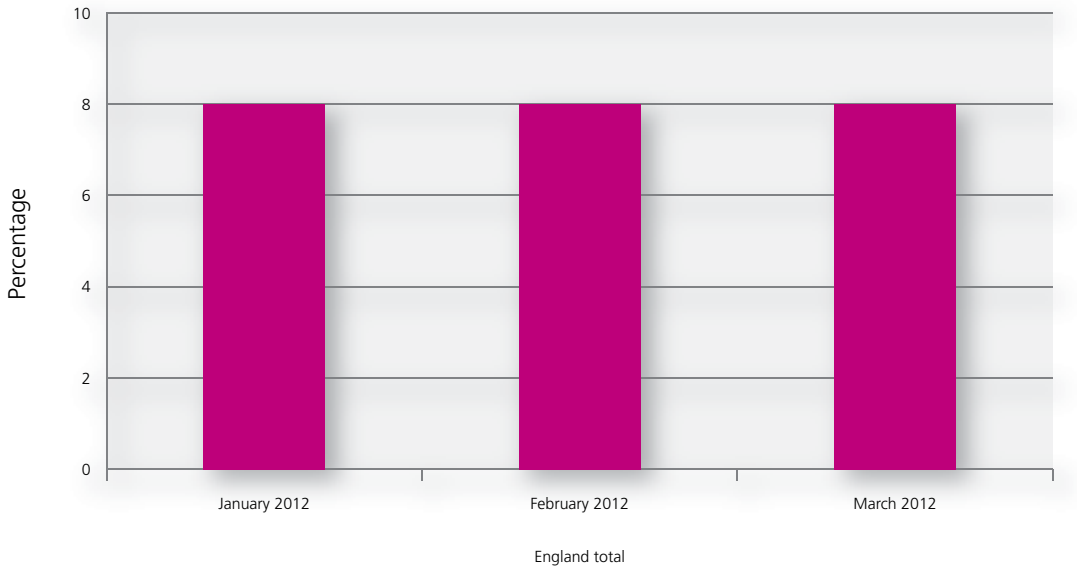


Trend in volume of patients being treated at non-NHS hospitals

Patients should have the opportunity to choose a range of providers for their first outpatient appointment, including those in the independent sector. This indicator shows a percentage of patients who have exercised choice, since it is likely that an alternative NHS provider was also offered to them.

An increasing percentage of Choose and Book bookings being made to the independent sector may be indicative of more choice being offered to patients. This indicator should also be considered in conjunction with the system indicator, 'Use of Choose and Book'. Relatively high percentages of Choose and Book bookings to the independent sector may not be indicative of what is happening overall, if Choose and Book utilisation is low.

Figure 30: Proportion of patients being treated at non-NHS hospitals



Improving people's electronic access to services and their own health and care records

The Information Strategy for Health and Adult Social Care, *The Power of Information: Putting us all in control of the health and care information we need*[19], published on 21 May 2012, sets out a vision in which being able to access and share our own records can help us take part in decisions about our own care in a genuine partnership with professionals. It states that by 2015, all general practices will be expected to make available electronic booking and cancelling of appointments, ordering of repeat prescriptions, communication with the practice and access to records to anyone registered with the practice.

Based on data from systems suppliers, it is understood that at the end of March 2012 4,441 general practices (53.8 percent) had the functionality for patients to access their full medical records online and just 63 general practices (0.8 percent) had this functionality enabled for some of their patients. This represents no material change from the end 2011 figure of 67.

The same source also indicates that three quarters of general practices have systems with functionality that can be enabled so patients can view and request their repeat medication and over 90 percent have systems can be enabled so that patients can book or cancel appointments online.

The NHS IC for Health and Social Care is developing more comprehensive and detailed data for quarterly reporting during 2012/13. From April 2013 general practices which provide online access to records and other transactional services will be shown on the NHS Choices website (or its successor national online portal).

Summary Care Record (SCR)[20]

The SCR provides the minimum information required to support safe patient care in urgent or emergency situations. Patients can choose to opt out of having an SCR and will be asked for their permission before their SCR is accessed.

One in four citizens now have a record and as more records are created, local health communities across the country are beginning to demonstrate how use of the SCR is supporting patient safety, as well as NHS

19 http://informationstrategy.dh.gov.uk/

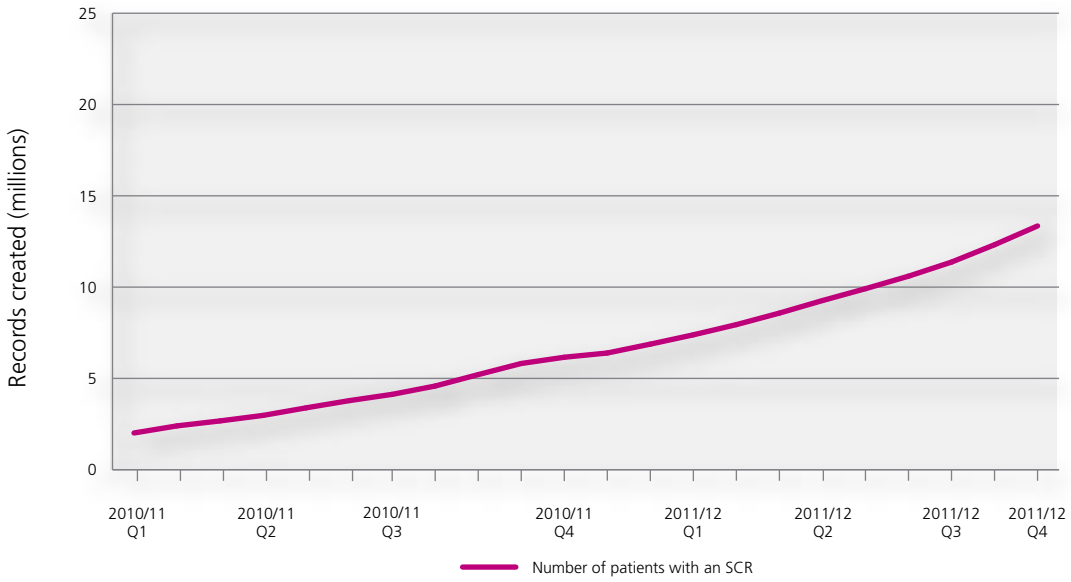
20 http://www.connectingforhealth.nhs.uk/systemsandservices/scr

efficiencies. During Q4, viewing of the SCR increased to an average of approximately 1,800 views per week. SCRs are mainly being accessed in GP out-of-hours services. In addition, access to the SCR is being used to support medicines reconciliation in hospital pharmacies.

Over 80 percent of GP practices have a system which is compliant with SCR. In Q4 the rate of creating SCRs increased, with 2.75 million new SCRs created for patients. This takes the total to 13.4 million patients with an SCR. In the quarter, 13 PCTs began creating records for patients, meaning a total of 93 PCTs have now created records for patients in 1,964 GP practices, with nineteen PCTs having a critical mass of over 60 percent of patients with an SCR. At the end of Q4, over 38.7 million patients had been written to about the SCR. Figure 31 shows the number of patients (records created) with an SCR.

While performance has improved, significant effort is required to ensure the SCR commitment in the NHS Operating Framework 2012/13 is met.

Figure 31: Number of summary care records (SCR) created



Provision

The Government continues with the commitment to reform the provider landscape by establishing an all FT sector, through the development of autonomous and sustainable providers that deliver safe, high quality care to patients.

It remains the strong expectation that all NHS trusts will achieve FT status on their own, as part of an existing FT or in another organisational form by April 2014. There are a small minority of trusts whose trajectory continues beyond this date. These later dates have only been agreed by exceptional agreement, made after scrutiny of clinical and financial feasibility, and with agreed management arrangements that will support this delivery.

As at 1 April 2012, there were 144 FTs, with 104 NHS trusts remaining in the FT pipeline. This position reflects a number of recent FT authorisations, alongside a number of organisational transactions, including mergers between NHS trusts. These have been driven by the objective for an all-FT landscape.

Tripartite Formal Agreements (TFAs) between NHS trusts, their SHAs and the Department are underpinning progress towards FT status for each organisation still in the FT pipeline. These set out the journey to FT status and the milestones to achieve this. The monitoring of progress against TFA milestones is a key part of making sure the necessary progress is being made by each organisation. Where an NHS trust is not delivering against the plans laid out in their TFA, there is a rules-based escalation process, where some intervention may be required to get back on track.

From May 2012, the monitoring of progress against TFA milestones will be integrated with the NHS Performance Framework. This brings together the key deliverables for NHS trusts, as follows:

- delivery of milestones and requirements to achieve FT status; and
- ongoing delivery against service, quality and financial requirements.

This integration makes clear NHS trusts must focus on both these areas. Where there is risk to delivery against either of these deliverables (e.g. underperformance against a key service performance target, or a key FT readiness milestone is missed) there will be a single escalation process to determine what action is needed.

To support the delivery of the FT pipeline a number of products and solutions have been introduced. These include the Board Governance Assurance Framework, a standard assurance mechanism used to make sure aspirant FT boards are able to operate effectively.

Other solutions relate to intractable financial issues in NHS trusts where there is no local solution available. These include circumstances where the affordability of PFI costs, in themselves, are a barrier to meeting the requirements of FT status. It also includes solutions where NHS trusts will not meet FT authorisation criteria because of their current liquidity, created from legacy financial issues.

Work with NHS trusts where strategic change may be required continues to be led by SHA clusters, including where mergers and acquisitions are the solution to enable sustainable quality healthcare services.

Alongside this, the establishment of the NHS Trust Development Authority (NTDA) as a new special health authority continues. The Chief Executive Designate and Chair have now been appointed. The NTDA came into being on 1 June 2012, and will run in shadow form from October 2012 and begin preparations for full operations in 2013. The NTDA will take over the current NHS trust accountabilities of the SHA clusters from April 2013, including the delivery of the FT pipeline and ongoing oversight of the NHS trust sector.

Commissioning

Clinical commissioning groups (CCGs)

Authorisation

All 212 proposed CCG applicants have now agreed their authorisation wave. Applications for CCG authorisation will take place from July to November 2012 and the NHS Commissioning Board is on schedule to have completed the authorisation process by January 2013.

The 'wave' process will comprise: 35 proposed CCGs in wave one; 70 in wave two; 67 in wave three; and 40 in wave four.

The first wave of 35 CCGs to go through the authorisation process was announced at the beginning of May. This followed publication by the NHS Commissioning Board Authority of *Clinical commissioning group authorisation: draft guide for applicants* in April, following its formal ratification at a Board meeting.

Six aspiring CCGs have tested the 360-degree stakeholder survey and it has now been issued for wave one. Document assessors are being recruited, and an assessors' guide is also being developed. An authorisation stakeholder group is also being set up. This involves nine CCG clinical leads from across the country, who will feed in their views on the process design and its implementation.

Authorisation surgeries are being run in each region to support emerging CCGs with their applications – more details are available on the Board Authority's website[21].

The full list of proposed CCGs in each wave is available here (http://www.commissioningboard.nhs.uk/files/2012/05/board-item5c-310512.pdf)

Configuration

The NHS Commissioning Board Authority has published the proposed configuration and member practices for 212 proposed CCGs for the first time.

At its board meeting on 31 May 2012, the Board Authority agreed the configuration of CCGs as the basis of authorisation. National and regional CCG maps displaying the information are also available.

The paper confirms there are now proposed CCGs covering the whole of England. It also includes the detailed geographic areas, plus the planning assumptions about the member practices in each proposed CCG. This means everyone living in England will be covered by a CCG.

The full set of information is available here (http://www.commissioningboard.nhs.uk/2012/05/24/board-meet-21012/)

Development

A range of resources have been published in recent months to support the development of CCGs.

- Clinical commissioning group governing body members: Role outlines, attributes and skills[22]
- Clinical commissioning group governing body committees: Terms of reference templates[23]
- Model constitution framework for clinical commissioning groups[24]
- Best practice resource/practical toolkit – for the appointment of lay members to clinical commissioning groups[25]
- Clinical commissioning group HR guide[26]

The CCG HR guide is designed to support CCGs as they move towards establishment and authorisation, while reflecting the high-level

21 http://www.commissioningboard.nhs.uk/
22 http://www.commissioningboard.nhs.uk/files/2012/04/ccg-mem-roles.pdf
23 http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/ccg-tor/
24 http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/ccg-mod-cons-framework/
25 http://www.commissioningboard.nhs.uk/tk-appoint-lay-mem-ccg/
26 http://www.commissioningboard.nhs.uk/files/2012/05/ccg-hr-guide.pdf

principles governing the changes affecting staff across the NHS. It provides practical advice about how CCGs can approach the main HR issues they are likely to encounter as they become established, beginning with the senior appointments process, transfers of staff and remuneration. The guide has been developed with input from CCG leaders and in partnership with staff side, (recognised NHS trade unions) in order to protect and guide CCGs through complex HR issues and support their development to become good employers. A CCG HR 'frequently asked questions' guide is also available.

The full set of resources for CCGs is available here (http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/)

Commissioning support

Recruitment of managing directors

The recruitment process for commissioning support service (CSS) managing directors has been launched and appointments will be made from late June.

Business review and assurance

The 23 NHS CSSs have received development plans outlining the progress they need to make by August 2012, following the completion of the second stage of the business review and assurance process by the NHS Commissioning Board Authority.

Milestones in the plans will be agreed at meetings with the Board Authority during May and early June. The milestones will be binding and each CSS will have a monthly progress check with the Board Authority.

Overall, 'Checkpoint 2' of the CSS business review and assurance process, which took place during April and May, found that CSSs had:

- Good levels of leadership
- Good levels of engagement in developing their customer focus
- A need to further develop their business focus in line with the financial information being worked up.

The Board Authority published a report[27] on 14 May 2012 about the overall outcome of Checkpoint 2 and the development plans are the final part of the checkpoint.

In the case of those CSSs which will not proceed beyond Checkpoint 2 – West Mercia and Peninsula – local CCGs are in discussions with the Board Authority, SHA clusters and surrounding CSSs. A new configuration will be agreed during June.

Next steps have also been agreed which will ensure the development of a revised operating model for communications and engagement services, in line with the timescales for the business review and assurance process.

A 'hub and spoke' model – similar to that of the other 'at scale' CSSs – will be developed which links all CSS and CCGs across England, maps onto local engagement services, ensures staff are based appropriately in relation to local communities, and concentrates at scale work and additional communications expertise in a small number of hubs, not likely to exceed four to six.

It is envisaged the model will incorporate local delivery teams and 'at scale' services delivered to a set of professional and measurable service standards through the commissioning support community.

Additional tests for CSSs which aim to provide 'at scale' offers

CSSs which plan to offer business intelligence, healthcare (clinical) procurement and business support components to their customers will be subject to additional tests in June 2012, following the Checkpoint 2 assurance process.

These CSSs have already set out their working assumptions for these components within their outline business plans.

The tests will focus on:

- The CSSs' ability to deliver against defined standards
- Making sure the cost structure is appropriate and sustainable

27 http://www.commissioningboard.nhs.uk/2012/05/14/outcome-of-checkpoint-2/

- Making sure there is the capability to deliver good quality and the right expertise across an appropriate scale to customers.

CSSs are currently preparing their responses to the standards set out by the Board Authority. By early June 2012 each CSS must submit detailed proposals for the at scale services it wishes to provide.

By the end of June 2012, the Board Authority will have reviewed the CSS submissions and identified the final configuration and development plans.

Annex 1

NHS North of England

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
County Durham PCT	918	1,020	1,016	1,008	1,009,745	0.1%
Darlington PCT	301	301	315	316	186,020	0.2%
Gateshead PCT	146	504	192	35	396,013	0.0%
Hartlepool PCT	126	125	100	100	189,578	0.1%
Middlesbrough PCT	633	278	600	600	300,681	0.2%
Newcastle PCT	4,616	945	258	314	525,548	0.1%
North East SHA	99,407	72,036	64,754	59,319	346,815	17.1%
North Tyneside PCT	563	475	355	380	396,530	0.1%
Northumberland Care PCT	443	220	1,370	319	576,427	0.1%
Redcar and Cleveland PCT	380	513	150	150	264,179	0.1%
South Tyneside PCT	592	1,819	460	542	323,860	0.2%
Stockton-on-Tees Teaching PCT	156	424	400	400	338,789	0.1%
Sunderland Teaching PCT	388	845	382	976	561,280	0.2%
North East subtotal SHA/PCTs	**108,669**	**79,505**	**70,352**	**64,459**	**5,415,465**	**1.2%**

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Ashton, Leigh and Wigan PCT	2,495	640	1,900	2,726	585,538	0.5%
Blackburn with Darwen PCT	2,048	717	n/a	n/a	n/a	n/a
Blackburn with Darwen Teaching Care Trust Plus PCT (1)	n/a	n/a	1,373	1,376	297,695	0.5%
Blackpool PCT	3,193	2,532	1,392	1,399	305,259	0.5%
Bolton PCT	992	996	983	992	498,251	0.2%
Bury PCT	41	413	236	253	323,481	0.1%
Central and Eastern Cheshire PCT	336	1,007	1,501	3,474	727,593	0.5%
Central Lancashire PCT	8,558	3,030	1,632	3,662	795,653	0.5%
Cumbria Teaching PCT	233	229	(5,926)	4,195	903,963	0.5%
East Lancashire Teaching PCT	2,464	1,021	3,336	3,324	690,535	0.5%
Halton and St Helens PCT	420	295	500	500	621,545	0.1%
Heywood, Middleton and Rochdale PCT	3,051	579	1,933	2,155	395,806	0.5%
Knowsley PCT	4,819	576	1,610	1,617	343,521	0.5%
Liverpool PCT	6,429	5,287	14,768	9,204	1,053,868	0.9%
Manchester PCT	687	481	347	1,293	1,055,542	0.1%
North Lancashire Teaching PCT	2,051	1,565	2,200	2,200	579,040	0.4%
North West SHA	245,142	157,339	175,418	215,124	932,770	23.1%
Oldham PCT	1,528	1,381	1,000	2,015	437,416	0.5%
Salford PCT	1,991	993	2,319	2,180	492,417	0.4%
Sefton PCT	287	498	2,500	2,548	543,395	0.5%
Stockport PCT	238	231	350	695	478,058	0.1%
Tameside and Glossop PCT	1,980	980	1,000	1,000	428,826	0.2%
Trafford PCT	133	534	1,500	701	397,678	0.2%

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Warrington PCT	557	222	250	500	325,301	0.2%
Western Cheshire PCT	1,598	1,279	985	1,966	434,296	0.5%
Wirral PCT	3,310	2,047	2,031	2,001	621,228	0.3%
North West subtotal SHA/PCTs	**294,581**	**184,872**	**215,138**	**267,100**	**14,268,675**	**1.9%**

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Barnsley PCT	2,510	3,461	3,395	2,953	473,518	0.6%
Bassetlaw PCT (2)	n/a	n/a	n/a	1,680	195,048	0.9%
Bradford and Airedale Teaching PCT	3,457	7,550	6,680	8,165	930,483	0.9%
Calderdale PCT	2,000	2,679	4,224	3,468	357,822	1.0%
Doncaster PCT	2,760	4,177	2,691	2,688	586,773	0.5%
East Riding of Yorkshire PCT	1,997	3,684	5,185	5,197	511,185	1.0%
Hull Teaching PCT	6,548	3,820	3,714	3,113	535,196	0.6%
Kirklees PCT	2,787	2,928	7,900	8,239	691,590	1.2%
Leeds PCT	5,150	5,002	20,124	25,086	1,369,261	1.8%
North East Lincolnshire Care Trust Plus (3)	1,146	2,222	2,181	1,783	294,956	0.6%
North Lincolnshire PCT	1,107	1,249	3,693	1,998	276,801	0.7%
North Yorkshire and York PCT	2,401	317	242	209	1,261,374	0.0%
Rotherham PCT	1,597	2,042	2,192	2,196	459,779	0.5%
Sheffield PCT	1,712	4,479	499	489	999,966	0.0%
Wakefield District PCT	2,580	7,388	3,095	3,074	653,417	0.5%
Yorkshire and the Humber SHA	178,249	133,982	121,052	118,177	683,947	17.3%
Yorkshire and the Humber subtotal SHA/PCTs	**216,001**	**184,980**	**186,867**	**188,515**	**10,281,116**	**1.8%**
NHS North of England total SHA/PCTs	**619,251**	**449,357**	**472,357**	**520,074**	**29,965,256**	**1.7%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
North East Ambulance Service NHS Trust (4)	2,249	4,736	3,120	2,312	61,433	3.8%
Northumberland, Tyne and Wear NHS Trust (5)	3,852	5,296	n/a	n/a	n/a	n/a
South Tees Hospitals NHS Trust (6)	10,445	131	n/a	n/a	n/a	n/a
Tees, Esk and Wear Valleys NHS Trust (7)	483	n/a	n/a	n/a	n/a	n/a
North East subtotal trusts	**17,029**	**10,163**	**3,120**	**2,312**	**61,433**	**3.8%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
5 Boroughs Partnership NHS Trust (8)	1,482	2,210	n/a	n/a	n/a	n/a
Bolton Hospitals NHS Trust (9)	(2,351)	n/a	n/a	n/a	n/a	n/a
Bridgewater Community Healthcare NHS Trust (10)	n/a	n/a	388	1,804	166,304	1.1%
Calderstones NHS Trust (11)	1,520	n/a	n/a	n/a	n/a	n/a
Central Manchester and Manchester Children's University Hospitals NHS Trust (12)	4,715	n/a	n/a	n/a	n/a	n/a
East Cheshire NHS Trust	522	3,926	806	277	176,835	0.2%
East Lancashire Hospitals NHS Trust	133	287	723	3,025	389,797	0.8%
Liverpool Community Health NHS Trust (13)	n/a	n/a	2,654	3,530	143,021	2.5%
Liverpool Heart and Chest Hospital NHS Trust (14)	4,337	1,827	n/a	n/a	n/a	n/a
Manchester Mental Health and Social Care NHS Trust	521	532	(482)	1,516	103,633	1.5%
Mersey Care NHS Trust	500	3,000	7,359	5,000	196,181	2.5%
North Cheshire Hospitals NHS Trust (15)	1,060	n/a	n/a	n/a	n/a	n/a
North Cumbria University Hospitals NHS Trust	993	327	1,356	1,095	227,483	0.5%
North West Ambulance Service NHS Trust	840	1,041	2,065	1,558	259,176	0.6%
Pennine Acute Hospitals NHS Trust	48	620	259	3,553	578,090	0.6%
Pennine Care NHS Trust (16)	388	n/a	n/a	n/a	n/a	n/a
Royal Liverpool Broadgreen University Hospitals NHS Trust	2,781	4,021	4,238	5,472	424,633	1.3%
Royal Liverpool Children's NHS Trust (17)	301	n/a	n/a	n/a	n/a	n/a
Southport and Ormskirk Hospital NHS Trust	802	500	853	204	178,182	0.1%
St Helens and Knowsley Teaching Hospitals NHS Trust	(22,687)	225	296	305	263,864	0.1%
Wirral Community NHS Trust (18)	n/a	n/a	n/a	717	65,026	1.1%
Trafford Healthcare NHS Trust	(2,186)	(6,048)	319	482	98,904	0.5%
University Hospitals of Morecambe Bay NHS Trust (19)	1,889	2,126	305	n/a	n/a	n/a
Walton Centre for Neurology and Neurosurgery NHS Trust (20)	2,812	424	n/a	n/a	n/a	n/a
Wrightington, Wigan and Leigh NHS Trust (21)	(13,002)	n/a	n/a	n/a	n/a	n/a
North West subtotal trusts	**(14,582)**	**15,018**	**21,139**	**28,538**	**3,271,129**	**0.9%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Airedale NHS Trust (22)	759	605	49	n/a	n/a	n/a
Bradford District Care Trust	546	103	104	108	167,091	0.1%
Hull and East Yorkshire Hospitals NHS Trust	5,020	7,601	4,701	4,878	499,538	1.0%
Humber Mental Health Teaching NHS Trust (23)	1,376	1,351	n/a	n/a	n/a	n/a
Leeds Community Healthcare NHS Trust (24)	n/a	n/a	n/a	2,577	134,978	1.9%
Leeds Teaching Hospitals NHS Trust	471	963	2,051	4,207	970,709	0.4%
Mid Yorkshire Hospitals NHS Trust	32,706	871	983	(19,217)	456,954	(4.2%)
Scarborough and North East Yorkshire Healthcare NHS Trust	1,873	1,914	1,874	1,899	125,608	1.5%
Sheffield Care Trust (25)	80	n/a	n/a	n/a	n/a	n/a
South West Yorkshire Mental Health NHS Trust (26)	1,015	569	n/a	n/a	n/a	n/a
Yorkshire Ambulance Service NHS Trust	151	518	237	428	200,333	0.2%
Yorkshire and the Humber subtotal trusts	**43,997**	**14,495**	**9,999**	**(5,120)**	**2,555,211**	**(0.2%)**
NHS North of England total trusts	**46,444**	**39,676**	**34,258**	**25,730**	**5,887,773**	**0.4%**

For foundation trusts the forecast position is only for the time when the organisation was an NHS trust

1 Blackburn with Darwen Teaching Care Trust Plus PCT was formerly Blackburn with Darwen PCT pre-April 2010.

2 Bassetlaw PCT is being reported under the Yorkshire and the Humber SHA region from 1 April 2011. Prior to this, they were reported under the East Midlands SHA region.

3 North East Lincolnshire Care Trust Plus was formed following the dissolution of North East Lincolnshire PCT on 1 September 2007.

4 North East Ambulance Service NHS Trust achieved foundation trust status on 1 November 2011.

5 Northumberland, Tyne and Wear NHS Trust achieved foundation trust status on 1 December 2009.

6 South Tees Hospitals NHS Trust achieved foundation trust status on 1 May 2009.

7 Tees, Esk and Wear Valleys NHS Trust achieved foundation trust status on 1 July 2008.

8 5 Boroughs Partnership NHS Trust achieved foundation trust status on 1 March 2010.

9 Bolton Hospitals NHS Trust achieved foundation trust status on 1 October 2008.

10 On 1 April 2011, Bridgewater Community Healthcare NHS Trust changed its name from Ashton, Leigh and Wigan Community Healthcare NHS Trust, which was established as an NHS trust on 1 November 2010, taking on the provider services of NHS Ashton, Leigh and Wigan.

11 Calderstones NHS Trust achieved foundation trust status on 1 April 2009.

12 Central Manchester and Manchester Children's University Hospitals NHS Trust achieved foundation trust status on 1 January 2009.

13 Liverpool Community Health NHS Trust was established as an NHS trust on 1 November 2010 taking on the provider services of Liverpool Primary Care Trust.

14 Liverpool Heart and Chest Hospital NHS Trust achieved foundation trust status on 1 December 2009.

15 North Cheshire Hospitals NHS Trust achieved foundation trust status on 1 December 2008.

16 Pennine Care NHS Trust achieved foundation trust status on 1 July 2008.

17 Royal Liverpool Children's NHS Trust achieved foundation trust status on 1 August 2008.

18 Wirral Community NHS Trust was formed on 1 April 2011.

19 University Hospitals of Morecambe Bay NHS Trust achieved foundation trust status on 1 October 2010.

20 Walton Centre for Neurology and Neurosurgery NHS Trust achieved foundation trust status on 1 August 2009.

21 Wrightington, Wigan and Leigh NHS Trust achieved foundation trust status on 1 December 2008.

22 Airedale NHS Trust achieved foundation trust status on 1 June 2010.

23 Humber Mental Health Teaching NHS Trust achieved foundation trust status on 1 February 2010.

24 Leeds Community Healthcare NHS Trust was formed on 1 April 2011.

25 Sheffield Care Trust achieved foundation trust status on 1 July 2008.

26 South West Yorkshire Mental Health NHS Trust achieved foundation trust status on 1 May 2009.

In addition to the operating deficits in 2011/12 shown above, the following organisation(s) also reported a technical deficit (£m) in the same period. A technical deficit is a deficit arising due to:
a) impairments, or
b) incurring additional revenue charges associated with bringing PFI assets on to the balance sheet due to the introduction of IFRS accounting in 2009/10.
c) the impact of the change in accounting for donated assets and government grant reserves.
This is not recognised for NHS budgeting purposes.

Bradford District Care NHS Trust (£5m)

Mersey Care NHS Trust (£2m)

Pennine Acute Hospitals NHS Trust (£6m)

Scarborough and North East Yorkshire NHS Trust (£0.1m)

St Helens and Knowsley Hospitals NHS Trust (£25m)

Trafford Healthcare NHS Trust (£5m)

Note: SHA and PCT turnover equals the Revenue Resource Limit (RRL) they are allocated. Trust turnover is all the income they receive including income from PCTs. Trust income should therefore be excluded from any aggregation of SHA economy turnover to avoid double counting resources.

Annex 2

NHS Midlands and East

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (rrl) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Bassetlaw PCT (1)	2,689	1,434	2,595	n/a	n/a	n/a
Derby City PCT	2,303	650	30	2,982	476,666	0.6%
Derbyshire County PCT	4,761	1,873	11,212	8,028	1,183,223	0.7%
East Midlands SHA	69,833	59,092	22,905	45,148	439,556	10.3%
Leicester City PCT	2,244	241	6,192	3,665	562,652	0.7%
Leicestershire County and Rutland PCT	1,049	1,148	10,502	6,270	976,218	0.6%
Lincolnshire Teaching PCT	7,011	7,264	14,314	9,525	1,226,611	0.8%
Milton Keynes PCT (2)	n/a	n/a	n/a	505	371,222	0.1%
Northamptonshire Teaching PCT	4,387	4,642	10,528	7,058	1,079,953	0.7%
Nottingham City PCT	2,283	2,448	6,841	3,412	571,133	0.6%
Nottinghamshire County Teaching PCT	10,003	4,514	5,017	3,372	1,083,444	0.3%
East Midlands subtotal SHA/PCTs	**106,563**	**83,306**	**90,136**	**89,965**	**7,970,678**	**1.1%**

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (rrl) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Birmingham East and North PCT	1,922	2,453	522	240	791,165	0.0%
Coventry Teaching PCT	4,983	4,644	6,247	5,766	613,657	0.9%
Dudley PCT	2,055	362	794	5,992	517,185	1.2%
Heart of Birmingham Teaching PCT	9,683	7,615	9,555	830	580,062	0.1%
Herefordshire PCT	475	778	111	291	298,528	0.1%
North Staffordshire PCT	1,999	515	1,162	714	350,101	0.2%
Sandwell PCT	7,020	89	1,222	8,889	591,062	1.5%
Shropshire County PCT	854	490	872	1,295	480,813	0.3%
Solihull PCT (3)	793	16	531	281	349,237	0.1%
South Birmingham PCT	6,505	4,700	500	736	660,864	0.1%
South Staffordshire PCT	4,676	2,200	378	353	970,588	0.0%
Stoke on Trent PCT	4,304	2,588	3,115	1,993	514,607	0.4%
Telford and Wrekin PCT	7,247	4,522	467	1,098	268,936	0.4%
Walsall Teaching PCT	11,602	6,022	5,437	2,597	489,757	0.5%
Warwickshire PCT	321	594	176	177	843,013	0.0%
West Midlands SHA	6,497	19,732	23,204	37,534	563,938	6.7%
Wolverhampton City PCT	24,874	19,365	15,692	19,682	474,905	4.1%
Worcestershire PCT	4,865	3,519	3,470	3,044	877,676	0.3%
West Midlands subtotal SHA/PCTs	**100,675**	**80,204**	**73,455**	**91,512**	**10,236,094**	**0.9%**

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Bedfordshire PCT	330	236	498	504	627,969	0.1%
Cambridgeshire PCT	760	501	398	499	896,651	0.1%
East of England SHA	124,757	135,389	83,960	94,829	659,254	14.4%
Great Yarmouth and Waveney PCT	230	352	1,625	1,009	412,774	0.2%
Hertfordshire PCT (4)	2,259	1,611	638	513	1,719,648	0.0%
Luton PCT	492	400	506	256	326,302	0.1%
Mid Essex PCT	940	1,007	3,767	1,121	535,529	0.2%
Norfolk PCT	1,079	695	959	1,403	1,232,886	0.1%
North East Essex PCT	1,348	2,993	2,998	1,143	544,344	0.2%
Peterborough PCT	2,896	(12,832)	389	343	286,124	0.1%
South East Essex PCT	852	2,014	1,093	879	566,439	0.2%
South West Essex PCT	688	1,614	48	252	665,768	0.0%
Suffolk PCT	1,315	2,578	3,560	1,070	944,657	0.1%
West Essex PCT	1,448	815	721	620	449,000	0.1%
East of England subtotal SHA/PCTs	**139,394**	**137,373**	**101,160**	**104,441**	**9,867,345**	**1.1%**
NHS Midlands and East total SHA/PCTs	**346,632**	**300,883**	**264,751**	**285,918**	**28,074,117**	**1.0%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Derbyshire Mental Health Services NHS Trust (5)	990	1,014	379	n/a	n/a	n/a
Derbyshire Community Health Services NHS Trust (6)	n/a	n/a	n/a	1,419	184,147	0.8%
East Midlands Ambulance Service NHS Trust	1,564	2,016	467	2,409	169,533	1.4%
Kettering General Hospital NHS Trust (7)	3,444	n/a	n/a	n/a	n/a	n/a
Leicestershire Partnership NHS Trust	683	1,732	1,700	6,562	282,464	2.3%
Lincolnshire Community Health Services NHS Trust (8)	n/a	n/a	n/a	1,081	108,738	1.0%
Northampton General Hospital NHS Trust	2,100	2,081	1,109	504	255,481	0.2%
Northamptonshire Healthcare NHS Trust (9)	342	29	n/a	n/a	n/a	n/a
Nottingham University Hospitals NHS Trust	5,557	7,256	5,010	4,764	784,605	0.6%
Nottinghamshire Healthcare NHS Trust	3,905	2,387	6,505	6,896	419,620	1.6%
United Lincolnshire Hospitals NHS Trust	366	1,282	(13,880)	320	407,975	0.1%
University Hospitals of Leicester NHS Trust	3,018	51	1,013	88	719,154	0.0%
East Midlands subtotal trusts	**21,969**	**17,848**	**2,303**	**24,043**	**3,331,717**	**0.7%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Birmingham and Solihull Mental Health NHS Trust (10)	1,206	n/a	n/a	n/a	n/a	n/a
Birmingham Community Health Care Trust (11)	n/a	n/a	686	2,559	255,892	1.0%
Burton Hospitals NHS Trust (12)	2,666	n/a	n/a	n/a	n/a	n/a
Coventry and Warwickshire Partnership NHS Trust (13)	1,863	3,690	2,936	4,589	207,689	2.2%
Dudley and Walsall Mental Health Partnership NHS Trust	202	376	883	1,163	67,298	1.7%
Dudley Group of Hospitals NHS Trust (14)	3,886	n/a	n/a	n/a	n/a	n/a

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
George Eliot Hospital NHS Trust	964	1,164	112	45	117,011	0.0%
North Staffordshire Combined Healthcare NHS Trust	256	449	698	891	83,063	1.1%
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust (15)	999	2,054	1,618	741	26,599	2.8%
Royal Wolverhampton Hospitals NHS Trust	6,913	8,035	7,964	9,297	374,417	2.5%
Sandwell & West Birmingham Hospitals NHS Trust	2,547	7,260	2,193	1,863	424,144	0.4%
Sandwell Mental Health NHS and Social Care Trust (16)	60	n/a	n/a	n/a	n/a	n/a
Shrewsbury and Telford Hospital NHS Trust	4,127	712	26	59	299,850	0.0%
Shropshire Community Health NHS Trust (17)	n/a	n/a	n/a	1,397	80,802	1.7%
Staffordshire and Stoke on Trent Partnership NHS Trust (18)	n/a	n/a	n/a	1,527	204,268	0.7%
South Warwickshire General Hospitals NHS Trust (19)	6,842	5,581	n/a	n/a	n/a	n/a
University Hospital of North Staffordshire NHS Trust	3,008	5,644	4,141	1,050	426,319	0.2%
University Hospitals Coventry and Warwickshire NHS Trust	4,825	10,234	4,162	1,465	484,816	0.3%
Walsall Healthcare NHS Trust (20)	353	1,998	3,247	4,164	226,983	1.8%
West Midlands Ambulance Service NHS Trust	156	255	99	925	197,299	0.5%
Worcestershire Acute Hospitals NHS Trust	5,833	3,135	287	88	336,594	0.0%
Worcestershire Health and Care NHS Trust (21)	2	700	700	1,500	171,083	0.9%
Wye Valley NHS Trust (22)	544	1,165	46	71	171,898	0.0%
West Midlands subtotal trusts	**47,252**	**52,452**	**29,798**	**33,394**	**4,156,025**	**0.8%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Bedford Hospitals NHS Trust	2,118	612	274	197	212,893	0.1%
Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (23)	751	463	n/a	n/a	n/a	n/a
Cambridgeshire and Peterborough Mental Health Partnership NHS Trust (24)	71	n/a	n/a	n/a	n/a	n/a
Cambridgeshire Community Services NHS Trust (25)	n/a	n/a	1,044	681	158,331	0.4%
East and North Hertfordshire NHS Trust	2,070	2,499	3,328	3,568	346,402	1.0%
East of England Ambulance Service NHS Trust	283	757	2,364	3,121	226,874	1.4%
Essex Rivers Healthcare NHS Trust (26)	875	n/a	n/a	n/a	n/a	n/a
Hertfordshire Community NHS Trust (27)	n/a	n/a	184	1,030	127,203	0.8%
Hinchingbrooke Health Care NHS Trust	98	598	79	186	107,259	0.2%
Mid Essex Hospital Services NHS Trust	7,316	2,551	3,660	(2,156)	262,953	(0.8%)
Norfolk Community Health and Care NHS Trust (28)	n/a	n/a	552	637	127,725	0.5%
Norfolk and Norwich University Hospitals NHS Trust (29)	2,409	n/a	n/a	n/a	n/a	n/a
Suffolk Mental Health Partnership NHS Trust (30)	1,504	1,513	335	n/a	n/a	n/a
Ipswich Hospital NHS Trust	4,580	3,351	1,260	137	238,150	0.1%
Princess Alexandra Hospital NHS Trust	3,222	511	415	461	180,790	0.3%
Queen Elizabeth Hospital Kings Lynn NHS Trust (31)	6,158	4,510	1,931	n/a	n/a	n/a
West Hertfordshire Hospitals NHS Trust	4,405	5,699	7,358	3,657	266,716	1.4%
West Suffolk Hospitals NHS Trust (32)	4,600	6,273	194	251	106,131	0.2%
East of England subtotal trusts	**40,460**	**29,337**	**22,978**	**11,770**	**2,361,427**	**0.5%**
NHS Midlands and East total trusts	**109,681**	**99,637**	**55,079**	**69,207**	**9,849,169**	**0.7%**

Please note, Peterborough PCT are currently based on 2011/12 Draft accounts.

For foundation trusts the forecast position is only for the time when the organisation was an NHS trust

1 Bassetlaw PCT is being reported under the Yorkshire and the Humber SHA region from 1 April 2011.

2 Milton Keynes PCT became part of East Midlands SHA from 1 April 2011. Prior to this, they were reported under the South Central SHA region.

3 Solihull Care Trust changed its name to Solihull Primary Care Trust following the transfer of their community services to other organisations on 1 April 2011.

4 Hertfordshire PCT was formed by the merger of East and North Hertfordshire (5P3) and West Hertfordshire PCT (5P4) on 1 April 2010.

5 Derbyshire Mental Health Services NHS Trust achieved foundation trust status on 1 February 2011.

6 Derbyshire Community Health Services NHS Trust was formed on 1 April 2011.

7 Kettering General Hospital NHS Trust achieved foundation trust status on 1 November 2008.

8 Lincolnshire Community Health Services NHS Trust was formed on 1 April 2011.

9 Northamptonshire Healthcare NHS Trust achieved foundation trust status on 1 May 2009.

10 Birmingham and Solihull Mental Health NHS Trust achieved foundation trust status on 1 July 2008.

11 Birmingham Community Health Care NHS Trust (RYW) was established as an NHS Trust on 1 November 2010, taking on the provider services of NHS Birmingham East and North, NHS Heart of Birmingham and NHS South Birmingham.

12 Burton Hospitals NHS Trust achieved foundation trust status on 1 November 2008.

13 Coventry and Warwickshire Partnership NHS Trust was formed from the Mental Health elements of Rugby, Coventry Teaching, North Warwickshire and South Warwickshire PCTs.

14 Dudley Group of Hospitals NHS Trust achieved foundation trust status on 1 October 2008.

15 Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust achieved foundation trust status on 1 August 2011.

16 Sandwell Mental Health and Social Care NHS Trust achieved foundation trust status on 1 February 2009.

17 Shropshire Community Health NHS Trust was formed on 1 July 2011. The new Trust will combine community health services from Shropshire County PCT and Telford and Wrekin PCT into a single organisation.

18 Staffordshire and Stoke on Trent NHS Partnership Trust (R1E) was formed on 1 September 2011, bringing together community health services previously provided by NHS North Staffordshire, NHS Stoke-on-Trent and South Staffordshire PCTs.

19 South Warwickshire General Hospitals NHS Trust achieved foundation trust status on 1 March 2010.

20 Walsall Healthcare NHS Trust was formed on 1 April 2011 following the integration of Walsall Hospitals NHS Trust and NHS Walsall Community Health.

21 Worcestershire Health and Care NHS Trust was established on 1 July 2011 to manage the vast majority of the services which were previously managed by Worcestershire Primary Care NHS Trust's provider arm, as well as the mental health services previously managed by Worcestershire Mental Health Partnership NHS Trust.

22 Hereford Hospitals NHS Trust changed its name to Wye Valley NHS Trust on 1 April 2011 following Herefordshire's health and adult social care providers joining to form an integrated provider of acute, community and social care in England.

23 On 1 April 2010, South Essex Partnership University NHS Foundation Trust (SEPT) took over Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (BLPT). BLPT is the first NHS trust to put itself forward for merger with an established NHS foundation trust (FT).

24 Cambridgeshire and Peterborough Mental Health Partnership NHS Trust achieved foundation trust status on 1 June 2008.

25 Cambridgeshire Community Services NHS Trust is a new trust formed on 1 April 2010.

26 Essex Rivers Healthcare NHS Trust achieved foundation trust status on 1 May 2008.

27 Hertfordshire Community NHS Trust (RY4) was established on 1 November 2010, taking on the provider services of Hertfordshire PCT.

28 Norfolk Community Health and Care NHS Trust (RY3) was established on 1 November 2010, taking on the provider services of Norfolk Primary Care Trust.

29 Norfolk and Norwich University Hospitals NHS Trust achieved foundation trust status on 1 May 2008.

30 Suffolk Mental Health Partnership NHS Trust (RT6), which merged with Norfolk and Waveney Mental Health NHS Foundation Trust on 1 January 2012 to become Norfolk and Suffolk NHS Foundation Trust.

31 Queen Elizabeth Hospital King's Lynn NHS Trust achieved foundation trust status on 1 February 2011.

32 West Suffolk Hospitals NHS Trust achieved foundation trust status on 1 December 2011.

In addition to the operating deficits in 2011/12 shown above, the following organisation(s) also reported a technical deficit (£m) in the same period. A technical deficit is a deficit arising due to:
a) impairments, or
b) incurring additional revenue charges associated with bringing PFI assets on to the balance sheet due to the introduction of IFRS accounting in 2009/10.
c) the impact of the change in accounting for donated assets and government grant reserves.
This is not recognised for NHS budgeting purposes.

George Eliot Hospital NHS Trust (£0.2m)
Hinchingbrooke Healthcare NHS Trust (£0.7m)
North Staffordshire Combined Healthcare NHS Trust (£8m)
Northampton General Hospital NHS Trust (£2m)
Nottingham University Hospitals NHS Trust (£50m)
Princess Alexandra Hospital NHS Trust (£5m)
Shrewsbury and Telford Hospital NHS Trust (£1m)
United Lincolnshire Hospitals NHS Trust (£7m)
University Hospital of North Staffordshire Hospital NHS Trust (£125m)
University Hospitals Coventry and Warwickshire NHS Trust (£18m)
University Hospitals of Leicester NHS Trust (£28m)
Worcestershire Acute Hospitals NHS Trust (£1m)
Worcestershire Health and Care NHS Trust (£0.9m)

Note: SHA and PCT turnover equals the Revenue Resource Limit (RRL) they are allocated. Trust turnover is all the income they receive including income from PCTs. Trust income should therefore be excluded from any aggregation of SHA economy turnover to avoid double counting resources.

Annex 3

NHS London

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (rrl) £000s	2011/12 Annual accounts surplus/ (deficit) as % rrl
Barking and Dagenham PCT	18,439	3,377	62	3,567	345,414	1.0%
Barnet PCT	5,860	139	134	(13,955)	598,153	(2.3%)
Bexley Care PCT	130	51	486	2,274	356,723	0.6%
Brent Teaching PCT	12,584	16,334	17,416	21,576	565,171	3.8%
Bromley PCT	188	249	6,899	6,111	520,354	1.2%
Camden PCT	4,340	12	11,807	43,162	559,316	7.7%
City and Hackney Teaching PCT	100	9,346	6,594	13,164	536,549	2.5%
Croydon PCT	6,000	3,412	5,535	838	612,663	0.1%
Ealing PCT	4,686	3	34	37	605,473	0.0%
Enfield PCT	20	(10,491)	11	(17,188)	496,009	(3.5%)
Greenwich Teaching PCT	1,531	608	5,327	4,770	492,036	1.0%
Hammersmith and Fulham PCT	18,617	10,538	3,513	5,496	370,800	1.5%
Haringey Teaching PCT	1,983	29	170	(17,439)	473,614	(3.7%)
Harrow PCT	1,432	126	677	150	368,111	0.0%
Havering PCT	748	1,528	932	873	430,689	0.2%
Hillingdon PCT	2	19,380	5	44	415,624	0.0%
Hounslow PCT	48	40	42	150	431,198	0.0%
Islington PCT	6,617	1,121	10,261	20,837	491,988	4.2%
Kensington and Chelsea PCT	8,760	3,985	3,410	10,166	373,521	2.7%
Kingston PCT	117	103	2,623	4,515	280,033	1.6%
Lambeth PCT	2,907	988	6,430	6,867	687,317	1.0%
Lewisham PCT	339	90	5,287	5,445	553,048	1.0%
London SHA	187,527	288,675	257,187	255,672	1,980,055	12.9%
Newham PCT	6,665	1,107	7,104	9,738	585,266	1.7%
Redbridge PCT	9,893	6,232	6,217	6,644	423,771	1.6%
Richmond and Twickenham PCT	708	112	2,845	7,742	286,655	2.7%
Southwark PCT	218	628	1,365	5,987	558,237	1.1%
Sutton and Merton PCT	76	(2,286)	266	6,457	608,713	1.1%
Tower Hamlets PCT	6,881	6,753	6,973	8,985	543,393	1.7%
Waltham Forest PCT	201	0	27	100	441,746	0.0%
Wandsworth PCT	3,930	4,386	12,322	16,709	598,205	2.8%
Westminster PCT	15,534	15,010	9,866	22,890	578,782	4.0%
London total SHA/PCTs	**327,081**	**381,585**	**391,827**	**442,384**	**17,168,627**	**2.6%**
NHS London total SHA/PCTs	**327,081**	**381,585**	**391,827**	**442,384**	**17,168,627**	**2.6%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Barking, Havering and Redbridge Hospitals NHS Trust	(35,674)	(22,309)	(32,986)	(49,913)	419,121	(11.9%)
Barnet and Chase Farm Hospitals NHS Trust	155	5,069	3,154	2,221	351,005	0.6%
Barnet, Enfield and Haringey Mental Health NHS Trust	(5,451)	239	274	2,023	190,725	1.1%
Barts and London NHS Trust	7,532	11,423	6,012	2,612	819,715	0.3%
Bromley Hospitals NHS Trust	(4,858)	n/a	n/a	n/a	n/a	n/a
Central London Community Healthcare NHS Trust (1)	n/a	n/a	2,196	3,835	190,946	2.0%
Croydon Health Services NHS Trust (2)	2,149	1,106	4,913	3,967	236,941	1.7%
Ealing Hospital NHS Trust	2,125	36	28	2,304	234,630	1.0%
Epsom and St Helier University Hospitals NHS Trust	4,902	2,877	3,332	(12,277)	331,320	(3.7%)
Great Ormond Street Hospital for Children NHS Trust (3)	1,348	7,368	8,617	1,869	328,688	0.6%
Hounslow and Richmond Community Healthcare NHS Trust (4)	n/a	n/a	n/a	1,667	54,480	3.1%
Imperial College Healthcare NHS Trust (5)	12,025	9,102	5,146	(8,419)	941,690	(0.9%)
Lewisham Hospital NHS Trust	(3,929)	6,753	1,058	1,427	229,184	0.6%
Kingston Hospital NHS Trust	807	2,412	2,724	3,184	204,525	1.6%
London Ambulance Service NHS Trust	725	1,425	1,002	2,751	281,731	1.0%
Newham University Hospital NHS Trust	201	55	(7,913)	(176)	172,631	(0.1%)
North East London Mental Health NHS Trust (6)	379	n/a	n/a	n/a	n/a	n/a
North Middlesex University Hospitals NHS Trust	5,031	6,044	3,103	669	181,283	0.4%
North West London Hospitals NHS Trust	117	(8,025)	258	(7,534)	385,707	(2.0%)
Queen Elizabeth Hospital NHS Trust	(5,481)	n/a	n/a	n/a	n/a	n/a
Queen Mary's Sidcup NHS Trust	(10,991)	n/a	n/a	n/a	n/a	n/a
Royal Brompton and Harefield NHS Trust (7)	3,173	547	n/a	n/a	n/a	n/a
Royal Free Hampstead NHS Trust	3,791	2,035	6,587	8,200	561,371	1.5%
South London Healthcare NHS Trust (8)	n/a	(42,067)	(40,865)	(65,063)	438,949	(14.8%)
South West London and St George's Mental Health NHS Trust	(3,246)	2,286	2,579	2,158	167,281	1.3%
St George's Healthcare NHS Trust	1,718	12,933	6,459	6,101	620,411	1.0%
Hillingdon Hospital NHS Trust (9)	2,196	258	307	n/a	n/a	n/a
Royal National Orthopaedic Hospital NHS Trust	483	1,026	(911)	1,102	111,762	1.0%
West London Mental Health NHS Trust	352	1,167	3,970	4,881	244,907	2.0%
West Middlesex University Hospital NHS Trust	(3,534)	(4,996)	214	1,777	148,943	1.2%
Whipps Cross University Hospitals NHS Trust	810	229	395	(6,376)	251,300	(2.5%)
Whittington Hospital NHS Trust	1,938	139	508	1,120	278,212	0.4%
London total trusts	**(21,207)**	**(2,868)**	**(19,839)**	**(95,890)**	**8,377,458**	**(1.1%)**
NHS London total trusts	**(21,207)**	**(2,868)**	**(19,839)**	**(95,890)**	**8,377,458**	**(1.1%)**

For foundation trusts the forecast position is only for the time when the organisation was an NHS Trust

1 Rebranding of Central West London Community Services to Central London Community Healthcare completed in July 2009. Central London Community Healthcare NHS Trust (RYX) was established on 1 November 2010.

2 Mayday Healthcare NHS Trust changed its name to Croydon Health Services NHS Trust (RJ6) on 1 October 2010.

3 Great Ormond Street Hospital for Children NHS Trust achieved foundation trust status on 1 March 2012.

4 Hounslow and Richmond Community Healthcare NHS Trust was formed on 1 April 2011.

5 Imperial College Healthcare NHS Trust was formed from St Mary's NHS Trust and Hammersmith Hospitals NHS Trust.

6 North East London Mental Health NHS Trust achieved foundation trust status on 1 June 2008.

7 Royal Brompton and Harefield NHS Trust achieved foundation trust status on 1 June 2009.

8 South London Healthcare NHS Trust was formed from the merger of Queen Elizabeth Hospital NHS Trust (RG2), Bromley Hospitals NHS Trust (RG3), and Queen Mary's Sidcup NHS Trust (RGZ).

9 Hillingdon Hospital NHS Trust achieved foundation trust status on 1 April 2011.

In addition to the operating deficits in 2011/12 shown above, the following organisation(s) also reported a technical deficit (£m) in the same period. A technical deficit is a deficit arising due to:
a) impairments, or
b) incurring additional revenue charges associated with bringing PFI assets on the balance sheet due to the introduction of IFRS accounting in 2009/10.
c) the impact of the change in accounting for donated assets and government grant reserves.
This is not recognised for NHS budgeting purposes.

Barking, Havering and Redbridge University Hospitals NHS Trust (£0.3m)
Barnet, Enfield and Haringey Mental Health NHS Trust (£7m)
Barts and the London NHS Trust (£266m)
Epsom and St Helier University Hospitals NHS Trust (£5m)
Imperial College Healthcare NHS Trust (£12m)
Newham University Hospital NHS Trust (£2m)
North Middlesex University Hospital NHS Trust (£16m)
North West London Hospitals NHS Trust (£9m)
South London Healthcare NHS Trust (£22m)
Whipps Cross University Hospital NHS Trust (£3m)
Whittington Hospital NHS Trust (£3m)

Note: SHA and PCT turnover equals the Revenue Resource Limit (RRL) they are allocated. Trust turnover is all the income they receive including income from PCTs. Trust income should therefore be excluded from any aggregation of SHA economy turnover to avoid double counting resources.

Annex 4

NHS South of England

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Brighton and Hove City Teaching PCT	124	1,071	4,618	4,604	494,254	0.9%
East Sussex Downs and Weald PCT	2,440	1,230	2,656	476	586,326	0.1%
Eastern and Coastal Kent PCT	5,046	6,130	11,972	8,957	1,322,204	0.7%
Hastings and Rother PCT	3,631	3,841	6,496	2,707	338,440	0.8%
Medway PCT	5,059	3,689	4,282	4,496	450,401	1.0%
South East Coast SHA	39,976	44,586	45,768	62,090	350,472	17.7%
Surrey PCT	225	(13,622)	(11,934)	1,028	1,695,962	0.1%
West Kent PCT	4,397	2,013	776	1,066	1,056,975	0.1%
West Sussex PCT	728	725	733	512	1,325,427	0.0%
South East Coast subtotal SHA/PCTs	**61,626**	**49,663**	**65,367**	**85,936**	**7,620,461**	**1.1%**

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Berkshire East PCT	80	101	147	1,250	594,063	0.2%
Berkshire West PCT	1,287	1,449	1,646	3,580	667,707	0.5%
Buckinghamshire PCT	(7,459)	1,368	715	127	724,752	0.0%
Hampshire PCT	258	486	457	4,015	1,912,793	0.2%
Isle of Wight NHS PCT	1,246	2,382	2,519	2,508	266,643	0.9%
Milton Keynes PCT (1)	1,100	605	551	n/a	n/a	n/a
Oxfordshire PCT	2,181	1,901	2,250	2,224	977,428	0.2%
Portsmouth City Teaching PCT	5,810	5,207	724	1,674	358,276	0.5%
South Central SHA	39,632	45,125	54,788	54,785	386,592	14.2%
Southampton City PCT	155	917	2,885	1,965	409,107	0.5%
South Central subtotal SHA/PCTs	**44,290**	**59,541**	**66,682**	**72,128**	**6,297,361**	**1.1%**

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
Bath and North East Somerset PCT	1,752	1,924	2,685	2,685	288,381	0.9%
Bournemouth and Poole Teaching PCT	5,403	2,886	5,356	5,356	571,326	0.9%
Bristol Teaching PCT	4,514	4,974	6,955	3,955	795,060	0.5%
Cornwall and Isles of Scilly PCT	5,622	6,064	8,562	8,570	933,702	0.9%
Devon PCT	15	237	3,546	3,538	1,243,276	0.3%
Dorset PCT	4,057	4,374	6,133	6,133	669,345	0.9%
Gloucestershire PCT	5,784	6,216	8,685	8,685	939,206	0.9%
North Somerset PCT	48	48	1,552	1,063	342,464	0.3%
Plymouth Teaching PCT	2,745	1,400	4,190	2,204	456,036	0.5%
Somerset PCT	5,235	5,751	7,965	7,965	866,981	0.9%

SHA and PCT name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (deficit) £000s	2010/11 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts surplus/ (deficit) £000s	2011/12 Annual accounts revenue resource limit (RRL) £000s	2011/12 Annual accounts surplus/ (deficit) as % RRL
South Gloucestershire PCT	48	39	1,527	1,397	372,118	0.4%
South West SHA	63,822	56,756	51,054	117,832	508,623	23.2%
Swindon PCT	1,930	2,080	1,096	2,967	315,753	0.9%
Torbay Care Trust	1,640	1,808	2,494	2,494	270,849	0.9%
Wiltshire PCT	1,167	0	3,200	2,005	676,513	0.3%
South West subtotal SHA/PCTs	**103,782**	**94,557**	**115,000**	**176,849**	**9,249,633**	**1.9%**
NHS South of England total SHA/PCTs	**209,698**	**203,761**	**247,049**	**334,913**	**23,167,455**	**1.4%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Ashford and St Peter's Hospitals NHS Trust (2)	5,513	6,275	3,188	n/a	n/a	n/a
Brighton and Sussex University Hospitals NHS Trust	9,925	10,227	4,512	42	574,218	0.0%
Dartford and Gravesham NHS Trust	4,015	115	206	393	169,244	0.2%
East Kent Hospitals University NHS Trust (3)	13,087	n/a	n/a	n/a	n/a	n/a
East Sussex Healthcare NHS Trust (4)	1,017	350	(4,704)	87	385,281	0.0%
Kent and Medway NHS and Social Care Partnership Trust	1,384	1,524	13	538	178,468	0.3%
Kent Community Health NHS Trust (5)	n/a	n/a	1,429	1,470	210,135	0.7%
Maidstone and Tunbridge Wells NHS Trust	143	189	1,710	300	345,101	0.1%
Royal Surrey County Hospital NHS Trust (6)	2,930	4,554	n/a	n/a	n/a	n/a
South East Coast Ambulance Service NHS Trust (7)	658	1,130	3,153	n/a	n/a	n/a
Surrey and Borders Partnership NHS Trust (8)	(307)	n/a	n/a	n/a	n/a	n/a
Surrey and Sussex Healthcare NHS Trust	7,048	7,755	875	(6,056)	209,582	(2.9%)
Sussex Community NHS Trust (9)	92	649	675	1,918	185,342	1.0%
Sussex Partnership NHS Trust (10)	1,698	n/a	n/a	n/a	n/a	n/a
Royal West Sussex NHS Trust	1,758	n/a	n/a	n/a	n/a	n/a
Western Sussex Hospitals NHS Trust (11)	n/a	4,138	5,234	5,350	367,816	1.5%
Worthing and Southlands Hospitals NHS Trust	408	n/a	n/a	n/a	n/a	n/a
South East Coast subtotal trusts	**49,369**	**36,906**	**16,291**	**4,042**	**2,625,187**	**0.2%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Buckinghamshire Healthcare NHS Trust (12)	(2,750)	146	1,026	2,848	340,397	0.8%
Hampshire Partnership NHS Trust (13)	2,597	n/a	n/a	n/a	n/a	n/a
Nuffield Orthopaedic NHS Trust	59	311	882	n/a	n/a	n/a
Oxford Learning Disability NHS Trust	631	181	161	59	39,942	0.1%
Oxford Radcliffe Hospitals NHS Trust	2,405	106	1,289	n/a	n/a	n/a
Oxford University Hospital NHS Trust (14)	n/a	n/a	n/a	7,157	788,220	0.9%
Portsmouth Hospitals NHS Trust	159	(14,877)	159	148	440,231	0.0%
South Central Ambulance Service NHS Trust (15)	559	602	1,383	2,049	126,570	1.6%

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Southampton University Hospitals NHS Trust (16)	13,591	6,777	2,859	(1,908)	260,534	(0.7%)
Solent NHS Trust (17)	n/a	n/a	n/a	1,863	193,935	1.0%
Winchester and Eastleigh Healthcare NHS Trust (18)	286	224	147	n/a	n/a	n/a
South Central subtotal trusts	**17,537**	**(6,530)**	**7,906**	**12,216**	**2,189,829**	**0.6%**

Trust name	2008/09 Annual accounts surplus/ (deficit) £000s	2009/10 Annual accounts surplus/ (operating deficit) £000s	2010/11 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts surplus/ (operating deficit) £000s	2011/12 Annual accounts turnover £000s	2011/12 Annual accounts surplus/ (operating deficit) as % turnover
Avon and Wiltshire Mental Health Partnership NHS Trust	1,827	1,113	3,219	3,541	192,190	1.8%
Cornwall Partnership NHS Trust (19)	402	1,250	n/a	n/a	n/a	n/a
Devon Partnership NHS Trust	1,298	209	616	789	140,003	0.6%
Great Western Ambulance Service NHS Trust	5	94	849	404	89,727	0.5%
North Bristol NHS Trust	3,036	6,177	7,888	9,002	519,430	1.7%
Northern Devon Healthcare NHS Trust	7,902	0	252	1,719	211,041	0.8%
Plymouth Hospitals NHS Trust	5,023	2,010	18	15	391,862	0.0%
Royal Cornwall Hospitals NHS Trust	2,009	8,349	7,544	4,437	314,246	1.4%
Royal United Hospital Bath NHS Trust	5,600	5,800	4,195	6,215	223,678	2.8%
Somerset Partnership NHS and Social Care NHS Trust (20)	94	n/a	n/a	n/a	n/a	n/a
South Western Ambulance Service NHS Trust (21)	325	511	890	n/a	n/a	n/a
Swindon and Marlborough NHS Trust (22)	1,274	n/a	n/a	n/a	n/a	n/a
United Bristol Healthcare NHS Trust (23)	3,706	n/a	n/a	n/a	n/a	n/a
Weston Area Health NHS Trust	408	2,448	2,607	3,610	95,306	3.8%
South West subtotal trusts	**32,909**	**27,961**	**28,078**	**29,732**	**2,177,483**	**1.4%**
NHS South of England total trusts	**99,815**	**58,337**	**52,275**	**45,990**	**6,992,499**	**0.7%**

Please note, Buckinghamshire PCT and Oxfordshire PCT are currently based on 2011/12 draft accounts.

For foundation trusts the forecast position is only for the time when the organisation was an NHS trust

1 Milton Keynes PCT is being reported under the East Midlands SHA region from 1 April 2011.

2 Ashford and St Peter's Hospitals NHS Trust achieved foundation trust status on 1 December 2010.

3 East Kent Hospitals University NHS Trust achieved foundation trust status on 1 March 2009.

4 East Sussex Hospitals NHS Trust (RXC) became East Sussex Healthcare NHS Trust on 1 April 2011.

5 Kent Community Health NHS Trust (RYY) was established as an NHS trust on 1 November 2010 as Eastern and Coastal Kent Community Health NHS Trust, taking on the provider services of Eastern and Coastal Kent PCT, and changed its name on 1 April 2011, after taking on the provider services of West Kent PCT.

6 Royal Surrey County Hospital NHS Trust achieved foundation trust status on 1 December 2009.

7 South East Coast Ambulance Service NHS Trust achieved foundation trust status on 1 March 2011.

8 Surrey and Borders Partnership NHS Trust achieved foundation trust status on 1 May 2008. It was forecasting a technical deficit relating to a phasing issue in the months before it became a foundation trust.

9 Sussex Community NHS Trust (RDR) was formerly South Downs Health NHS Trust, and changed its name on 1 October 2010.

10 Sussex Partnership NHS Trust achieved foundation trust status on 1 August 2008.

11 Western Sussex Hospitals NHS Trust was formed from the merger of Royal West Sussex NHS Trust (RPR) and Worthing and Southlands Hospitals NHS Trust (RPL).

12 Buckinghamshire Healthcare NHS Trust (RXQ) was formerly Buckinghamshire Hospitals NHS Trust. The name change was effective from 1 November 2010.

13 Hampshire Partnership NHS Trust achieved foundation trust status on 1 April 2009.

14 Oxford University Hospitals NHS Trust (RTH) was formed from the merger of Nuffield Orthopaedic NHS Trust (RB1) and Oxford Radcliffe Hospitals NHS Trust (RTH) on 1 November 2011.

15 South Central Ambulance Service NHS Trust achieved foundation trust status on 1 March 2012.

16 Southampton University Hospitals NHS Trust achieved foundation trust status on 1 October 2011. The deficit is a technical deficit due to a phasing issue in the months before it became a foundation trust.

17 The integration of PCT provider functions, part of NHS Southampton and NHS Portsmouth's provider arm services, created a new community services and mental health provider, Solent NHS Trust in 1 April 2011, which is operating as a direct provider organisation under NHS Southampton City.

18 Winchester and Eastleigh Healthcare NHS Trust merged with Basingstoke and North Hampshire NHS Foundation Trust (RN5), on 9 January 2012. As a result of this merger, Basingstoke and North Hampshire have changed their name to Hampshire Hospitals NHS Foundation Trust.

19 Cornwall Partnership NHS Trust achieved foundation trust status on 1 March 2010.

20 Somerset Partnership NHS and Social Care NHS Trust achieved foundation trust status on 1 May 2008.

21 South Western Ambulance Service NHS Trust achieved foundation trust status on 1 March 2011.

22 Swindon and Marlborough NHS Trust achieved foundation trust status on 1 December 2008.

23 United Bristol Healthcare NHS Trust achieved foundation trust status on 1 June 2008.

In addition to the operating deficits in 2011/12 shown above, the following organisation(s) also reported a technical deficit (£m) in the same period. A technical deficit is a deficit arising due to:
a) impairments, or
b) incurring additional revenue charges associated with bringing PFI assets on the balance sheet due to the introduction of IFRS accounting in 2009/10.
c) the impact of the change in accounting for donated assets and government grant reserves.
This is not recognised for NHS budgeting purposes.

Brighton and Sussex University Hospitals NHS Trust (£16m)
Dartford and Gravesham NHS Trust (£1m)
East Sussex Healthcare NHS Trust (£0.4m)
Great Western Ambulance Service NHS Trust (£1m)
Maidstone and Tunbridge Wells NHS Trust (£27m)
North Bristol NHS Trust (£73m)
Northern Devon Healthcare NHS Trust (£6m)
Oxford Learning Disability NHS Trust (£0.8m)
Plymouth Hospitals NHS Trust (£3m)
Surrey and Sussex Healthcare NHS Trust (£0.1m)
University Hospital Southampton NHS Foundation Trust (£2m)
Weston Area Health NHS Trust (£2m)

Note: SHA and PCT turnover equals the Revenue Resource Limit (RRL) they are allocated. Trust turnover is the total income they receive including income from PCTs. Trust income should therefore be excluded from any aggregation of SHA economy turnover to avoid double counting resources.

NHS Q4 Performance Framework results

The Q4 2011/12 Performance Framework results reveal that Finance performance has improved since the previous quarter. However, since the last quarter performance has worsened on Quality of Services.

The Q4 Finance results reveal that nationally, there are 60 trusts 'Performing' (53 acute trusts and all seven ambulance trusts), two acute trusts 'Performance under review', and four acute trusts 'Underperforming'.

Figure 1 – Comparison of acute & ambulance trusts Q3 2011/12 and Q4 2011/12 finance results by category

Finance					
Q3 2011/12				Q4 2011/12	
Performing:	54			Performing:	60
Performance Under Review:	8			Performance Under Review:	2
Underperforming	6			Underperforming	4
Challenged:	6			Challenged:	6
Total:	74			Total:	72

The Q4 Quality of Service results reveal that there are 39 trusts 'Performing' (32 acute trusts and all seven ambulance trusts), 15 acute trusts 'Performance under review', and 14 acute trusts 'Underperforming'.

Figure 2 – Comparison of acute & ambulance trusts Q3 2011/12 and Q4 2011/12 quality of service results by category

Quality of services					
Q3 2011/12				Q4 2011/12	
Performing:	49			Performing:	39
Performance Under Review:	9			Performance Under Review:	15
Underperforming	12			Underperforming	14
Challenged:	4			Challenged:	4
Total:	74			Total:	72

The six trusts 'Challenged' on Finance are:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Imperial College Healthcare NHS Trust
- North West London Hospitals NHS Trust
- South London Healthcare NHS Trust
- West Middlesex University Hospital NHS Trust

The four trusts 'Challenged' on Quality of Services are:

- East Sussex Healthcare NHS Trust
- Imperial College Healthcare NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Surrey and Sussex Healthcare NHS Trusts

Based on indicators underpinning the Performance Framework, organisations will be categorised as Performing, Performance under review, Underperforming, or Challenged:

- Performance under review describes an organisation with minor concerns.
- Underperforming refers to an organisation with more serious performance issues.
- Challenged is used to signify organisations that have had serious ongoing performance concerns for an extended period of time.

Organisations are not allowed to remain in a poor performance category indefinitely – they must take steps to improve within a realistic timeframe. Being in one category for three consecutive quarters will relegate a trust to the category below.

Figure 3 – Comparison of mental health trusts Q2 2011/12 and Q3 2011/12 finance results by category

Finance					
Q2 2011/12			**Q3 2011/12**		
Performing:	13		Performing:	13	
Performance Under Review:	0		Performance Under Review:	0	
Underperforming	0		Underperforming	0	
Challenged:	0		Challenged:	0	
Total:	13		Total:	13	

Figure 4 – Comparison of mental health trusts Q2 2011/12 and Q3 2011/12 quality of service results by category

Quality of services					
Q2 2011/12			**Q3 2011/12**		
Performing:	11		Performing:	11	
Performance Under Review:	2		Performance Under Review:	2	
Underperforming	0		Underperforming	0	
Challenged:	0		Challenged:	0	
Total:	13		Total:	13	

Q3 mental health trust results show that currently all non-FT mental health trusts in England are 'Performing' on Finance. On Quality of services, there are 11 trusts 'Performing', and two trusts 'Performance under review'.

Annex 5

Q4 NHS Performance Framework acute trust results

			Performance rating after escalation				Quality: standards & integrated performance measures		Quality: user experience		Quality: CQC registration
Trust name	**Overall finance score**	**Overall quality of services score**	**Finance**		**Quality of services**		**Score**	**Rating**	**Score**	**Rating**	**Rating**
Barking, Havering and Redbridge University Hospitals NHS Trust	Underperforming	Performance under review	Escalated	Challenged			2.32	Performance under review	0	Underperforming	Performance under review
Barnet and Chase Farm Hospitals NHS Trust	Performing	Performing					2.64	Performing	5	Performing	Performing
Barts and the London NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.30	Performance under review	2	Performance under review	Performing
Bedford Hospital NHS Trust	Performing	Performing					2.71	Performing	5	Performing	Performing
Brighton and Sussex University Hospitals NHS Trust	Performing	Performance under review					2.91	Performing	0	Underperforming	Performing
Buckinghamshire Healthcare NHS Trust	Performing	Performing					2.71	Performing	5	Performing	Performing
Croydon Health Services NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.70	Performing	0	Underperforming	Performing
Dartford and Gravesham NHS Trust	Performing	Performance under review					2.27	Performance under review	0	Underperforming	Performing
Ealing Hospital NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.69	Performing	0	Underperforming	Performing
East and North Hertfordshire NHS Trust	Performing	Performance under review					2.71	Performing	1	Underperforming	Performing
East Cheshire NHS Trust	Performing	Performing					2.85	Performing	5	Performing	Performing
East Lancashire Hospitals NHS Trust	Performing	Performing					2.78	Performing	5	Performing	Performing
East Sussex Healthcare NHS Trust	Performing	Underperforming			Escalated	Challenged	2.09	Underperforming	5	Performing	Performing
Epsom and St Helier University Hospitals NHS Trust	Underperforming	Performing	Escalated	Challenged			2.76	Performing	5	Performing	Performing
George Eliot Hospital NHS Trust	Performing	Performing					2.71	Performing	3	Performance under review	Performing
Hinchingbrooke Health Care NHS Trust	Underperforming	Performance under review					2.40	Performance under review	5	Performing	Performing
Hull and East Yorkshire Hospitals NHS Trust	Performing	Performing					2.50	Performing	5	Performing	Performing
Imperial College Healthcare NHS Trust	Underperforming	Underperforming	Escalated	Challenged	Escalated	Challenged	1.21	Underperforming	5	Performing	Performing
Ipswich Hospital NHS Trust	Performing	Performing					2.93	Performing	5	Performing	Performing

Key: Performing | Performance under review | Underperforming | Escalated | Challenged

			Performance rating after escalation				Quality: standards & integrated performance measures		Quality: user experience		Quality: CQC registration
Trust name	**Overall finance score**	**Overall quality of services score**	**Finance**		**Quality of services**		**Score**	**Rating**	**Score**	**Rating**	**Rating**
Isle of Wight NHS PCT	Performing	Performance under review			Escalated	Underperforming	2.37	Performance under review	5	Performing	Performing
Kingston Hospital NHS Trust	Performing	Performance under review					2.33	Performance under review	4	Performing	Performing
Leeds Teaching Hospitals NHS Trust	Performing	Performing					2.45	Performing	5	Performing	Performing
Lewisham Healthcare NHS Trust	Performing	Performing					2.85	Performing	3	Performance under review	Performing
Maidstone and Tunbridge Wells NHS Trust	Performing	Performance under review					2.34	Performance under review	4	Performing	Performing
Mid Essex Hospital Services NHS Trust	Underperforming	Performance under review					2.56	Performing	5	Performing	Performance under review
Mid Yorkshire Hospitals NHS Trust	Underperforming	Underperforming			Escalated	Challenged	1.62	Underperforming	5	Performing	Performing
Newham University Hospital NHS Trust	Underperforming	Performing					2.70	Performing	2	Performance under review	Performing
North Bristol NHS Trust	Performing	Underperforming					1.89	Underperforming	5	Performing	Performing
North Cumbria University Hospitals NHS Trust	Performing	Performing					2.48	Performing	5	Performing	Performing
North Middlesex University Hospital NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.96	Performing	1	Underperforming	Performing
North West London Hospitals NHS Trust	Underperforming	Underperforming	Escalated	Challenged			2.02	Underperforming	0	Underperforming	Performing
Northampton General Hospital NHS Trust	Performing	Performing					2.50	Performing	5	Performing	Performing
Northern Devon Healthcare NHS Trust	Performing	Performing					2.62	Performing	5	Performing	Performing
Nottingham University Hospitals NHS Trust	Performing	Performing					2.59	Performing	5	Performing	Performing
Oxford University Hospitals NHS Trust	Performing	Underperforming					2.07	Underperforming	5	Performing	Performing
Pennine Acute Hospitals NHS Trust	Performing	Performing					2.87	Performing	5	Performing	Performing
Plymouth Hospitals NHS Trust	Performing	Performance under review					2.36	Performance under review	5	Performing	Performing
Portsmouth Hospitals NHS Trust	Performing	Performance under review					2.39	Performance under review	5	Performing	Performing
Royal Cornwall Hospitals NHS Trust	Performing	Performing					2.86	Performing	5	Performing	Performing
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Performing	Performing					3.00	Performing	5	Performing	Performing

Key: Performing Performance under review Underperforming Escalated Challenged

			Performance rating after escalation				Quality: standards & integrated performance measures		Quality: user experience		Quality: CQC registration
Trust name	**Overall finance score**	**Overall quality of services score**	**Finance**		**Quality of services**		**Score**	**Rating**	**Score**	**Rating**	**Rating**
Royal National Orthopaedic Hospital NHS Trust	Performing	Performing					2.50	Performing	5	Performing	Performing
Royal United Hospital Bath NHS Trust	Performing	Performing					2.93	Performing	4	Performing	Performing
Sandwell and West Birmingham Hospitals NHS Trust	Performing	Performing					2.93	Performing	5	Performing	Performing
Scarborough and North East Yorkshire Health Care NHS Trust	Performing	Performing					2.71	Performing	5	Performing	Performing
Shrewsbury and Telford Hospital NHS Trust	Performing	Underperforming					1.86	Underperforming	5	Performing	Performing
South London Healthcare NHS Trust	Underperforming	Performance under review	Escalated	Challenged			2.21	Performance under review	2	Performance under review	Performing
Southport and Ormskirk Hospital NHS Trust	Performing	Performance under review					2.85	Performing	5	Performing	Performance under review
St George's Healthcare NHS Trust	Performing	Performance under review					2.20	Performance under review	5	Performing	Performing
St Helens and Knowsley Hospitals NHS Trust	Performing	Performing					3.00	Performing	5	Performing	Performing
Surrey and Sussex Healthcare NHS Trust	Performance under review	Underperforming			Escalated	Challenged	1.98	Underperforming	0	Underperforming	Performing
The Princess Alexandra Hospital NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.33	Performance under review	1	Underperforming	Performing
The Royal Wolverhampton Hospitals NHS Trust	Performing	Performing					2.64	Performing	5	Performing	Performing
The Whittington Hospital NHS Trust	Performing	Performing					3.00	Performing	4	Performing	Performing
United Lincolnshire Hospitals NHS Trust	Performing	Performance under review					2.13	Performance under review	4	Performing	Performing
University Hospital of North Staffordshire NHS Trust	Performing	Performing					2.50	Performing	5	Performing	Performing
University Hospitals Coventry and Warwickshire NHS Trust	Performing	Performing					2.64	Performing	5	Performing	Performing
University Hospitals of Leicester NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.21	Performance under review	4	Performing	Performing
Walsall Healthcare NHS Trust	Performing	Performing					2.71	Performing	5	Performing	Performing
West Hertfordshire Hospitals NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.25	Performance under review	5	Performing	Performing
West Middlesex University Hospital NHS Trust	Underperforming	Performance under review	Escalated	Challenged			2.70	Performing	1	Underperforming	Performing

Key: Performing Performance under review Underperforming Escalated Challenged

			Performance rating after escalation				Quality: standards & integrated performance measures		Quality: user experience		Quality: CQC registration
Trust name	**Overall finance score**	**Overall quality of services score**	**Finance**		**Quality of services**		**Score**	**Rating**	**Score**	**Rating**	**Rating**
Western Sussex Hospitals NHS Trust	Performing	Performing					3.00	Performing	5	Performing	Performing
Weston Area Health NHS Trust	Performing	Performing					2.42	Performing	4	Performing	Performing
Whipps Cross University Hospital NHS Trust	Performance under review	Performance under review			Escalated	Underperforming	2.20	Performance under review	1	Underperforming	Performing
Worcestershire Acute Hospitals NHS Trust	Performing	Performing					2.60	Performing	5	Performing	Performing
Wye Valley NHS Trust	Performing	Performance under review			Escalated	Underperforming	2.38	Performance under review	3	Performance under review	Performing
Key: Performing Performance under review Underperforming Escalated Challenged											

1 Please note that the Isle of Wight score includes performance from the ambulance providers and where stated commissioner elements.
2 Score moderated. Where patient experience score is underperforming, the highest score a trust can achieve is performance under review.
3 If a trust has been assessed as 'performance under review' for 3 consecutive quarters, it will be categorised here as 'underperforming'. If a trust has been assessed as 'underperforming' for 3 consecutive quarters, it will be categorised here as 'challenged'. In addition, independent over-riding rules may be used to categorise a trust as 'challenged' or 'underperforming'.

Annex 6

Q4 NHS Performance Framework ambulance trusts results

			Escalation statuses[1]				Quality: standards & integrated performance measures		Quality: registration
Trust name	**Overall finance score**	**Overall quality score[1]**	**Financial escalation status**		**Quality of services escalation status**		**Score**	**Rating**	**Rating**
East Midlands Ambulance Service NHS Trust	Performing	Performing					2.50	Performing	Performing
East of England Ambulance Service NHS Trust	Performing	Performing					2.50	Performing	Performing
Great Western Ambulance Service NHS Trust	Performing	Performing					3.00	Performing	Performing
London Ambulance Service	Performing	Performing					3.00	Performing	Performing
North West Ambulance Service NHS Trust	Performing	Performing					2.50	Performing	Performing
West Midlands Ambulance Service NHS Trust	Performing	Performing					3.00	Performing	Performing
Yorkshire Ambulance Service NHS Trust	Performing	Performing					3.00	Performing	Performing
Key: Performing Performance under review Underperforming Escalated Challenged									

1 If a trust has been assessed as 'performance under review' for 3 consecutive quarters, it will be categorised here as 'underperforming', if a trust has been assessed as 'underperforming' for 3 consecutive quarters, it will be categorised here as 'challenged'. In addition, independent over-riding rules may be used to categorise a trust as challenged or underperforming.

Annex 7

Q3 NHS Performance Framework mental health trusts results

			Escalation statuses[1]				Quality: standards & vital signs		Quality: user experience		Quality: registration
Trust name	**Overall finance score**	**Overall quality score[1]**	**Financial escalation status**		**Quality of services escalation status**		**Score**	**Rating**	**Score**	**Rating**	**Rating**
Avon and Wiltshire Mental Health Partnership NHS Trust	Performing	Performing					2.18	Performing	4	Performing	Performing
Barnet, Enfield and Haringey Mental Health NHS Trust	Performing	Performance under review					1.55	Performance under review	4	Performing	Performing
Bradford District Care Trust	Performing	Performing					2.55	Performing	4	Performing	Performing
Coventry and Warwickshire Partnership NHS Trust	Performing	Performing					2.60	Performing	2	Performance under review	Performing
Devon Partnership NHS Trust	Performing	Performing					2.45	Performing	2	Performance under review	Performing
Dudley and Walsall Mental Health Partnership NHS Trust	Performing	Performing					2.18	Performing	4	Performing	Performing
Kent and Medway NHS and Social Care Partnership Trust	Performing	Performance under review					1.90	Performance under review	1	Underperforming	Performing
Leicestershire Partnership NHS Trust	Performing	Performing					2.91	Performing	3	Performance under review	Performing
Manchester Mental Health and Social Care Trust	Performing	Performing					2.50	Performing	4	Performing	Performing
Mersey Care NHS Trust	Performing	Performing					2.45	Performing	4	Performing	Performing
North Staffordshire Combined Healthcare NHS Trust	Performing	Performing					2.73	Performing	4	Performing	Performing
South West London and St George's Mental Health NHS Trust	Performing	Performing					2.91	Performing	2	Performance under review	Performing
West London Mental Health NHS Trust	Performing	Performing					2.80	Performing	3	Performance under review	Performing

Key: Performing Performance under review Underperforming Escalated Challenged

1 Score moderated where patient experience score is underperforming - in this case highest score trust can achieve is performance under review. Otherwise the score is the lowest rating from the other domains.